

Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy

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INTRODUCTION

In just twenty years, the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) produced one of the worst pandemics in history,¹ with no signs that their wrath is abating.² During this time, the United States emerged as the strongest country on earth, winning the Cold War and surpassing in power any other nation or collection of countries.³ The horrifying scale of the HIV/AIDS pandemic in the developing world, particularly sub-Saharan Africa,⁴ in conjunction with the U.S. rise to hegemonic status, have placed U.S. foreign policy toward HIV/AIDS under scrutiny.⁵ Although the HIV/AIDS pandemic reached staggering proportions before the U.S. elected George W. Bush as president, the Bush Administration has not escaped criticism stimulated by the contrast between the devastation HIV/AIDS causes in developing countries and the preponderance of U.S. global power.⁶

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1. *Report on the Global HIV/AIDS Epidemic* 2002, U.N. Programme on HIV/AIDS [UNAIDS] and WHO, 56th Sess., at 44, U.N. Doc. UNAIDS/02.26E (2002) [hereinafter UNAIDS Report].

2. *Id.* See also *AIDS Epidemic Update: December 2002*, UNAIDS and WHO, 56th Sess., at 4, U.N. Doc. UNAIDS/02.46E (2002) (noting that “[b]est . . . projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries . . . between 2002 and 2010”); Richard G. A. Feachem, *AIDS Hasn't Peaked Yet—And That's Not the Worst of It*, WASH. POST, Jan. 12, 2003, at B03 (“Horrifyingly, the worst is still to come.”).

3. PRESIDENT OF THE UNITED STATES OF AMERICA, NATIONAL SECURITY STRATEGY OF THE UNITED STATES 1 (Sept. 2002), available at <http://www.whitehouse.gov/nsc/nss.pdf> [hereinafter NATIONAL SECURITY STRATEGY] (last visited Jan. 13, 2004).

4. UNAIDS Report, *supra* note 1, at 22; UNAIDS, *supra* note 2, at 17.

5. See generally David P. Fidler, *Racism or Realpolitik? U.S. Foreign Policy and the HIV/AIDS Catastrophe in Sub-Saharan Africa*, 7 J. GENDER RACE & JUST. 97 (2003).

6. See, e.g., Jeffrey Sachs, *The World Must Set Its Own Agenda*, FIN. TIMES, Oct. 14, 2003 (criticizing the Bush Administration's fixation on the war on terrorism while “starving international initiatives on disease control”).

Discontent with U.S. foreign policy on HIV/AIDS remains high despite initiatives the Bush Administration launched as responses to the worsening pandemic.⁷ These initiatives, the most prominent being the Emergency Plan for AIDS Relief,⁸ involve significant increases in U.S. political and financial commitments to the HIV/AIDS fight. These commitments signal that the Bush Administration has made HIV/AIDS in developing countries a serious U.S. foreign policy concern. Nevertheless, discontent with the Bush Administration's handling of HIV/AIDS continues and flows from a variety of concerns, including the perceived inadequacy of U.S. financial contributions,⁹ the speed with which U.S. contributions will reach affected countries,¹⁰ the manner in which the United States has increased its commitment to fight HIV/AIDS,¹¹ the conditions imposed by the United States for use of its financial contributions,¹² and the underlying policy rationales for heightened U.S. concern with HIV/AIDS.¹³

This Article examines the Bush Administration's foreign policy approach to the HIV/AIDS pandemic and focuses on the policy rationales of this approach and the manner in which the administration seeks to achieve its objectives. Discontent with the Bush Administration's foreign policy on HIV/AIDS stems from conceptual disagreements as well as dissatisfaction with the level of U.S. financial contributions. Such disagreements often connect with the leading role international human rights law has played in the global campaign against HIV/AIDS.¹⁴ The Bush Administration's foreign policy on HIV/AIDS is not motivated by international human rights law and thus diverges from the human rights template built since the 1980s by the World Health Organization (WHO), the Joint United Nations Programme on AIDS (UNAIDS), and non-governmental organizations (NGOs) to address the HIV/AIDS pandemic. The Bush Administration has constructed, however, a foreign policy on HIV/AIDS that includes human rights ideas, which fit within an overarching neoconservative strategy on the global

7. See, e.g., *Taking AIDS Seriously*, WASH. POST, Sept. 28, 2003, at B06 (drawing attention to problems with the Bush Administration's approach to HIV/AIDS); Naomi Klein, *Bush's AIDS Test*, NATION, Oct. 27, 2003, at 12 (criticizing Bush Administration actions on HIV/AIDS since the announcement of the Emergency Plan for AIDS Relief).

8. President George W. Bush, Address Before a Joint Session of the Congress on the State of the Union, 39 WEEKLY COMP. PRES. DOC. 109, 112 (Feb. 3, 2003) (President Bush proposed the \$15 billion, five-year Emergency Plan for AIDS Relief in his State of the Union Address in January 2003).

9. Fidler, *supra* note 5, at 121–23.

10. *Taking AIDS Seriously*, *supra* note 7, at B06 (“The real problem . . . seems to lie not in Africa but in the administration's inability to distribute the money.”); Mike Allen, *Bono Recounts “Row” with President Over AIDS Funds*, WASH. POST, Sept. 17, 2003, at A03 (reporting on AIDS activists' concerns that the United States is delaying HIV/AIDS short-term funding).

11. Fidler, *supra* note 5, at 141 (discussing criticism of the unilateralism of the Emergency Plan for AIDS Relief).

12. *Pregnant Pause: How the Bush Administration's Family-Planning Policy Undermines its AIDS Promises*, ECONOMIST, Sept. 27, 2003, at 31.

13. Fidler, *supra* note 5, at 133–35 (presenting a *realpolitik* explanation of the Bush Administration's behavior on the HIV/AIDS pandemic).

14. See *infra* Part II.B.

HIV/AIDS problem. Perhaps surprisingly, the Bush Administration has articulated a unique strategic approach to HIV/AIDS to support the historic increases it has proposed for HIV/AIDS funding.

This Article argues, however, that discontent will continue in terms of the relationship between international human rights and U.S. foreign policy on HIV/AIDS. The Bush Administration's neoconservative position takes its human rights inspiration from U.S. political and constitutional traditions of protecting civil and political rights, rather than from the international human rights law animating the HIV/AIDS efforts by international organizations and NGOs. Further, the Bush Administration rejects thinking about health in terms of economic, social, and cultural rights (a key feature of UNAIDS policy) and re-conceptualizes health as dependent on the achievement of non-negotiable demands of human dignity, all of which reflect civil and political rights at the core of U.S. political and constitutional practice. Thus, the Bush Administration and the multilateral campaign against HIV/AIDS rely on divergent policy rationales. In addition, the Bush Administration's HIV/AIDS strategy relies heavily on the unilateral exercise of U.S. power as opposed to the multilateralism that characterizes global HIV/AIDS activities.

My analysis proceeds in four Parts. First, I provide background on the foreign policy challenges presented by infectious diseases generally and HIV/AIDS specifically (Part I). Second, the Article examines two historic governance responses to deal with infectious diseases and how the response to HIV/AIDS relates to these two frameworks (Part II). International human rights law heavily influenced one of these governance frameworks, and the human rights approach crafted by the multilateral campaign against HIV/AIDS adopted and advanced this framework. Third, I explore U.S. foreign policy and HIV/AIDS, beginning with an overview of U.S. foreign policy approaches to infectious diseases from the Carter to the Clinton Administrations before focusing on the Bush Administration's strategy toward the HIV/AIDS pandemic (Part III). Fourth, the Article analyzes two dilemmas—the hegemony and human rights dilemmas—that reveal the difficulties and dangers of attempting to confront HIV/AIDS specifically and infectious disease threats generally in a unipolar world (Part IV).

I. THE AXIS OF ILLNESS AND THE HIV/AIDS PANDEMIC

A. *Infectious Diseases as a Foreign Policy Problem*

The HIV/AIDS pandemic is a disturbing example of the foreign policy problem created by “emerging infectious diseases,” defined as “diseases of infectious origin whose incidence in humans has increased within the past two decades or threatens to increase in the near future.”¹⁵ Emerging infectious diseases became a significant public health issue during the 1990s, as evi-

15. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, ADDRESSING EMERGING INFECTIOUS DISEASE THREATS: A PREVENTION STRATEGY FOR THE UNITED STATES 1 (1994).

denced by the WHO's warning in 1996 that the world confronted a crisis in the resurgence of infectious diseases.¹⁶ Concern about emerging infectious diseases did not remain confined to public health because this threat became a foreign policy and national security topic for the United States during the Clinton Administration.¹⁷ The Central Intelligence Agency's issuance in 2000 of a national intelligence estimate on the danger infectious diseases posed to U.S. national interests, foreign policy, and national security symbolized the elevation of infectious diseases to a matter of "high politics" in international relations.¹⁸

Although emerging infectious diseases involve more than HIV/AIDS,¹⁹ this virus and disease helped transform public health from an obscure, neglected area of diplomacy into a U.S. foreign policy and national security concern. During the 1990s, the HIV/AIDS pandemic grew to horrifying proportions in the developing world, with sub-Saharan Africa suffering most.²⁰ Significant morbidity and mortality from other infectious diseases, such as malaria and tuberculosis, also grew during the 1990s and early 2000s,²¹ but HIV/AIDS became a profound public health menace, rivaling some of the greatest plagues in history.

HIV/AIDS' emergence to such proportions in less than two decades provides a disturbing perspective on the foreign policy challenge emerging infectious diseases pose. To design a foreign policy response, countries have to understand the problem they face. Leading analyses of emerging infectious diseases list many factors that contribute to disease emergence and spread. In 1992, the Institute of Medicine produced a seminal analysis of the threat of emerging infectious diseases.²² It identified six factors behind the emergence and spread of pathogenic microbes: human demographics and behavior; technology and industry; economic development and land use; international travel and commerce; microbial adaptation and change; and breakdown of public

16. WHO, *THE WORLD HEALTH REPORT 1996: FIGHTING DISEASE, FOSTERING DEVELOPMENT* 105 (1996).

17. *See, e.g.*, COMMITTEE ON INTERNATIONAL SCIENCE, ENGINEERING, & TECHNOLOGY WORKING GROUP ON EMERGING & RE-EMERGING INFECTIOUS DISEASES, NATIONAL SCIENCE & TECHNOLOGY COUNCIL, *INFECTIOUS DISEASES: A GLOBAL HEALTH THREAT* (1995) [hereinafter CISET REPORT] (Clinton Administration interagency working group's report on the threat infectious diseases pose to U.S. foreign policy and national security).

18. NATIONAL INTELLIGENCE COUNCIL, *THE GLOBAL INFECTIOUS DISEASE THREAT AND ITS IMPLICATIONS FOR THE UNITED STATES* (2000), at <http://www.cia.gov/nic/graphics/infectiousdiseases.pdf> (last visited Oct. 6, 2003).

19. *See, e.g.*, COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH IN THE 21ST CENTURY, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *MICROBIAL THREATS TO HEALTH: EMERGENCE, DETECTION, AND RESPONSE* 23–51 (Mark S. Smolinski, Joshua Lederberg & Margaret Hamburg eds., 2003) [hereinafter INSTITUTE OF MEDICINE 2003] (analyzing microbial threats facing the United States).

20. UNAIDS, *20 Years of AIDS*, June 2001 (on file with author).

21. INSTITUTE OF MEDICINE 2003, *supra* note 19, at 29–32.

22. COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH, INSTITUTE OF MEDICINE, *EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE UNITED STATES* (Joshua Lederberg et al. eds., 1992) [hereinafter INSTITUTE OF MEDICINE 1992].

health measures.²³ Eleven years later, the Institute of Medicine released another report, *Microbial Threats to Health*,²⁴ which added seven more factors to the six identified in 1992: human susceptibility to infection; climate and weather; changing ecosystems; poverty and social inequality; war and famine; lack of political will; and intent to harm.²⁵

Comprehensive analysis of these factors is beyond this Article's scope, but the identification of multiple factors communicates the complexity of the policy task of confronting emerging infectious diseases. The number and diversity of the factors make simple responses inadequate. Long lists of factors make organizing policy on this problem difficult. The next Section develops the "axis of illness"²⁶ as one way to organize the factors into categories in order to locate areas for policy intervention. This approach is important for understanding how and why human rights concepts enter into foreign policy strategies against infectious diseases generally and HIV/AIDS specifically.

B. *The Axis of Illness*

President Bush announced a new strategic doctrine for achieving U.S. national security against what he called the "axis of evil."²⁷ Putting rhetoric to one side, the Bush Administration constructed the axis of evil to identify the most important threats to U.S. national security in the post-September 11 period: the interdependence of repressive regimes, weapons of mass destruction, and international terrorism.²⁸ The axis of evil produces a strategic doctrine to guide the application of U.S. power. Among other things, the axis of evil raised the importance of public health in U.S. foreign and national security policy. The threat of terrorism conducted with weapons of mass destruction prompted the United States to improve public health and health care capabilities.²⁹ The bioterrorism threat in particular raised the national and homeland security importance of the U.S. public health system, a situation this system has never before experienced. Improvements in U.S. public health through bioterrorism preparedness flow from the threats identified by the axis of evil.

23. *Id.* at 34–112.

24. INSTITUTE OF MEDICINE 2003, *supra* note 19.

25. *Id.* at 53–147.

26. I have also applied this concept in DAVID P. FIDLER, SARS, GOVERNANCE, AND THE GLOBALIZATION OF DISEASE 180–85 (2004) (forthcoming) and David P. Fidler, *Caught Between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness*, MCGEORGE L. REV. (2003) (forthcoming).

27. President George W. Bush, Address Before a Joint Session of Congress on the State of the Union, 38 WEEKLY COMP. PRES. DOC. 133, 135 (Feb. 4, 2002).

28. *Id.* The "axis of evil" is commonly understood to refer to Iraq, Iran, and North Korea, because President Bush singled out these three states by name in his speech. My analysis focuses on the substantive policy reasons why the President identified these three states as threats to U.S. national security.

29. NATIONAL SECURITY STRATEGY, *supra* note 3, at 6; OFFICE OF HOMELAND SECURITY, NATIONAL STRATEGY FOR HOMELAND SECURITY 43 (2002), available at http://www.whitehouse.gov/homeland/book/nat_strat_hls.pdf (last visited Jan. 13, 2004).

The construction of a strategic doctrine for emerging infectious diseases might not be possible given the complexity of this phenomenon. The “axis of illness” identifies factors of central policy relevance for dealing with emerging infectious diseases. The axis of illness contains five interdependent components, each of which I explain and illustrate with examples from HIV/AIDS. The first component is microbial resilience. Literature on emerging infectious diseases stresses the microbial world’s evolutionary and adaptive powers.³⁰ HIV/AIDS exemplifies microbial resilience because it involves a retrovirus never identified in human populations before the early 1980s, evades and compromises the immune system,³¹ is difficult to control with antiretroviral treatments,³² has developed resistance to such treatments,³³ and has so far stymied efforts to develop vaccines.³⁴

The next two components of the axis of illness amplify microbial transmission—human mobility and social determinants of health. The history of infectious diseases is, in many ways, the history of human mobility. Human mobility includes the spread of disease vectors, such as rats and mosquitoes, that travel where humans travel. HIV/AIDS became a pandemic because of humanity’s mobility; global travel brought people infected with HIV/AIDS to unaffected regions, and these carriers seeded new epidemics.³⁵ Regional and local mobility patterns, such as labor migration and commercial travel, contributed to the spread of HIV/AIDS within and among countries.³⁶ The combination of HIV’s microbial resilience and human mobility has proved devastating from the local to the global level.

Human mobility and microbial resilience might not make such a dynamic duo but for adverse social determinants of health. Infectious disease spread involves behavioral, social, and environmental factors that shape a population’s susceptibility to infection.³⁷ Many factors identified by the In-

30. INSTITUTE OF MEDICINE 1992, *supra* note 22, at 84 (noting that “[t]he ability to adapt is required for the successful competition and evolutionary survival of any microbial form, but it is particularly crucial for pathogens, which must cope with host defenses as well as microbial competition”). A recent example of microbial resilience was the emergence of the new coronavirus responsible for the global outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003. Experts believe that the SARS coronavirus (SARS-CoV) spread from animals to humans in Guangdong Province, China, before or during November 2002. See Robert F. Breiman et al., *Role of China in the Quest to Define and Control Severe Acute Respiratory Syndrome*, 9 EMERGING INFECTIOUS DISEASES 1073 (2003). WHO epidemiologist Klaus Stöhr described SARS-CoV as “unlike any known human or animal member of this virus family.” WHO, Severe Acute Respiratory Syndrome (SARS) Multi-Country Outbreak, Update 12, Mar. 27, 2003, at http://www.who.int/csr/sars/archive/2003_03_27b/en/ (last visited Oct. 6, 2003).

31. ROBERT GALLO, *VIRUS HUNTING: AIDS, CANCER, & THE HUMAN RETROVIRUS* (1991).

32. INSTITUTE OF MEDICINE 2003, *supra* note 19, at 198.

33. *Id.* at 201.

34. *Id.* at 198.

35. *Id.* at 97.

36. UNAIDS Report, *supra* note 1, at 114.

37. INT’L FED’N OF RED CROSS AND RED CRESCENT SOCIETIES AND FRANÇOIS-XAVIER BAGNOUD CTR. FOR HEALTH AND HUMAN RIGHTS, *Public Health: An Introduction*, in HEALTH AND HUMAN RIGHTS 29, 34 (J. M. Mann et al. eds., 1999) (“Public health . . . includes efforts to ensure societal opportunities (such as education), a healthful environment (including housing, nutrition, and workplace safety) and prevention of threats to mental or social well-being (such as violence or persecution).”); see also INSTITUTE

stitute of Medicine in 2003 are social determinants of health, including poverty and social inequalities, war and famine, human demographics and behavior, technology and industry, and environmental degradation.³⁸ Social determinants of health result in the recognition “that many of the best allies of pestilence arise from a lack of determination to confront poverty, urbanization, environmental degradation, the collapse of public health systems, and other man-made causes of infectious diseases.”³⁹ HIV/AIDS illustrates the importance of social determinants of health in disease emergence and spread. For example, HIV/AIDS has become a “disease of poverty” globally because the vast majority of infections arise in developing countries, with one of the poorest regions, sub-Saharan Africa, suffering most.⁴⁰ The spread of HIV/AIDS through sexual intercourse and intravenous drug use also reveals the key role social determinants of health play in this pandemic.⁴¹

The triple threat of microbial resilience, human mobility, and the susceptibility of human populations to infection interact with the fourth factor: globalization. Globalization amplifies the effect of human mobility and social determinants of health by increasing human interconnectedness.⁴² Globalization’s multiplier effect also affects social determinants of health. Globalization, particularly in the economic realm, often exacerbates social ills that render populations susceptible to pathogenic microbes.⁴³ Globalization brings populations into greater contact with microbial threats while accelerating social and economic processes, such as urbanization and environmental degradation, which provide microbes with fertile conditions for human-to-human transmission. The connection between the spread of HIV/AIDS and globalization is important in this pandemic’s story. Jennifer Brower and Peter Chalk argued, for example, that “[o]ne disease that has certainly reached pandemic proportions at least partly as a result of globalization and the international movement of goods and people is AIDS.”⁴⁴ Globalization also

OF MEDICINE, *THE FUTURE OF THE PUBLIC’S HEALTH IN THE 21ST CENTURY* 56–71 (2003) [hereinafter *THE FUTURE OF THE PUBLIC’S HEALTH*].

38. INSTITUTE OF MEDICINE 2003, *supra* note 19, at 54.

39. David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 868 (1997).

40. UNAIDS Report, *supra* note 1, at 34 (indicating that approximately 70% of the estimated number of HIV/AIDS cases in the world are in sub-Saharan Africa).

41. INSTITUTE OF MEDICINE 1992, *supra* note 22, at 54–57.

42. JENNIFER BROWER & PETER CHALK, *THE GLOBAL THREAT OF NEW AND REEMERGING INFECTIOUS DISEASES: RECONCILING U.S. NATIONAL SECURITY AND PUBLIC HEALTH POLICY* 14 (2003) [hereinafter *BROWER & CHALK*] (putting “the number of people crossing international frontiers on board commercial flights at more than 500 million every year”).

43. David Sanders & Mickey Chopra, *Globalization and the Challenge of Health for All: A View From Sub-Saharan Africa*, in *HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE* 105, 118 (K. Lee ed., 2003) (arguing “that the forces of globalization . . . have had continuing negative impacts on poor families and on their social safety net, including basic health care. Additionally, contemporary instruments of globalization, such as TRIPS and GATS, threaten to further undermine the capacity of poor governments to adequately serve the social and health needs of the majority of their populations.”).

44. BROWER & CHALK, *supra* note 42, at 16.

connects with social determinants of health, such as rural-to-urban migration, that stimulate the spread of HIV in cities and rural areas.⁴⁵

The fifth component of the axis of illness focuses on policy and governance problems that arise in confronting infectious diseases. Responding to pathogenic threats represents a collective action challenge at domestic and international levels. Domestically, governments must organize, fund, and sustain public health capabilities, such as surveillance, to control infectious diseases.⁴⁶ The breakdown of national public health systems is a factor in disease emergence and spread.⁴⁷ Repairing such breakdowns is a collective action problem within states. Internationally, infectious disease control represents a collective action problem that arises within the context of anarchy.⁴⁸ The mantra that “germs do not recognize borders” means no state can, on its own, deal with pathogenic threats. International cooperation is required to create surveillance, response, and prevention strategies.⁴⁹ Governance among sovereign states for purposes of infectious disease control is therefore a collective political task of vital importance.⁵⁰

The HIV/AIDS pandemic illustrates why collective action problems form part of the axis of illness. The pandemic’s penetration of populations across the world reveals the failure of national governments to confront this microbial threat.⁵¹ Denial of the threat fueled the disease’s rampage locally, nationally, and globally. In terms of international collective action, lamentations about the inadequacy of the international response to HIV/AIDS have frequently been voiced, including at the September 2003 Special Session of the U.N. General Assembly devoted to reviewing the global response to the HIV/AIDS pandemic.⁵²

The executive director of UNAIDS, Peter Piot, captured the frustration with international collective action when he asserted in 2002 that “[t]he world stood by while AIDS overwhelmed sub-Saharan Africa.”⁵³ In Septem-

45. INSTITUTE OF MEDICINE 2003, *supra* note 19, at 83.

46. *Id.* at 9 (“Strong and well-functioning local, state, and federal public health agencies working together represent the backbone of an effective response to infectious diseases.”).

47. INSTITUTE OF MEDICINE 1992, *supra* note 22, at 106–12; *see also* INSTITUTE OF MEDICINE 2003, *supra* note 19, at 107–21.

48. *See* David P. Fidler, *Disease and Globalized Anarchy: Theoretical Perspectives on the Pursuit of Public Health*, 1 *SOCIAL THEORY & HEALTH* 21 (2003).

49. *See* INSTITUTE OF MEDICINE 2003, *supra* note 19, at 149–59.

50. Ilona Kickbusch, *Global Health Governance: Some Theoretical Considerations on the New Political Space*, in *HEALTH IMPACTS OF GLOBALIZATION*, *supra* note 43, at 192, 202.

51. ANDREW T. PRICE-SMITH, *THE HEALTH OF NATIONS: INFECTIOUS DISEASE, ENVIRONMENTAL CHANGE, AND THEIR EFFECTS ON NATIONAL SECURITY AND DEVELOPMENT* 136 (2002) (“In the case of states such as South Africa and Zimbabwe, where there remains an enduring culture of denial regarding HIV/AIDS, this means that the international community has little choice but to stand by and watch the ruling elites of these countries preside over the destruction of their populaces.”).

52. *See Progress Report on the Global Response to the HIV/AIDS Epidemic 2003*, UNAIDS, 58th Sess., at 10, U.N. Doc. UNAIDS/03.37E (2003) (arguing that despite progress in increasing HIV/AIDS spending, “current spending is less than half of what will be needed by 2005 and less than one-third of needed amounts in 2007”).

53. Peter Piot, *Keeping the Promise*, Speech at XIV International AIDS Conference, at <http://www.>

ber 2003, Piot further argued that “[w]hile there has been some progress, the current pace and scope of the world’s response to HIV/AIDS remains wholly insufficient.”⁵⁴ Stephen Lewis, the U.N. Special Envoy on AIDS in Africa, expressed harsher sentiments in September 2003 when he argued:

How can this be happening, in the year 2003, when we can find over \$200 billion to fight a war on terrorism, but we can’t find the money to prevent children from living in terror? And when we can’t find the money to provide the antiretroviral treatment for all of those who need such treatment in Africa? This double standard is the grotesque obscenity of the modern world.⁵⁵

The axis of illness lays out threat factors but does not provide a template for addressing the overall threat or any individual factor. The axis of illness does not tell us whether policy should be informed by human rights norms and, if so, how those norms should inform strategies on human mobility, social determinants of health, globalization, and collective action problems. To learn how human rights came to inform strategies to combat infectious diseases, especially HIV/AIDS, I turn to the development of policy and governance responses to the threats posed by infectious diseases.

II. TAKING AIM AT THE AXIS: INTERNATIONAL GOVERNANCE, INFECTIOUS DISEASE THREATS, AND HIV/AIDS

A. *International Governance Responses to Infectious Disease Threats Prior to HIV/AIDS: Westphalian and Post-Westphalian Frameworks*

The threat posed by the axis of illness is not unique to the early twenty-first century. All five factors in the axis contributed to the emergence and spread of infectious diseases in the nineteenth century. International governance efforts on controlling microbial threats, therefore, have a lengthy historical record, dating back to the first International Sanitary Conference in 1851.⁵⁶ Two distinct governance approaches developed from the mid-nineteenth century until HIV/AIDS emerged in the 1980s: the Westphalian and post-Westphalian frameworks. Human rights concepts and international human rights law became leading characteristics of the post-Westphalian approach to infectious diseases.

unaids.org (last visited July 7, 2002).

54. Press Release, UNAIDS, Two Years After Historic UN Session on HIV/AIDS, New Reports Show Progress But Member Nations Fall Short of Goals, at <http://www.unaids.org> (Sept. 22, 2003).

55. Glenn Kessler & Rob Stein, *Powell Says U.S. Leading Effort on AIDS; United Nations Address Disputes Criticisms of White House Spending Priorities*, WASH. POST, Sept. 23, 2003, at A24.

56. For historical analyses of the development of international health diplomacy, see Neville M. Goodman, *INTERNATIONAL HEALTH ORGANIZATIONS AND THEIR WORK* (2d ed. 1971) and NORMAN HOWARD-JONES, *THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851–1938* (1975).

1. *The Westphalian Governance Framework*

The Westphalian governance framework developed during the first century of international health diplomacy, roughly from 1851 until the end of World War II. In this framework, infectious diseases were conceptualized as exogenous threats to a country's public health and economic interests, with threats to economic interests playing the more powerful role in international cooperation on infectious diseases. How a state organized domestic health was not a subject of diplomacy or international law on infectious diseases. Countries improved national public health capabilities in the face of microbial invasion,⁵⁷ but such improvements were acts of self-help rather than requirements created by international health cooperation. Further, Westphalian governance did not redistribute wealth from rich to poor countries to help the more vulnerable cope with pathogenic threats.⁵⁸ Whether an individual had access to clean water or medical services was not a concern of Westphalian governance on infectious diseases, which reflected the reality that, at this time, individuals were not subjects of international law.

This governance framework reflected the premises of the Westphalian structure of international politics that dominated this time period. The Westphalian international system's pillars were: (1) the principle of sovereignty;⁵⁹ (2) the principle of non-intervention in the domestic affairs of states;⁶⁰ and (3) the principle of consent-based international law.⁶¹ Westphalian governance on infectious diseases exhibited four key political characteristics. First, states were the dominant actors. Although non-state actors, such as merchants, helped spread microbes, international governance concerned only states and their interactions. Such state-centrism is not surprising because the Westphalian system focused predominantly on states and their relations.⁶² Second, the fears and interests of the great powers dominated international governance on infectious diseases. Nineteenth-century cholera inva-

57. See LAURIE GARRETT, *THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE* 242 (1994) (noting efforts in Europe and North America to improve urban hygiene and sanitation in the latter half of the nineteenth century, which reduced vulnerability to infectious disease epidemics).

58. International health organizations, such as the Health Organization of the League of Nations, did provide member states with assistance on internal public health matters upon request. See, e.g., HEALTH ORGANISATION OF THE LEAGUE OF NATIONS, HEALTH 30 (1931).

59. Jan Aart Scholte, *The Globalization of World Politics*, in *THE GLOBALIZATION OF WORLD POLITICS: AN INTRODUCTION TO INTERNATIONAL RELATIONS* 13, 20 (J. Baylis & S. Smith eds., 2001) (arguing that statehood and sovereignty stood at the core of the Westphalian system's governance framework).

60. *Id.* (noting that sovereignty meant a state had comprehensive, supreme, unqualified, and exclusive control over its territory); Robert H. Jackson, *The Evolution of International Society*, in *THE GLOBALIZATION OF WORLD POLITICS*, *supra* note 59, at 35, 43 (arguing that the early Westphalian principle of *cujus regio, ejus religio* (the ruler decides the religion of his realm) developed into the principle of non-intervention in the domestic affairs of sovereign states).

61. IAN BROWNLIE, *PRINCIPLES OF PUBLIC INTERNATIONAL LAW* 289 (5th ed. 1998) (stating that a principal corollary of sovereignty was "the dependence of obligations arising from customary law and treaties on the consent of the obligor").

62. Scholte, *supra* note 59, at 20.

sions provoked European governments to reduce their vulnerability to such threats through international cooperation.⁶³ The dominance of European nations can be seen in the diseases then subject to international cooperation—the so-called “Asiatic” diseases of cholera, plague, and yellow fever. These diseases were not endemic to Europe, and European governments wanted to keep such foreign diseases out of their territories.⁶⁴ More importantly, the economic costs of uncoordinated national quarantine measures frustrated leading powers such as Britain.⁶⁵ The solution was a harmonization of quarantine measures through international law.⁶⁶

Third, international cooperation only addressed inter-state features of the infectious disease threat. Westphalian governance targeted cross-border disease transmission and the trade effects of national health measures. The governance approach was horizontal and did not address infectious disease control inside states,⁶⁷ which reflects the principle of non-intervention. Fourth, states effected cooperation on infectious diseases through treaty law. Infectious disease treaties adopted in the first century of international health diplomacy reflect the Westphalian principle of regulating sovereignty through consent-based international law.⁶⁸ The major treaties created a regime focused on two objectives: to create a system of international surveillance by requiring states to notify other states of outbreaks of specified diseases within their territories,⁶⁹ and to harmonize national quarantine systems by establishing maximum trade-restricting health measures that states could use.⁷⁰ These measures were based on public health principles to ensure that trade

63. See GOODMAN, *supra* note 56, at 389 (arguing that fear of cholera and, later, plague and yellow fever was a prime motivation for international health cooperation).

64. See Norman Howard-Jones, *Origins of International Health Work*, BRIT. MED. J., May 6, 1950, at 1032, 1035 (noting that the European states' acting on fear of disease importation was “not a wish for the general betterment of the health of the world, but the desire to protect certain favoured (especially European) nations from contamination by their less-favoured (especially Eastern) fellows”).

65. See HOWARD-JONES, *supra* note 56, at 11 (observing that “the first faltering steps towards international health cooperation followed trade”); GOODMAN, *supra* note 56, at 389 (noting states' interests in “the obvious economies to trade in a uniform system of quarantine” as a primary motive for the development of international health cooperation).

66. See DAVID P. FIDLER, *INTERNATIONAL LAW AND INFECTIOUS DISEASES* 35–42 (1999) (analyzing the use of international law to harmonize national quarantine systems from 1851–1951).

67. Some experts on infectious diseases in the latter half of the nineteenth century criticized the horizontal nature of the Westphalian approach. Robert Koch, the German scientist credited with identifying the cholera bacterium in 1884, argued that “these international efforts are quite superfluous” because the best protection against cholera would be for each state “to seize cholera by the throat and stamp it out.” Quoted in HOWARD-JONES, *supra* note 56, at 76.

68. See FIDLER, *supra* note 66, at 22–23 (listing the many treaties on infectious diseases concluded between 1851–1951).

69. The International Sanitary Convention of 1926 provides an example of rules designed to create international surveillance for specific infectious diseases. Article 1 requires states to notify each other of cases of plague, cholera, and yellow fever identified in their territories and the existence of an epidemic of typhus or smallpox. International Sanitary Convention, June 21, 1926, art. 1, 762 U.S.T. 1, 76, 78 L.N.T.S. 229, 247; see FIDLER, *supra* note 66, at 42–47 (summarizing the use of international law to create an international surveillance system between 1851 and 1951).

70. International Sanitary Convention, *supra* note 69, art. 15, 762 U.S.T. at 80, 78 L.N.T.S. at 252–55.

restrictions were both scientifically necessary and the least trade-restrictive measures possible.⁷¹

2. *The Post-Westphalian Governance Framework*

The post-Westphalian governance framework conceptualizes infectious diseases as threats to human rights rather than as exogenous threats to a state's interests and power. The right to health provided normative energy for the post-Westphalian approach; this right places on the international public health and human rights agendas both state organization of domestic health systems and individual access to health services. Thus, human rights concepts and international human rights law structure post-Westphalian governance on infectious diseases.

Although the Westphalian approach survived into the latter half of the twentieth century,⁷² international public health policy turned its back on this approach in favor of something radically different after World War II. Between 1948 and 1978, a post-Westphalian governance framework developed that focused on individual rights, human solidarity, and universal justice. This framework eventually eclipsed the state-centric, horizontal, and great power dominated strategy that had evolved during the previous 100 years. The WHO Constitution, which was drafted in 1946 and entered into force in 1948,⁷³ first expressed this new conceptualization as an approach to global health. The WHO Constitution's preamble asserts that (1) health is the state of complete physical, mental, and social well-being and not merely the absence of disease; (2) the enjoyment of the highest attainable standard of health is a fundamental human right; (3) the health of all peoples is fundamental to attaining peace and security; (4) unequal development in different countries pose common dangers, particularly concerning infectious diseases; and (5) extending to all peoples the benefits of health-related technology and knowledge is essential to the attainment of health.⁷⁴

The preamble expresses a vision for international health cooperation that places human rights at the center of attention, not the state and its interactions with other states.⁷⁵ The Westphalian framework's fixation on trade finds no expression in the preamble. Rather than focusing on the great pow-

71. David P. Fidler, *Emerging Trends in International Law Concerning Global Infectious Disease Control*, 9 *EMERGING INFECTIOUS DISEASES* 285, 286 (2003).

72. The Westphalian regime continued in the post-World War II period in the form of the International Sanitary Regulations, adopted by the WHO in 1951, the name of which changed in the late 1960s to the International Health Regulations. The International Health Regulations are direct progeny of the treaties crafted between 1851 and the WHO's establishment. See International Health Regulations, July 25, 1969, *in* WHO, *INTERNATIONAL HEALTH REGULATIONS* (3d ann. ed. 1983).

73. Constitution of the World Health Organization, July 22, 1946, *in* WHO, *BASIC DOCUMENTS 1* (40th ed. 1994) [hereinafter WHO CONST.].

74. *Id.*

75. In this regard, the preamble partakes of the elevation of human rights that occurred after World War II, as illustrated by the adoption of the Universal Declaration of Human Rights in 1948. Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. Doc. A/RES/217 A (III) (1948).

ers' concerns, the preamble stresses the health interdependence of all peoples and the need to assist those most vulnerable to disease—children and the poor.⁷⁶ Helping the most vulnerable means redistributing wealth from rich to poor and ensuring that all peoples, not just those living in affluent countries, have access to health-related knowledge and technologies.⁷⁷

Developments at the WHO in the post–World War II period demonstrate that policy moved away from the Westphalian approach. Three shifts signaled the construction of post-Westphalian governance. First, policy began to focus on health inside states rather than just on cross-border disease transmission.⁷⁸ This shift revealed interest in attacking infectious diseases at their sources within countries rather than merely managing microbial traffic and its trade effects.⁷⁹ Post-Westphalian governance adopts a vertical approach rather than the horizontal strategy utilized in the Westphalian framework. Second, WHO efforts on eradicating infectious diseases and providing technical assistance to developing countries illustrated the transition toward vertical strategies.⁸⁰ Such strategies are also apparent in the increasing attention the WHO paid to health in developing countries, which was consistent with the WHO Constitution's emphasis on the health needs of the most vulnerable and the importance of equity in the enjoyment of health and access to health-related services.⁸¹

The third major policy shift involved the formulation of a holistic strategy called “Health for All” to advance the right to health, health solidarity among nations, and global redistributive justice for health. The Health for All strategy was articulated in the Declaration of Alma-Ata by the WHO/UNICEF International Conference on Primary Health Care in 1978.⁸² The Declaration of Alma-Ata connected the rights to health, health solidarity,

76. WHO CONST., *supra* note 73, at 1.

77. The redistributive thrust of the WHO Constitution's preamble is clear in its emphasis on the danger posed by the unequal development in different countries of the promotion of health and the control of disease and on the need to make the benefits of health-related technology and knowledge available to all peoples. *Id.*

78. Dyna Arhin-Tenkorang & Pedro Conceição, *Beyond Communicable Disease Control: Health in the Age of Globalization*, in PROVIDING GLOBAL PUBLIC GOODS: MANAGING GLOBALIZATION 484, 485–87 (I. Kaul et al. eds., 2003).

79. *Id.* at 487 (“In a period of great vitality in the scientific understanding of infectious diseases and of progress in medical technology—in vaccines for prevention and drugs for treatment—the WHO added eliminating communicable diseases at their sources to its mandate of containing their spread through more traditional functions of coordinating international health regulations and serving as an information clearinghouse.”).

80. *Id.*

81. CHARLES O. PANNENBORG, A NEW INTERNATIONAL HEALTH ORDER: AN INQUIRY INTO THE INTERNATIONAL RELATIONS OF WORLD HEALTH AND MEDICAL CARE 343 (1979) (arguing that the WHO “discards in all its principal policies both the first and second world almost completely focusing on the L[ess] D[eveloped] C[ountry]-world”).

82. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12, 1978, at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (last visited Oct. 6, 2003).

and universal justice⁸³ in the WHO Constitution with the vertical strategy of providing primary health care⁸⁴ to all the people by the year 2000.⁸⁵

By the end of the 1970s, the post-Westphalian governance approach dominated international public health policy. With the eradication of smallpox⁸⁶ and the adoption of Health for All occurring almost simultaneously, post-Westphalian governance looked toward a bright future. The failure of the Westphalian international legal regime on infectious diseases in the late 1970s, as embodied in the WHO's International Health Regulations,⁸⁷ also highlighted the ascendance of the new approach.⁸⁸

B. The Human-Rights Turn Accelerates: The Response to the HIV/AIDS Pandemic

The HIV/AIDS pandemic began in the early 1980s on the heels of the eradication of smallpox and the promulgation of the Health for All strategy. The international governance response to the HIV/AIDS outbreak accelerated the turn toward human rights as the guiding policy framework. Jonathan Mann, an architect of basing HIV/AIDS policy on international human rights, argued that “as respect for human rights and dignity is a *sine qua non* for promoting and protecting human well-being, the human rights framework offers public health a more coherent, comprehensive, and practical framework of analysis and action on the societal root causes of vulnerability to HIV/AIDS than any framework inherited from traditional health or biomedical science.”⁸⁹

The global HIV/AIDS strategy adopted international human rights principles as a core part of its approach. As UNAIDS expressed, “experience in addressing the HIV/AIDS epidemic has confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV/AIDS.”⁹⁰ The HIV/AIDS pandemic affected civil and political rights and economic, social, and cultural rights.⁹¹ The right to health—an economic, social, and cultural right—was

83. *Id.*

84. *Id.* (“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”).

85. *Id.* (“An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.”).

86. *See, e.g.,* DAVID KOPLOW, SMALLPOX: THE FIGHT TO ERADICATE A GLOBAL SCOURGE 21–31 (2003).

87. INTERNATIONAL HEALTH REGULATIONS, *supra* note 72.

88. On the failure of the International Health Regulations, see FIDLER, *supra* note 66, at 65–71.

89. Jonathan Mann, *Human Rights and AIDS: The Future of the Pandemic*, in HEALTH AND HUMAN RIGHTS, *supra* note 37, at 216, 223.

90. UNAIDS, HIV/AIDS, Human Rights & Law, at http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp (last visited Oct. 6, 2003).

91. *Id.* UNAIDS lists the following human rights principles as relevant to HIV/AIDS: nondiscrimina-

featured prominently in the WHO Constitution's preamble, but civil and political rights were not.⁹² Although human rights treaties have long recognized infectious disease control as a legitimate reason for restricting enjoyment of civil and political rights,⁹³ the relationship between public health and these rights was not prominent until after the WHO's creation. Various responses to HIV/AIDS, including quarantine and isolation, and widespread stigma and discrimination against people living with HIV or AIDS, brought renewed public health attention to civil and political rights.⁹⁴ Similarly, the HIV/AIDS pandemic highlighted the right to health, especially with respect to access to antiretroviral treatments for people in the developing world living with HIV/AIDS. Human rights advocates argued that access to such treatments formed part of the right to health under international law.⁹⁵ The global HIV/AIDS campaign embodied the inter-dependence and indivisibility of civil and political and economic, social, and cultural rights claimed in international human rights discourse.⁹⁶

The human rights emphasis in global HIV/AIDS strategies stimulated concern about the role of social determinants of health in the pandemic's spread. Public health has been criticized for its narrow "biomedical" outlook on disease and health.⁹⁷ Injecting human rights into public health expanded the horizons of traditional public health and stressed the need to examine societal dimensions of ill-health. The human rights turn underscored the importance of focusing on social determinants of health. In this vein, Mann argued:

Once we have determined that for HIV/AIDS, as for all other health problems, the major determinants are societal, it ought to be clear that since society is an essential part of the problem, a societal-level analysis and action will be required. In other words, the new public health considers that both disease and society are so in-

tion, equal protection, and equality before the law; life; the highest attainable standard of physical and mental health; liberty and security of person; freedom of movement; asylum; privacy; freedom of opinion and expression and the right to freely receive and impart information; freedom of association; work; marriage and family; equal access to education; an adequate standard of living; social security, assistance, and welfare; scientific advancement and its benefits; participation in public and cultural life; and freedom from torture and cruel, inhuman, or degrading treatment or punishment.

92. See WHO CONST., *supra* note 73, at 1.

93. See FIDLER, *supra* note 66, at 172–79.

94. *Id.* at 200–09; LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 12–27 (1997).

95. See, e.g., Médecins Sans Frontières (MSF), Statement by MSF on TRIPS and Affordable Medicines, at <http://www.accessmed-msf.org/prod/publications.asp?scntid=19920011011399&contenttype=PARA&> (Sept. 18, 2001) (quoting MSF representative arguing that “[a]ccess to essential medicines should not be a luxury reserved for the wealthy but should be reinforced as a critical component of the human right to health”).

96. U.N. GAOR, *World Conference on Human Rights: Vienna Declaration and Programme of Action*, ¶5, U.N. Doc. A/CONF.157/23 (1993), available at [http://www.unhcr.ch/huridocda/huridocda.nsf/\(Symbol\)/A.CONF.157.23.En?OpenDocument](http://www.unhcr.ch/huridocda/huridocda.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument) (last visited Oct. 6, 2003).

97. See, e.g., Fiona Godlee, *The World Health Organization: WHO in Retreat: Is It Losing Its Influence?*, 309 BRIT. MED. J. 1491, 1494 (1994) (“The lack of clear policy is aggravated by WHO’s failure to relinquish its hold on the traditional medical model of health.”).

terconnected that both must be considered dynamic. An attempt to deal with one, the disease, without the other, the society, would be inherently inadequate.⁹⁸

The significance the human rights strategy on HIV/AIDS gives to the social determinants of health affects how collective action problems are approached. The Westphalian framework addressed collective action problems in connection with globalization and human mobility to prevent trade- and travel-restricting health measures from unduly interfering with international commerce.⁹⁹ Adherence to the principle of non-intervention precluded strategies addressing social determinants of health within states. The interest of post-Westphalian governance in vertical strategies and human rights, in contrast, moved collective action toward dealing with social determinants of health. The global response to HIV/AIDS emphasized the contribution human rights could make to improving social determinants of health. Again, Mann argued that the human rights approach to HIV/AIDS involves “acting at the deeper level of societal causes, so as to help *uproot* the pandemic.”¹⁰⁰

The human rights turn in HIV/AIDS policy solidified the post-Westphalian move toward vertical strategies against infectious diseases. The horizontal approach developed in the Westphalian framework survived into the period in which HIV/AIDS emerged in the form of the International Health Regulations (IHR). Although the IHR were the only set of binding international legal rules adopted by the WHO for infectious disease control,¹⁰¹ the regulations proved irrelevant to the HIV/AIDS outbreak. WHO member states were not obligated to report cases of HIV/AIDS to the WHO because HIV/AIDS was not a disease subject to the IHR.¹⁰² Even IHR rules that had arguable relevance for HIV/AIDS were ignored by many WHO member states and not pushed by the WHO.¹⁰³ Further, WHO member states and public health experts decided not to use the IHR’s horizontal strategy to build a global response against HIV/AIDS. Instead, the global HIV/AIDS campaign pursued a vertical strategy based on respect for human rights.

This approach placed governmental responsibilities for public health under new scrutiny. As Sofia Gruskin and Daniel Tarantola argue, framing the HIV/AIDS strategy “in human rights terms . . . allowed it to become anchored in international law, thereby making governments and intergovernmental organizations publicly accountable for their actions toward people

98. Mann, *supra* note 89, at 222.

99. See *supra* Part II.A.1.

100. Mann, *supra* note 89, at 224.

101. WHO, *Global Crises—Global Solutions: Managing Public Health Emergencies of International Concern Through the Revised International Health Regulations*, at 1, WHO/CDS/CSR/GAR/2002/4/EN (2002).

102. At the time the HIV/AIDS outbreak began, only cholera, plague, and yellow fever were subject to IHR notification requirements. INTERNATIONAL HEALTH REGULATIONS, *supra* note 72, at Article 1.

103. Katarina Tomasevski, *Health*, in 2 UNITED NATIONS LEGAL ORDER 859, 867–68 (O. Schacter and C. Joyner, eds., 1995) (describing controversy involving AIDS-free certificates and Article 81 of the IHR).

living with HIV/AIDS.”¹⁰⁴ The human rights strategy conceptualizes collective action problems in a way that radically differs from the Westphalian framework. The human rights approach to HIV/AIDS challenged governments to be responsible to their citizens as opposed to only having to answer to other governments about cross-border disease concerns.¹⁰⁵

The human rights turn in HIV/AIDS policy stimulated a broader “health and human rights” movement.¹⁰⁶ Rather than human rights being an instrument for battling a single disease, experts applied the human rights framework to a variety of problems, including non-communicable diseases, reproductive health, access to health-related technologies, and children’s health. The “health and human rights” movement generated a powerful synergy because both “health and human rights are complementary approaches to the central problem of defining and advancing human well-being.”¹⁰⁷

The centrality of human rights in the global HIV/AIDS strategy contributed to the development of “global health governance.”¹⁰⁸ Experts distinguish global governance from international governance because the former involves non-state actors as well as state actors.¹⁰⁹ Building human rights into the HIV/AIDS fight created new opportunities for non-state actors, such as human rights NGOs, to become involved in public health issues locally, nationally, and internationally.¹¹⁰ Intense NGO involvement in HIV/AIDS efforts stimulated the development of public-private partnerships in which state and non-state actors work to prevent, control, and treat HIV/AIDS.¹¹¹ Public-private partnerships have become a defining feature of international infectious disease activities. For the WHO, public-private part-

104. Sofia Gruskin & Daniel Tarantola, *Health and Human Rights*, in OXFORD TEXTBOOK OF PUBLIC HEALTH 311 (Roger Detels et al. eds., 4th ed., 2002).

105. Such government responsibility to citizens was explicit in the WHO Constitution’s preamble (see WHO CONST., *supra* note 73, at 1) and the Declaration of Alma-Ata (see Declaration of Alma-Ata, *supra* note 82).

106. Gruskin & Tarantola, *supra* note 104, at 311.

107. Jonathan Mann et al., *Health and Human Rights*, in HEALTH AND HUMAN RIGHTS, *supra* note 104, at 1, 16.

108. See Richard Dodgson, Kelley Lee & Nick Drager, Global Health Governance: A Conceptual Review (Key Issues in Global Health Governance Discussion Paper No. 1) (Centre on Global Change & Health and World Health Organization, Feb. 2002); Kelly Loughlin & Virginia Berridge, Global Health Governance: Historical Dimensions of Global Governance (Key Issues in Global Health Governance Discussion Paper No. 2) (Centre on Global Change & Health and World Health Organization, Mar. 2002); David P. Fidler, Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health (Key Issues in Global Health Governance Discussion Paper No. 3) (Centre on Global Change & Health and World Health Organization, May 2002); Kickbusch, *supra* note 50, at 192–203.

109. Dodgson, Lee & Drager, *supra* note 108, at 16.

110. Kelley Lee & Anthony Zwi, *A Global Political Economy Approach to AIDS: Ideology, Interests and Implications*, in HEALTH IMPACTS OF GLOBALIZATION, *supra* note 43, at 13, 27.

111. See PUBLIC-PRIVATE PARTNERSHIPS FOR PUBLIC HEALTH (M. R. Reich ed., 2002); Kent Buse & Gill Walt, *Globalisation and Multilateral Public-Private Partnerships: Issues for Health Policy*, in HEALTH POLICY IN A GLOBALISING WORLD 41–62 (K. Lee et al. eds., 2002); Roy Widdus, *Public-Private Partnerships for Health: Their Main Targets, Their Diversity, and Their Future Directions*, 79 BULL. WORLD HEALTH ORG. 713 (2001).

nerships are changing the landscape of public health approaches to infectious diseases.¹¹²

Perhaps the most prominent public-private partnership is the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), which was created in 2002.¹¹³ This initiative differs radically from traditional intergovernmental approaches to public health because it involves non-state actors in the Fund's governance.¹¹⁴ The Global Fund pursues vertical strategies by funding disease prevention and treatment projects inside countries.¹¹⁵ It redistributes resources from rich to poor countries¹¹⁶ and is informed, particularly through NGO participation, by human rights principles.¹¹⁷ The Global Fund embodies the spirit and substance of post-Westphalian governance with respect to infectious diseases.

III. UNITED STATES FOREIGN POLICY AND HIV/AIDS

A. *From Carter to Clinton: Hybrid Approaches with Different Emphases*

Although infectious disease control had been a diplomatic issue since the mid-nineteenth century, public health did not, generally speaking, occupy an important place in U.S. foreign policy. Further, the importance to the United States of cooperation on infectious diseases declined in the post-World War II period because the United States, like other developed countries, reduced dramatically the burden of infectious diseases among its citizens through vaccines and antibiotics developed during and after World War II. The first American administration to create a strategic foreign policy role for public health was the Carter Administration. This Section outlines how public health and infectious diseases featured in U.S. foreign policy from the Carter to Clinton Administrations as a prelude to an analysis of the Bush Administration's approach to HIV/AIDS.

1. *The Carter Administration: Stressing Human Rights*

Almost simultaneously with the eradication of smallpox and the promulgation of the Health for All strategy, President Carter ordered a review of U.S. policy on international health.¹¹⁸ In 1978, President Carter's Special Assistant for Health Issues, Peter G. Bourne, issued *New Directions in Inter-*

112. WHO, GLOBAL DEFENCE AGAINST THE INFECTIOUS DISEASE THREAT 22 (M. K. Kindhauser ed., 2003).

113. Global Fund to Fight AIDS, Tuberculosis, and Malaria, at <http://www.theglobalfund.org/en/> (last visited Oct. 6, 2003) [hereinafter Global Fund].

114. *Id.* at http://www.globalfundatm.org/ngo_civil.html (last visited Oct. 6, 2003).

115. *Id.* at <http://www.globalfundatm.org/principles.html> (last visited Oct. 6, 2003).

116. *Id.* at <http://www.globalfundatm.org/overview.html> (last visited Oct. 6, 2003).

117. Global Fund, Principles, *supra* note 115 (including as a principle of the Global Fund the "[a]im to eliminate stigmatisation of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups").

118. THE WHITE HOUSE, NEW DIRECTIONS IN INTERNATIONAL HEALTH COOPERATION: A REPORT TO THE PRESIDENT (1978) [hereinafter NEW DIRECTIONS].

national Health Cooperation (New Directions), which “presents, for the first time, an overview of all aspects of the [U.S.] Government’s activities in international health.”¹¹⁹ This document sought to elevate health in U.S. foreign policy and included Westphalian and post-Westphalian elements. *New Directions* attempted to meld these two governance frameworks, but the distinguishing feature of the Carter Administration’s approach was its emphasis on human rights, especially the right to health.

In the report’s Preface, the Special Assistant for Health Issues expressed Westphalian reasons for why health should play a more prominent role in U.S. foreign policy:

[A] world in which people everywhere are healthy and adequately fed will be a world inherently satisfactory to the interests of the United States. Economically self-sufficient nations will no longer burden the United States and other developed countries; they can become viable markets for U.S. exports. Conversely, in a hungry, angry, and often bitter world we can hardly achieve vital foreign relations objectives. We are less able to reduce the buildup of conventional weapons, control the proliferation of nuclear arms, defuse international terrorism, protect our economic and security interests in outer space, or promote the advancement of human rights, for political instability in one nation threatens the peace and economic progress of all nations.¹²⁰

In keeping with the Westphalian perspective, this statement conceptualizes health problems in foreign countries as exogenous threats to U.S. national security and foreign policy objectives. Poor health in other countries created economic burdens for the United States, reduced U.S. export markets, and harmed economic development throughout the international system. Such conditions fed political dynamics that threatened U.S. national security by making arms control and the fight against terrorism more difficult and contributing to instabilities within countries that could undermine international peace and security.¹²¹

119. *Id.* at iii. The report notes a 1958 report championed by Senator Hubert Humphrey called *The U.S. Government and the Future of International Medical Research* that “extolled the many benefits to be derived from a strengthened global health policy,” and which was not subsequently supported and thus “did not result in major changes in U.S. international health activities.” *Id.* at xxii–xxiii.

120. *Id.* at, xxi.

121. The Carter Administration’s identification of health problems abroad as exogenous threats to U.S. national security and foreign policy differs from the original Westphalian framework because *New Directions* did not stress threats of direct infectious disease importation into the United States or the problems that foreign quarantine systems posed for U.S. trade. The *New Directions* list of global health problems did not include, for example, infectious diseases. *See id.* at 45 (listing atmospheric pollution, depletion of the ozone layer, pollution of the oceans, explosive world population growth, international migration, and inadequate world food supply as global problems affecting health). The report did not express concerns about protecting the United States from foreign-source disease importation. *Id.* at 203–04 (discussing infectious disease control). The exogenous threats identified by the Carter Administration were more indirect and less tied to infectious diseases than the threats that drove the first century of

New Directions complimented its Westphalian arguments with assertions that resonated with the WHO Constitution and the Declaration of Alma-Ata. For President Carter, the right to health was a fundamental right that should animate U.S. foreign policy on infectious diseases and other public health problems.¹²² *New Directions* stated that “[t]he right to health and our Nation’s moral commitment to help guarantee that right form an integral part of the foreign policy of the Carter Administration,”¹²³ and that “[a]s a nation we recognize and reaffirm the fundamental human right of people everywhere to enjoy the highest possible health standards.”¹²⁴ The Special Assistant for Health Issues declared that the world had “the scientific and technological potential to provide a basic minimum level of health care for everyone in the world by the year 2000,”¹²⁵ an unmistakable reference to the Health for All campaign. Health for All’s influence can also be seen in the assertion that “[s]afe water, nutritious food, moderate family size, and primary and preventive health services constitute the basic means to attain good health.”¹²⁶

New Directions listed freedom from hunger, physical suffering, war, disease, pollution, homelessness, and servitude to others as universal needs and aspirations supporting a greater foreign policy emphasis on health.¹²⁷ It elevated the right to health to a status equal to civil and political rights.¹²⁸ The Carter Administration rose above a purely Westphalian ideology to advance international health as a U.S. foreign policy objective.¹²⁹

2. *The Clinton Administration: Stressing Exogenous Threats to the United States*

The Carter Administration’s vision of health as a strategic U.S. foreign policy goal did not continue during the Reagan and first Bush Administra-

international health cooperation. Nevertheless, *New Directions* contained a perspective that viewed poor health conditions in foreign nations as a threat to the achievement of a range of U.S. foreign policy and national security objectives, stretching the frame of reference for the Westphalian governance perspective.

122. *Id.* at v (arguing that basic human rights include “the right of every human being to be free from unnecessary disease”).

123. *Id.* at 1.

124. *Id.* at 3.

125. *Id.* at xxi.

126. *Id.* at 1.

127. *Id.* at xx.

128. *Id.* at 43 (“Cooperation with other nations to improve social and economic conditions should be balanced with our concern for political and civil rights. In both domestic and international forums, we should be able to cite strategies for positive action to meet social and economic needs as well as to avoid infringement on civil and political rights Alleviation of unnecessary suffering and ill health in any country is as important a part of respect for human rights as protection of civil and political rights.”).

129. *Id.* at 44 (“Human rights policy . . . requires continued efforts to build upon cultural, scientific, and technological exchanges with a view toward improving social and economic rights. For example, expansion of trade with Communist countries has been stressed in recent years: The health sector can and should play a leading role in this exchange We have witnessed the extraordinary health progress made by China with relatively few resources, and we can readily see the similarity between the United States and the Soviet Union in problems, resources, and issues related to health.”).

tions.¹³⁰ Infectious diseases and public health were not prominent in U.S. foreign policy again until the Clinton Administration, which argued that infectious diseases, including HIV/AIDS, were a national security and foreign policy issue.¹³¹ By the time President Clinton took office, global policy efforts on the pandemic included a well-developed human rights approach to HIV/AIDS and public health, as outlined earlier. Human rights did not, however, distinguish the Clinton Administration's concern about HIV/AIDS and other infectious diseases. Rather, the Clinton Administration prominently conceptualized HIV/AIDS and other infectious diseases as exogenous threats to the United States.¹³² Whereas the Carter Administration emphasized human rights in U.S. foreign policy concerning health, the Clinton Administration rejuvenated the Westphalian framework as the strategic guide to foreign policy on infectious disease threats.¹³³

Two developments produced the Clinton Administration's elevation of public health as a foreign policy concern: bioterrorism¹³⁴ and emerging infectious diseases.¹³⁵ Throughout the 1990s, worries about U.S. vulnerability to mi-

130. HIV/AIDS was a foreign policy issue during the Reagan and Bush Administrations, but only a minor one. U.S. assistance for international HIV/AIDS began in 1986 during President Reagan's second term in office. See United States Agency for International Development, *Stepping Up the War on HIV/AIDS*, at http://www.usaid.gov/pop_health/aids/News/expandedresponsefactsheet.html (last visited Oct. 6, 2003). From 1986 to 1988, U.S. funding on HIV/AIDS problems internationally remained under \$50 million annually, increasing to approximately \$75 million in 1991 and nearly \$100 million in 1992, the last year of the Bush Administration. *Waking Up to Devastation*, WASH. POST, July 2000, <http://washingtonpost.com/wp-srv/world/daily/july00/aidsgraphic2.htm> (last visited Oct. 6, 2003). The Reagan and Bush Administrations did not, however, integrate the growing HIV/AIDS problem into foreign policy and national security agendas. See J. M. Spectar, *The Olde Order Crumbleth: HIV-Pestilence as a Security Issue & New Thinking about Core Concepts in International Affairs*, 13 *IND. INT'L & COMP. L. REV.* 481, 507 (2003) (discussing lack of priority the Reagan and Bush Administrations placed on the HIV/AIDS problem, despite evidence of the growing scale of the pandemic).

131. See, e.g., Ciset Report, *supra* note 17, and NATIONAL INTELLIGENCE COUNCIL, *supra* note 18.

132. Ciset Report, *supra* note 17, at 3–4 (“Diseases that arise in other parts of the world are repeatedly introduced into the United States, where they may threaten our national health and security. Thus, controlling disease outbreaks in other countries is important not only for humanitarian reasons. It also prevents those diseases from entering the United States, at great savings of U.S. lives and dollars. Moreover, U.S. support for disease investigations in other countries provides U.S. scientists with opportunities to bring U.S. capacity to focus on new pathogens like Ebola virus and consider how best to control, prevent, and treat them internationally before they arrive on our shores. Thus, U.S. interests are served while providing support to other nations.”).

133. NATIONAL INTELLIGENCE COUNCIL, *supra* note 18 (“New and reemerging infectious diseases will pose a rising global health threat and will complicate US and global security over the next twenty years. These diseases will endanger US citizens at home and abroad, threaten US armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which the United States has significant interests.”).

134. The seminal 1992 Institute of Medicine report on microbial threats to health in the United States did not mention the threat of bioterrorism. See INSTITUTE OF MEDICINE 1992, *supra* note 22. By 2000, the bioterrorist threat had become a serious national security concern. See NATIONAL INTELLIGENCE COUNCIL, *supra* note 18 (“The biological warfare and terrorism threat to US national security is on the rise as rogue states and terrorist groups also exploit the ease of global travel and communication in pursuit of their goals.”).

135. See INSTITUTE OF MEDICINE 1992, *supra* note 22; U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 15; Ciset Report, *supra* note 17; NATIONAL INTELLIGENCE COUNCIL, *supra* note 18.

crobial invasion grew.¹³⁶ This sense of vulnerability stimulated efforts to understand the infectious disease threat and craft policy responses.¹³⁷ Echoing the Westphalian framework, the Clinton Administration conceived of emerging infectious diseases and bioterrorism as exogenous threats to U.S. public health, national security, and foreign policy objectives.¹³⁸

The growth of the HIV/AIDS pandemic during the 1990s was a catalyst in the Westphalian framework's appeal during the Clinton years. The Clinton Administration argued that HIV/AIDS in developing countries, especially sub-Saharan Africa, represented a national security threat because of the political instability that HIV/AIDS-related damage could cause in badly affected nations.¹³⁹ The Clinton Administration successfully pushed to have the U.N. Security Council consider the threat HIV/AIDS posed to international peace and security; this represented the first time in the history of the Security Council that it had debated the consequences of a naturally occurring pathogenic microbe.¹⁴⁰

The Clinton Administration also experienced another Westphalian episode with respect to HIV/AIDS. As discussed earlier,¹⁴¹ a central part of the Westphalian framework involved states attempting to reduce trade frictions caused by infectious diseases abroad. The Clinton Administration's resistance to compulsory licensing and parallel importing of antiretroviral HIV/AIDS drugs under the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS),¹⁴² which were supported by develop-

136. NATIONAL INTELLIGENCE COUNCIL, *supra* note 18 ("Emerging and reemerging infectious diseases, many of which are likely to continue to originate overseas, will continue to kill at least 170,000 Americans annually. Many more could perish in an epidemic of influenza or yet-unknown disease or if there is substantial decline in the effectiveness of available HIV/AIDS drugs.")

137. *See, e.g.*, INSTITUTE OF MEDICINE, AMERICA'S VITAL INTEREST IN GLOBAL HEALTH (1997); U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, PREVENTING EMERGING INFECTIOUS DISEASES: A STRATEGY FOR THE 21ST CENTURY (1998); CHEMICAL & BIOLOGICAL ARMS CONTROL INSTITUTE & CENTER FOR STRATEGIC & INTERNATIONAL STUDIES INTERNATIONAL SECURITY PROGRAM, CONTAGION AND CONFLICT: HEALTH AS A GLOBAL SECURITY CHALLENGE (2000); LAURIE GARRETT, BETRAYAL OF TRUST: THE COLLAPSE OF GLOBAL PUBLIC HEALTH (2000); JONATHAN BAN, HEALTH, SECURITY, AND U.S. GLOBAL LEADERSHIP (2001); JORDAN S. KASSALOW, WHY HEALTH IS IMPORTANT TO U.S. FOREIGN POLICY (2001).

138. PRICE-SMITH, *supra* note 51, at 122 ("In the Clinton administration's national security strategy of 'engagement and enlargement,' the proliferation of infectious disease was identified as a novel threat to American foreign policy interests, particularly to the central policy pillars of global economic growth and the expansion and consolidation of stable and functional democracies throughout the developing world and in the former Soviet Union."); *see also* Spectar, *supra* note 130, at 540.

139. NATIONAL INTELLIGENCE COUNCIL, *supra* note 18.

140. The U.N. Security Council met on January 10, 2000 to discuss "The Situation in Africa: the Impact of AIDS on Peace and Security in Africa." *Round-Up: Developments throughout Africa, Renewed Violence in Middle East Among Key Issues for Security Council in 2000*, U.N. SCOR, 56th Sess., U.N. Doc. SC/6987 (2001). In a follow-up action to this meeting, the U.N. Security Council passed Resolution 1308 in July 2000 on the impact of HIV/AIDS on international peacekeeping efforts. S.C. Res. 1308, U.N. SCOR, 55th Sess., U.N. Doc. S/Res/1308 (2000). For analysis of these Security Council actions, see Spectar, *supra* note 130, at 515-18.

141. *See supra* Part II.A.1.

142. Agreement on Trade-Related Aspects of Intellectual Property Rights, Agreement Establishing the World Trade Organization, Annex 1C, 33 I.L.M. 81 (1994).

ing countries, demonstrated that foreign infectious disease problems could complicate and frustrate U.S. trade policy.¹⁴³ In the face of a critical global campaign, the Clinton Administration retreated from its hard-line position against developing countries such as South Africa.¹⁴⁴

The clash under TRIPS between the Clinton Administration's policy on the intellectual property rights of U.S. pharmaceutical companies and efforts to increase access to antiretroviral drugs in developing countries brought renewed attention to the right to health. The 1990s witnessed the dramatic worsening of the HIV/AIDS problem in the developing world¹⁴⁵ and the development of effective but expensive antiretroviral drugs in the developed countries.¹⁴⁶ This situation created a tension between the Clinton Administration's position on the intellectual property rights of pharmaceutical companies and the global advocacy campaign to increase access to antiretroviral drugs in the developing world.¹⁴⁷ The advocacy campaign linked its position to the right to health, which the advocates believed required all governments to increase access to antiretroviral therapies for infected populations in low-income countries.¹⁴⁸

This episode demonstrated that, unlike the Carter Administration, the Clinton Administration did not champion the right to health in its foreign policy on emerging infectious diseases or HIV/AIDS. The Clinton Administration was not hostile toward the right to health specifically or to economic, cultural, and social rights generally,¹⁴⁹ but whatever attractiveness

143. For analysis of the Clinton Administration's hard-line position on parallel importing and compulsory licensing, see Caroline Thomas, *Trade Policy, the Politics of Access to Drugs and Global Governance for Health*, in *HEALTH IMPACTS OF GLOBALIZATION*, *supra* note 43, at 177, 182–85.

144. *Id.* at 184–85 (discussing the Clinton Administration's policy reversal). The Bush Administration continued the retreat at the WTO ministerial meeting in Doha, Qatar in November 2001. See World Trade Organization, *Declaration on the TRIPS Agreement and Public Health*, WTO Doc. WT/MIN(01)/DEC/2 (Nov. 20, 2001) [hereinafter Doha Declaration].

145. See UNAIDS, *supra* note 20.

146. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS UPDATE: A GLANCE AT THE EPIDEMIC, at <http://www.cdc.gov/nchstp/od/news/At-a-glance.pdf> (last visited Oct. 6, 2003) (“During the mid-to-late 1990’s, advances in HIV treatments led to dramatic decline in AIDS deaths and slowed the progression from HIV to AIDS [in the United States].”).

147. Thomas, *supra* note 104, at 180 (“Since the late 1990s, a small number of developing countries, with the support of a transnational alliance of NGOs, have been battling for affordable access to essential ARV drugs These efforts of a few developing countries to pursue legitimate strategies to secure drugs for their people at affordable prices have been obstructed by the combined might of the pharmaceutical industry and the US government.”).

148. Press Release, MSF, Statement by MSF on TRIPS and Affordable Medicines, at <http://www.accessmed-msf.org/prod/publications.asp?scntid=1992001107508&contenttype=PARA&> (June 19, 2001) (“In 1999 MSF started the Campaign for access to essential medicines in response to the ever growing access to medicines gap between the developing and developed world Today, there is a dire imbalance between the sanctity of patents and the health of people. Access to essential medicines should not be a luxury reserved for the wealthy, but should be reinforced as a critical component of the human right to health.”).

149. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 *IND. L. REV.* 1457, 1462 (2001) (noting that the Clinton Administration supported but did not achieve ratification of international treaties containing economic, social, and cultural rights, including the right to health).

these rights held for the Clinton Administration did not inform its policy with respect to the “patents vs. access” controversy, despite the administration’s acknowledgment of the dreadful impact the pandemic was having on poor countries and regions, especially sub-Saharan Africa.

Arguably, the Clinton Administration’s single policy innovation concerning the global HIV/AIDS problem was framing the crisis as a threat to U.S. national security and international peace and security—an approach that resonated with the Westphalian framework. Although not a strategic objective, the Clinton Administration’s policy on intellectual property rights and antiretroviral treatments had the unintended effect of rejuvenating interest in, and advocacy for, the right to health, particularly with respect to access to antiretroviral drugs for people living with HIV in developing countries.¹⁵⁰ By the end of Clinton Administration, the HIV/AIDS pandemic had managed to get both the Westphalian and post-Westphalian strategies into play.

As the controversy over access to antiretroviral drugs demonstrates, Clinton Administration policy on HIV/AIDS did not represent the convergence of these two frameworks as had the Carter Administration’s vision in *New Directions*. By the end of the Clinton years, Westphalian and post-Westphalian approaches were concurrently active with respect to HIV/AIDS, but not melded together in coherent policy. With both frameworks alive when the Bush Administration took office in January 2001, the next question is how the Bush Administration has structured its approach to HIV/AIDS.

B. A “Distinctly American Internationalism”: The Bush Administration’s Strategy on HIV/AIDS

To paraphrase the Bush Administration, its approach to the HIV/AIDS pandemic is “based on a distinctly American internationalism that reflects the union of our values and our national interests.”¹⁵¹ The Bush Administration’s perspective on HIV/AIDS as a foreign policy issue represents a hybrid strategy reflecting Westphalian and post-Westphalian concepts. The Bush Administration’s strategy does not, however, mirror the Carter or Clinton approaches to infectious diseases. Bush Administration policy on HIV/AIDS in developing countries partakes of the Westphalian concern with reducing the friction infectious disease problems create for achieving other foreign policy objectives. In this respect, the Bush Administration follows the Westphalian path used by Carter and emphasized by Clinton. Simultaneously, the Bush Administration has linked the HIV/AIDS problem in the developing world with U.S. aspirations to champion human dignity, which echoes the post-Westphalian connection between health and human rights.

150. See, e.g., *Access to Medication in the Context of Pandemics Such as HIV/AIDS*, U.N. Commission on Human Rights, Res. 2001/33, 57th Sess., 71st mtg., U.N. Doc. E/CN.4/RES/2001/33 (2001).

151. NATIONAL SECURITY STRATEGY, *supra* note 3, at 1.

International human rights law, however, does not inform the Bush Administration's emphasis on human dignity in connection with HIV/AIDS. The Bush Administration's human rights position on HIV/AIDS is, thus, clearer than the Clinton Administration's but is radically at odds with the human rights emphasis of President Carter. The Bush Administration's human rights inspiration on HIV/AIDS is the U.S. constitutional and political tradition of protecting civil and political rights. In its approach to HIV/AIDS, the Bush Administration rejects economic, social, and cultural rights, such as the right to health. The human rights component of the Bush Administration's HIV/AIDS strategy differs radically from not only the Carter Administration's approach but also global policy on HIV/AIDS.

The Bush Administration's perspective on infectious diseases and HIV/AIDS represents the first time an administration controlled by the Republican Party has integrated global health into its vision for U.S. national security and foreign policy. The perspective outlined below is seminal for conservative and neoconservative thinking on U.S. foreign policy. What the Bush Administration has said and done on the global HIV/AIDS problem, especially the Emergency Plan for AIDS Relief, has an eye-opening "Nixon goes to China" quality that deserves analysis and scrutiny rather than cynical rejection. Even those not disposed to praise the Bush Administration have captured the surprising significance of the Bush Administration's policy on HIV/AIDS.¹⁵² *New York Times* columnist Nicholas Kristof argued, for example, that "Mr. Bush is doing more about AIDS in Africa than President Bill Clinton ever did."¹⁵³

The Bush Administration's neoconservative perspective on HIV/AIDS raises many questions about how this approach will affect the global effort to contain HIV/AIDS. Although the Bush Administration has increased the U.S. foreign policy stakes of addressing HIV/AIDS in developing countries, its approach is, in fundamental ways, at odds with the multilateral, human rights-based strategy built during the 1980s and 1990s. Whether neoconservatism provides effective U.S. leadership on HIV/AIDS remains an open question, but the Bush Administration has made the HIV/AIDS pandemic a major test of the neoconservative approach to global health specifically and U.S. foreign policy generally.

1. "Our National Interests": HIV/AIDS, Foreign Policy, and National Security

The Bush Administration's position that the HIV/AIDS pandemic threatens U.S. strategic interests echoes arguments developed during the Clinton Administration. The Bush Administration has, however, taken this Westphalian outlook to a new level through its (1) comprehensive weaving of the

152. See Fidler, *supra* note 5, at 114 (providing quotes from HIV/AIDS experts and activists praising the Emergency Plan for AIDS Relief).

153. Nicholas D. Kristof, *When Prudery Kills*, N.Y. TIMES, Oct. 8, 2003, at A31.

HIV/AIDS threat in the developing world into its vision of U.S. national security and foreign policy; and (2) various foreign policy initiatives on HIV/AIDS, highlighted by the Emergency Plan for AIDS Relief, “the largest, single up front commitment in history for an international public health initiative involving a specific disease.”¹⁵⁴

The Westphalian framework conceptualized infectious diseases as exogenous threats to a country’s national interests in two ways: (1) the threat of microbial invasion; and (2) infectious disease prevalence in other countries, which could trigger consequences harmful to U.S. foreign policy objectives such as the promotion of trade. The Carter and Clinton Administrations added a third way in which infectious diseases were exogenous threats—infectious disease epidemics can undermine state capacity and domestic stability, creating negative externalities for other states ranging from economic harm (e.g., lost export markets) to national security concerns (e.g., regional instability leading to the need for outside intervention).

The Bush Administration’s policy on the HIV/AIDS pandemic incorporates this Westphalian perspective. At a general level, the frequency with which the Bush Administration’s *National Security Strategy for the United States of America* (*National Security Strategy*), released in September 2002, mentions HIV/AIDS demonstrates that its national security and foreign policy teams believed that this problem deserved prominent attention.¹⁵⁵ The *National Security Strategy* does not identify the HIV/AIDS pandemic as the leading threat to U.S. national security, but it provides the pandemic with a high profile in the Bush Administration’s vision for U.S. national security and foreign policy.

Specifically, the *National Security Strategy* mentions HIV/AIDS with respect to important U.S. foreign policy and national security concerns. The Bush Administration conceptualizes the HIV/AIDS problem as a threat to U.S. objectives in the areas of national security, trade liberalization, and economic development in the developing world. In terms of national security, the Bush Administration argued that disease in Africa threatens the strategic priority of combating global terrorism,¹⁵⁶ which represents one of the most important strategic goals laid out in the *National Security Strategy*.¹⁵⁷ With respect to U.S. interests in trade liberalization, the Bush Administra-

154. President George W. Bush, Remarks by the President on Signing of H.R. 1298, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003. For other international HIV/AIDS initiatives highlighted by the Bush Administration, see Press Release, The White House, The President’s [\$500 million] International Mother to Child HIV Prevention Initiative, at <http://www.whitehouse.gov/news/releases/2002/06/20020619-1.html> (June 19, 2002); The White House, U.S. Commits \$1.65 Billion to Global Fund: Seven Times Greater Than the Next Largest Donor, at http://www.whitehouse.gov/g8/global_facts.html (June 1, 2003); Press Release, The White House, U.S.-Brazil Joint Venture on HIV/AIDS in Lusophone, Africa, at <http://www.state.gov/p/wha/rls/21817.htm> (June 20, 2003).

155. NATIONAL SECURITY STRATEGY, *supra* note 3, at vi, 19, 22, 23, and 27.

156. *Id.* at 10.

157. *Id.* at 5–7.

tion indicated that promoting the connection between trade and development is important and that “[b]eyond market access, the most important area where trade intersects with poverty is public health.”¹⁵⁸ Thus, the Bush Administration promised that the United States “will ensure that the WTO intellectual property rules are flexible enough to allow developing nations to gain access to critical medicines for extraordinary dangers like HIV/AIDS, tuberculosis, and malaria.”¹⁵⁹

The acrimonious controversy about the U.S. position on access to essential medicines and intellectual property rights under TRIPS, which began during the Clinton Administration and continues with the Bush Administration, suggests that many people would interpret this promise from the Bush Administration skeptically.¹⁶⁰ Such skepticism, however, supports my point: the *National Security Strategy* recognizes that HIV/AIDS in the developing world creates problems for U.S. promotion of trade liberalization, which includes strong protection for intellectual property rights.

The *National Security Strategy* also contains evidence that the Bush Administration considers HIV/AIDS important for U.S. policies toward specific regions and countries. Disease is a serious threat, along with war and desperate poverty, to Africa’s future.¹⁶¹ The Bush Administration mentions “the spread of HIV/AIDS” as a threat that U.S.-Chinese relations will confront.¹⁶² Elsewhere, the Bush Administration has made HIV/AIDS in Russia part of U.S. engagement with the Russian government.¹⁶³

HIV/AIDS features prominently in the Bush Administration’s strategic aim of expanding “the circle of development by opening societies and building the infrastructure of democracy.”¹⁶⁴ Securing public health is a major strat-

158. *Id.* at 19.

159. *Id.*

160. Skeptics might point to the Bush Administration’s opposition to resolving expeditiously the problem of third-party compulsory licensing identified for resolution in paragraph 6 of the Doha Declaration. See MÉDECINS SANS FRONTIÈRES, DOHA DERAILED: A PROGRESS REPORT ON TRIPS AND ACCESS TO MEDICINES 2 (2003) (“The past two years have clearly shown—most explicitly in the debates over the “Paragraph 6” issue—that the Doha Declaration must be actively implemented and defended if it is to have force . . . [C]ontrary to the spirit of Doha, the United States, European Union, Canada, Switzerland, and Japan negotiated fiercely at the TRIPS Council to handicap any proposed solution by introducing unnecessary procedural complications and/or limitations.”). WTO member states finally reached an agreement on this issue in late August 2003 prior to the September Cancún WTO Ministerial Meeting. See TRIPS Council, Decision on the Implementation of Paragraph 6 of the Declaration on the TRIPS Agreement and Public Health (WT/L/540, Aug. 30, 2003), available at http://www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm. Concerns exist, however, that the Bush Administration might be trying to dilute this decision. See Klein, *supra* note 7, at 12 (raising concerns that the Bush Administration might resort to NAFTA to prevent Canada from implementing plans to export generic versions of patented antiretroviral drugs).

161. NATIONAL SECURITY STRATEGY, *supra* note 3, at 10.

162. *Id.* at 27.

163. Press Release, The White House, US-Russian HIV/AIDS Cooperation Initiative, at <http://www.state.gov/p/eur/rls/fs/24610.htm> (Sept. 27, 2003); Paula J. Dobriansky, Under Secretary of State for Global Affairs, The Emerging Security Threat of HIV/AIDS: Russia, at <http://www.state.gov/g/rls/rm/2003/18480.htm> (Feb. 28, 2003).

164. NATIONAL SECURITY STRATEGY, *supra* note 3, at 21.

egy for achieving “an ambitious and specific target: to double the size of the world’s poorest economies within a decade.”¹⁶⁵ The Bush Administration acknowledged that “[i]n countries afflicted by epidemics and pandemics like HIV/AIDS, malaria, and tuberculosis, growth and development will be threatened until these scourges can be contained.”¹⁶⁶ HIV/AIDS factors into two other present national security strategies designed to help double the size of the world’s poorest economies. First, the United States and other affluent countries should use results-based grants rather than loans in supporting economic development in poor countries.¹⁶⁷ Second, the Bush Administration also seeks to emphasize education and bring information technology to bear in many societies “whose education systems have been devastated by HIV/AIDS.”¹⁶⁸

In sum, the *National Security Strategy* identifies HIV/AIDS in the developing world as a strategic challenge for achieving U.S. national interests with respect to national security, economic prosperity at home and development abroad through free trade and free markets, and the promotion of democracy. In light of this perspective, the Bush Administration’s proposed \$15 billion, five-year Emergency Plan for AIDS Relief¹⁶⁹ represents more than a humanitarian effort but forms part of a strategic outlook on the exercise of U.S. power in the early twenty-first century. Secretary of State Colin Powell asserted that “[r]esponding to HIV/AIDS is not only a humanitarian and a public health issue; HIV/AIDS also carries profound implications for prosperity, democracy and security.”¹⁷⁰ President Bush echoed the strategic nature of the Emergency Plan when he compared it to the Marshall Plan, the Berlin Airlift, and the Peace Corps.¹⁷¹

2. “Our Values”: HIV/AIDS and Human Dignity

The Bush Administration’s perspective on HIV/AIDS does not follow the post-Westphalian template described earlier that informed the global strategy on HIV/AIDS, but it contains elements that make the HIV/AIDS fight a matter of human dignity and human rights. Bush Administration policy breaks with the post-Westphalianism of the global HIV/AIDS effort because

165. *Id.*

166. *Id.* at 23.

167. *Id.* at 22.

168. *Id.* at 23.

169. Bush, *supra* note 8. Congress subsequently passed legislation to implement the Emergency Plan for AIDS Relief. See U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act, Pub. Law 108-25, May 27, 2003. As of the date of this writing, Congress had not, however, actually appropriated funds for the Emergency Plan.

170. Colin Powell, Secretary of State, Remarks at Bill Signing Ceremony for the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, at <http://www.state.gov/secretary/rm/2003/20969.htm> (May 27, 2003).

171. President George W. Bush, Remarks by the President on the Signing of H.R. 1298, *supra* note 154.

it narrows the human rights to be protected to civil and political rights and reflects a preference for unilateralism over multilateralism.

In its *National Security Strategy*, the Bush Administration stressed that a great task before the United States was to champion aspirations for human dignity.¹⁷² The United States, the Bush Administration proclaimed, “must stand firmly for the nonnegotiable demands of human dignity: the rule of law; limits on the absolute power of the state; free speech; freedom of worship; respect for women; religious and ethnic tolerance; and respect for private property.”¹⁷³ These “nonnegotiable demands of human dignity” echo principles of civil and political rights established in international law.¹⁷⁴ The Bush Administration did not, however, refer to international human rights law in the *National Security Strategy*. U.S. political and constitutional traditions of protecting civil and political rights—“our values”—animate the Bush Administration’s stance on human dignity, not international human rights law.

Missing from the Bush Administration’s conditions for achieving human dignity is a prominent feature of the post-Westphalian framework’s development: the right to health. The human rights turn in global HIV/AIDS policy included both civil and political rights and the right to health, an economic, social, and cultural right in international law.¹⁷⁵ The Bush Administration’s appeal to “our values” does not include the right to health. This situation reflects the Bush Administration’s rejection of a rights-based approach to economic and social issues.¹⁷⁶ The post-Westphalianism of the Bush Administration’s perspective on HIV/AIDS is not as expansive as the integration of human rights norms in UNAIDS policy. The non-negotiability of demands for human dignity illustrates the Bush Administration’s belief that these American values reflect inalienable rights possessed by individuals in every country of the world. In remarks concerning the global fight against HIV/AIDS, President Bush declared that the United States has “a strength in the universality of human rights and the human condition” that guides U.S. policy on this problem.¹⁷⁷ This emphasis on certain civil and political rights and their universal application does not respect the non-intervention principle of Westphalian governance and thus is post-Westphalian.

The Bush Administration connects its non-negotiable demands for human dignity to HIV/AIDS by opposing discrimination against people living with HIV/AIDS. According to the U.S. State Department, “[s]tigma and discrimination against people living with HIV/AIDS creates conditions for

172. NATIONAL SECURITY STRATEGY, *supra* note 3, at 3.

173. *Id.*

174. *See, e.g.*, International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 UNTS 171.

175. UNAIDS, *supra* note 90.

176. L. Kathleen Roberts, *The United States and the World: Changing Approaches to Human Rights Diplomacy under the Bush Administration*, 21 BERKELEY J. INT’L L. 631, 643 (2003) (citing U.S. opposition at the U.N. Human Rights Commission to approaching economic and social matters through a rights-based strategy).

177. President George W. Bush, Remarks by the President on Global and Domestic HIV/AIDS, at <http://www.state.gov/g/oes/rls/rm/2003/17155.htm> (Jan. 31, 2003).

the virus to spread in populations. Efforts should be aimed at fighting the virus, not the people who are living with it.”¹⁷⁸ These sentiments mirror positions taken by UNAIDS on treating people with HIV/AIDS in a non-discriminatory manner and guaranteeing freedom of expression and opinion in relation to HIV/AIDS matters.¹⁷⁹

The Bush Administration’s emphasis on certain civil and political rights as the path to human dignity expresses a broader belief that the resolution of social problems, such as poor health within a country, requires as preconditions a free people and a government accountable to the people. The section on championing the aspirations of human dignity in the *National Security Strategy* mentions neither disease nor health,¹⁸⁰ suggesting that the Bush Administration cannot divorce health from ideology. Elsewhere, the document conceptualizes disease as a threat to human dignity,¹⁸¹ but this threat arises because disease can undermine the conditions and institutions necessary for liberty to thrive in a society. In other words, poor health conditions and epidemics, such as HIV/AIDS, are threats to the effective exercise of civil and political rights rather than threats to the right to health. Further, the Bush Administration emphasizes the need to condition U.S. aid on recipient countries undertaking national reforms. The *National Security Strategy* declares that “[g]overnments must fight corruption, respect basic human rights, embrace the rule of law, invest in health care and education, follow responsible economic policies, and enable entrepreneurship.”¹⁸² Health-related U.S. assistance requires “honest governance” in recipient countries.¹⁸³

By intertwining health and ideology, the Bush Administration follows Thomas Jefferson’s argument that “sick populations were the product of sick political systems.”¹⁸⁴ The Jeffersonian linkage between the type of government and the public’s health produces a radically different approach to the social determinants of health and collective action problems in the axis of illness. The human rights approach to HIV/AIDS policy helped focus more attention on the underlying social causes fueling the pandemic, which ranged from ignorance of the HIV threat to individual health, to lack of equitable and affordable access to health-related services, and to widespread societal poverty. The right to health played a critical role in this governance approach to social determinants of health because it asserted that governments, of all ideologies, had legal and moral obligations to provide the

178. U.S. Department of State, The United States Emergency Plan for HIV/AIDS Relief, at <http://www.state.gov/g/oes/rls/or/21202.htm> (June 10, 2003).

179. UNAIDS, *supra* note 90.

180. NATIONAL SECURITY STRATEGY, *supra* note 3, at 3–4.

181. *Id.* at 10 (“In Africa, promise and opportunity sit side by side with disease, war, and desperate poverty. This threatens both a core value of the United States—preserving human dignity—and our strategic priority—combating global terror.”).

182. *Id.* at 22.

183. *Id.* at 23.

184. *Quoted in* DOROTHY PORTER, HEALTH, CIVILIZATION, AND THE STATE 57 (1999).

highest attainable standard of health.¹⁸⁵ Thus, the right to health approach resembles a 'bottom-up' approach to social determinants of health, which are identified epidemiologically and then transformed into claims for reforms to correct collective action failures.

The Jeffersonian approach, in contrast, is a 'top-down' collective action strategy on social determinants of health. Under this perspective, appealing to corrupt, illiberal governments to improve human health produces futile results. Health without liberty is more dangerous to human dignity than liberty without health. Fundamental political and economic macro-level reform is required to establish a foundation on which improved health conditions for the people, of the people, and by the people can be built. The Bush Administration's non-negotiable demands of human dignity are the pillars on which improved health on a national and global basis can be constructed. The collective action problems at the national level have to be resolved in a certain way that reflects not the right to health but the non-negotiable demands of human dignity.

This approach explains why the Bush Administration wants to channel the vast majority of the funds in the Emergency Plan for AIDS Relief through bilateral channels rather than multilateral vehicles, such as the Global Fund.¹⁸⁶ The United States wants to maximize its leverage with other countries through the funds available for distribution in the Emergency Plan for AIDS Relief. The Global Fund and other multilateral venues do not possess the same top-down leverage as does the United States in demanding fundamental national-level reforms.

3. *Neoconservatism, HIV/AIDS, and Human Rights*

This analysis of the Bush Administration's conceptualization of the HIV/AIDS pandemic raises the important question of whether the differences between the neoconservative approach and the multilateral strategy based in international human rights law matter. One could argue that the Bush Administration's approach promises to (1) increase spending on HIV/AIDS treatment and prevention in developing countries, which is also the goal of advocates for the right to health; and (2) emphasize the importance of not discriminating against people living with HIV/AIDS, which is also the objective of advocates of respecting the civil and political rights of infected persons. Is the Bush Administration rejecting the conventional international human rights strategy on HIV/AIDS but seeking outcomes compatible with the ambitions of this strategy?

The Bush Administration and the global campaign on HIV/AIDS are indeed strange bedfellows: the two perspectives on the pandemic have little in

185. WHO CONST., *supra* note 73, at 1; Declaration of Alma-Ata, *supra* note 82.

186. Critics of the Bush Administration have attacked the unilateralism that they see reflected in the Emergency Plan for AIDS Relief. See Fidler, *supra* note 5, at 141 n.196.

common conceptually, suggesting that whatever synergy currently exists is superficial and fragile. Bush Administration policy on HIV/AIDS flows from premises that fundamentally challenge the interdependence and indivisibility of human rights at the heart of the global HIV/AIDS strategy. First, the Bush Administration stresses the threat the HIV/AIDS pandemic poses for U.S. national security and foreign policy. This Westphalian perspective did not inform the development of the human rights based global strategy against HIV/AIDS. Reliance on Westphalian considerations undermines the thrust of the human rights approach to infectious diseases that places individuals, not states, at the center of policy formulation and action.

Second, the Bush Administration's human rights outlook on HIV/AIDS rejects two critical elements of the global strategy against HIV/AIDS: (1) the multilateralism of international human rights law; and (2) the right to health. The post-Westphalianism of the Bush approach regards the post-Westphalianism of the global HIV/AIDS strategy with skepticism bordering on contempt. This context is a recipe for serious friction between the Bush Administration and global HIV/AIDS efforts. Reports of Bush Administration officials being upset at multilateral HIV/AIDS efforts stealing the limelight from President Bush's Emergency Plan for AIDS Relief¹⁸⁷ reveal more than petty political petulance—they reveal a context in which the strange bedfellows do not enjoy conceptual conjugation of any kind. Such dissonance is also apparent in the controversy between the Bush Administration and multilateral/NGO efforts over the level of short-term financial spending on HIV/AIDS.¹⁸⁸

The differences between the Bush Administration's neoconservatism and the global HIV/AIDS strategy's post-Westphalianism reveal an ideologicalization of the HIV/AIDS problem that may undermine efforts to advance either conception of human rights. The Bush Administration's insistence on abstinence in HIV/AIDS policy represents one example of the consequences of fighting battles over moral philosophy in the context of a catastrophic pandemic.¹⁸⁹ Similarly, the "unilateralism vs. multilateralism" debate trig-

187. John Donnelly, *US and Britain Look to Slow Pace of Spending on AIDS*, BOSTON GLOBE, Oct. 15, 2003, at A24 ("But one US senior health official in Washington, who asked not to be named, and WHO officials said that White House officials have become angry over the attention given to the Global Fund and the WHO for their efforts in fighting AIDS. The US official said that the Bush Administration believes its largely bilateral program promising \$15 billion over five years—\$14 billion of which will be distributed directly to other countries—will be the centerpiece of the AIDS fight and should receive the bulk of credit.").

188. See Allen, *supra* note 10, at A03 (describing NGO concerns about Bush Administration plans to seek only \$2 billion in HIV/AIDS appropriations for fiscal 2004); Kristof, *supra* note 153, at A31 (criticizing President Bush for backtracking on fiscal 2004 financial commitments and for trying to cut urgently needed contributions to the Global Fund); David Brown, *Global Fund Slows Aid Going to Fight 3 Diseases*, WASH. POST, Oct. 17, 2003, at A02 (reporting on U.S. efforts to slow down the pace of spending by the Global Fund).

189. See, e.g., *Pregnant Pause*, *supra* note 12, at 31 (reporting the controversy surrounding the Bush Administration's emphasis on abstinence in HIV/AIDS policy); Kristof, *supra* note 153, at A31 (criticizing the Bush Administration's emphasis on abstinence); Joseph Loconte, *The ABCs of AIDS*, WEEKLY

gered by the Bush approach further illustrates the danger that HIV/AIDS may become a mere backdrop to arguments about the appropriate way the United States should engage in global politics in the twenty-first century.

Political incentives exist, however, that may mitigate any adverse consequences from the ideologicalization of the HIV/AIDS pandemic. Multilateral efforts on HIV/AIDS have incentives not to antagonize the Bush Administration too much because these efforts require the political and financial involvement of the hegemonic United States. The Bush Administration has incentives not to let ideology defeat progress on HIV/AIDS because the administration has given HIV/AIDS such a significant political profile that it cannot, if it is sincere, afford to have its neoconservative vision crushed by the pandemic's unmitigated wrath. As Kristof warned, unless President Bush "delivers on his promises, then it will all look like the most cynical of gestures—using the great health tragedy of our age as a cheap photo-op to drape the White House with compassion."¹⁹⁰ These incentive structures point to the need for constructive concurrency rather than convergence between the neoconservative and multilateral perspectives on addressing the global HIV/AIDS crisis. Crafting constructive concurrency that engages U.S. hegemony and promotes human rights will, as the next Part of the Article explores, prove difficult for reasons that go beyond the Bush Administration's neoconservatism.

IV. HEGEMONY, HUMAN RIGHTS, AND HIV/AIDS: THE AXIS OF ILLNESS IN A UNIPOLAR WORLD

A. *The Hegemony Dilemma*

The attention focused on Bush Administration policy on HIV/AIDS reflects the importance of engaging U.S. power in the global fight against HIV/AIDS and other infectious disease threats.¹⁹¹ U.S. hegemonic power creates a dilemma for efforts to increase the role of international human rights law, including the right to health, in the HIV/AIDS battle. The global HIV/AIDS endeavor has no choice other than persuading or confronting the United States in order to get the hegemon more involved. Hegemony means, however, that the United States enjoys immense freedom of action in its foreign policy because of its unmatched power.¹⁹² This context is an unattractive envi-

STANDARD, Oct. 27, 2003 (defending the Bush Administration's emphasis on abstinence).

190. Kristof, *supra* note 153, at A31.

191. Kickbusch, *supra* note 50, at 199–200 (analyzing what role the U.S. hegemon will play in global health); Ilona Kickbusch, *Influence and Opportunity: Reflections on the U.S. Role in Global Public Health*, 21 HEALTH AFFAIRS 131 (2002). *But see* Sachs, *supra* note 6 (arguing that the world community should not let the United States determine the global agenda because the U.S. perspective leaves long-term challenges, such as infectious diseases, marginalized).

192. A striking thing about reading *New Directions* and the *National Security Strategy* is the emergence of the United States as the hegemon of international politics. In *New Directions*, the Special Assistant for Health Issues observed in 1978 that "[o]ur military and economic supremacy have been increasingly called into question." NEW DIRECTIONS, *supra* note 118, at xix. In 2002, President Bush argued that

ronment in which to effect significant change in U.S. foreign policy on HIV/AIDS with respect to international human rights law. Those who want to increase the role of such law have to appeal to a hegemon that does not need such law to have influence.

The hegemony dilemma does not mean that getting the United States to pay more attention to the global HIV/AIDS problem is impossible. After all, the importance of HIV/AIDS as a U.S. foreign policy issue increased in the post-Cold War period in which the United States emerged as hegemon. Both the Clinton and Bush Administrations approached HIV/AIDS as a serious foreign policy problem. The dominant feature of the increased U.S. foreign policy interest in HIV/AIDS has, however, been conceptualizing the problem as a threat to material U.S. political, security, and economic interests. The Clinton Administration framed the HIV/AIDS pandemic as a threat to U.S. national security, and the Bush Administration continued this approach. Human rights concepts and international human rights law have not driven the hegemon's growing concern about the HIV/AIDS problem. The hegemony dilemma also does not mean that U.S. foreign policy on HIV/AIDS is immutable because of the hegemonic status of the United States. Developing countries and NGOs forced the United States to acknowledge the primacy of public health over intellectual property rights in the battle concerning TRIPS and access to antiretroviral drugs.¹⁹³ The difficulty of achieving this outcome reflects, however, the hegemonic power of the United States.

The U.S. retreat in the access to antiretrovirals controversy does not indicate its acceptance of the right-to-health arguments of advocates for greater access. The retreat reflects the hegemon's calculation that resolving the access issue would defuse the potential for the HIV/AIDS pandemic to create obstacles for the achievement of strategic U.S. national security and trade objectives.¹⁹⁴ This reality reveals that the HIV/AIDS pandemic has become an important foreign policy problem for the United States because of the pandemic's potential to frustrate U.S. strategic interests in areas in which the United States, even as hegemon, needs cooperation, such as the war on terrorism and trade liberalization.

Although this dynamic reveals the foreign policy impact of HIV/AIDS, it also reflects the dominance of the Westphalian framework and does not represent a human rights based transformation of the premises of U.S. foreign

"the United States enjoys a position of unparalleled military strength and great economic and political influence." NATIONAL SECURITY STRATEGY, *supra* note 3, at iv. The *National Security Strategy* further states that "[t]he United States possesses unprecedented—and unequalled—strength and influence in the world." *Id.* at 1. The Carter Administration's embrace of the right to health could be seen as a sign of declining U.S. power and influence and as a strategy to gain the United States more influence and credibility in its struggle with opposing countries and ideologies. Similarly, the Bush Administration's embrace of "our values" signals the self-confidence of a hegemonic power facing no political or philosophical challengers.

193. Doha Declaration, *supra* note 144; TRIPS Council, *supra* note 160.

194. Fidler, *supra* note 5, at 121–22.

policy in the manner contemplated by the Carter Administration. Shifting these premises from their traditional Westphalian template toward making international human rights law, including the right to health, the centerpiece of U.S. foreign policy on HIV/AIDS is a challenge that the hegemony dilemma renders difficult, if not impossible. This situation is disturbing because it means that U.S. foreign policy engagement with HIV/AIDS depends on the pandemic being severe enough to worry the hegemon. Support for this argument can be found in the rise of the HIV/AIDS problem as a U.S. foreign policy issue *after* the pandemic had reached catastrophic proportions.

The seriousness of the hegemony dilemma extends beyond the Bush Administration's neoconservatism, although this philosophical stance is a major impediment to harmonizing U.S. foreign policy with the human rights driven global HIV/AIDS strategy. Hegemony provides the United States extensive freedom in constructing foreign policy. Adopting a foreign policy on HIV/AIDS centered around international human rights law would restrict the policy discretion hegemony creates. The horrific scale of the HIV/AIDS problem would also influence hegemonic resistance to policies based primarily on human rights. The pandemic has grown so large that a serious human rights approach from the United States would create enormous demands on its political power and economic resources. The disproportionate burden the developing world suffers from HIV/AIDS would mean that a human rights based foreign policy on this disease would have to shift significantly more resources toward countries and regions that otherwise have only marginal strategic importance for the United States, such as sub-Saharan Africa.¹⁹⁵ Hegemonic policy discretion is much better served by conceptualizing HIV/AIDS as a threat to national security or macroeconomic concerns.

B. *The Human Rights Dilemma*

Policymakers seeking to increase the role of international human rights law in U.S. foreign policy on HIV/AIDS must also face the human rights dilemma. This dilemma begins with the point made above: HIV/AIDS only became a prominent U.S. foreign policy issue after the pandemic reached disturbing proportions in the developing world. U.S. foreign policy on global health, from Carter to Bush, combined Westphalian and post-Westphalian elements. No administration has approached the axis of illness only on post-Westphalian terms. The human rights element in U.S. foreign policy on health appears to depend on the existence of disease threats serious enough to trouble material U.S. power and interests. The stronger the link-

195. Nicholas Eberstadt, *The Future of AIDS: Grim Toll in Russia, China, and India*, FOREIGN AFF., Nov./Dec. 2002, at 22–23 (“Africa’s AIDS catastrophe is a humanitarian disaster of world historic proportions, yet the political and economic reverberations from this crisis have been remarkably muted outside the continent itself. The explanation for this awful dissonance lies in the region’s marginal status in global economics and politics.”).

age between Westphalian and post-Westphalian elements in U.S. foreign policy on HIV/AIDS, the worse the human rights situation concerning HIV/AIDS seems to be. But disease problems serious enough to trouble the United States typically involve a failure of national or international collective action against deteriorating social determinants of health exacerbated by accelerating human mobility and globalization.

The public health turn toward international human rights law, evident from the preamble to the WHO Constitution and the strategy of UNAIDS, was designed to prevent significant infectious disease crises through respect for civil and political rights and fulfillment of economic, social, and cultural rights. The Westphalian conceptualization of HIV/AIDS as a national security threat to the United States demonstrates that the human rights prevention strategy failed on a global basis because the pandemic has raged to the point of threatening the economic and demographic stability of many developing nations.

The human rights dilemma does not mean that human rights concepts have faded from the policy picture. For example, the controversy over access to antiretrovirals has raised the profile of the right to health; and this right continues to receive significant attention, as evidenced by the work of the Special Rapporteur on the Right to Health.¹⁹⁶ This new attention on the right to health has taken place, however, against the backdrop of a terrible pandemic that has produced, and continues to generate, massive human rights violations and problems around the world.¹⁹⁷ The kind of attention the right to health now receives reflects a dreadful reality the human rights strategy on HIV/AIDS tried unsuccessfully to prevent.

Although human rights continue to play a role in thinking about the HIV/AIDS pandemic, the repeated efforts that have been made within and outside government to connect the HIV/AIDS pandemic and the infectious disease threat generally to the political, security, and economic interests of the United States reinforce both manifestations of the human rights dilemma. First, repeated and high-profile appeals to the self-interest of the hegemon communicate the message that a human rights approach is not sufficient on its own to motivate serious U.S. engagement. Second, arguments about the threat HIV/AIDS poses to the material political, security, and economic interests of the United States rely on the pandemic's massive scale in constructing the threat, but this approach merely underscores the ineffectiveness of the human rights based strategy in motivating governments to deal vigorously and appropriately with HIV/AIDS. The human rights approach

196. Paul Hunt, Report of the Special Rapporteur: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. ESCOR, 59th Sess., Agenda Item 10, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003).

197. According to UNAIDS, fundamental human rights of people living with HIV/AIDS continue to be violated around the world in spite of the evidence that confirms "that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV/AIDS." UNAIDS, *supra* note 90.

to the global HIV/AIDS problem finds itself in the worst of all possible worlds—its policy prominence depends on appeals to the material interests of the United States. These appeals depend on the serious damage HIV/AIDS causes in developing countries. In turn, this damage reflects the ineffectiveness of the human rights strategy constructed to control and mitigate the epidemic.

CONCLUSION: THE AXIS OF ILLNESS IN A UNIPOLAR WORLD

The hegemony and human rights dilemmas suggest that obstacles to strengthening the role of international human rights law in U.S. foreign policy on HIV/AIDS remain beyond the Bush Administration's neoconservatism. The HIV/AIDS problem illustrates the difficulty of fighting the axis of illness in a unipolar world. The Bush Administration argued in the *National Security Strategy* that it wanted to preserve and enhance U.S. hegemony, especially in the military realm, in order to deal effectively with threats to U.S. national security, such as the threat posed by the axis of evil.¹⁹⁸ Maintaining or enhancing U.S. political, military, and economic hegemony will, in all likelihood, make the axis of illness more rather than less dangerous.

The United States has strong political, security, and economic interests in deepening and expanding international trade, commerce, and investment.¹⁹⁹ Pursuit of these interests will stimulate the microbial resilience, human mobility, and globalization risk factors behind the HIV/AIDS pandemic and other infectious disease threats. U.S. hegemony ensures that stimulation of these risk factors will occur without significant opposition and barriers.²⁰⁰ The dominance of the Westphalian framework in U.S. foreign policy on global health means that the United States has less interest in, and less well-developed policies respecting, the risk factors of social determinants of health and collective action problems. U.S. hegemony means that, without U.S. leadership in addressing these risk factors more forthrightly, public health capabilities within and among countries may not keep pace with the demands and dangers generated by accelerated microbial resilience, human mobility, and globalization.

The HIV/AIDS pandemic serves as a warning about the potential harm that the axis of illness can produce, especially in countries suffering adverse

198. NATIONAL SECURITY STRATEGY, *supra* note 3, at 29.

199. *Id.* at 17–20 (describing policies designed to “ignite a new era of global economic growth through free markets and free trade”).

200. The failure of the World Trade Organization's Cancún Ministerial Meeting in September 2003 is not evidence that the U.S. desire for further trade liberalization has been successfully opposed. The United States is moving ahead with trade liberalization through bilateral and regional trade agreements. See *Raising the Barricades*, *ECONOMIST*, Sept. 20, 2003, at 26, 28 (discussing the failure at Cancún and noting that “President Bush has just signed free-trade agreements with Chile and Singapore. In the past year, the Bush team has initiated bilateral trade deals with all Central American countries and five countries in southern Africa, as well as Morocco and Australia. It has also promised to start trade talks with Bahrain and the Dominican Republic. More are likely to follow.”).

social determinants of health and inadequate public health capabilities. Further, as HIV/AIDS also illustrates, U.S. hegemony will not insulate the United States from the direct and indirect threats, crises, and problems that infectious diseases generate in the globalized world of the twenty-first century. The dynamics of a unipolar world will force U.S. domestic and foreign policy to confront infectious diseases and other public health problems more frequently than at any other time in U.S. history.²⁰¹ The fact that the neo-conservative Bush Administration felt compelled to make the HIV/AIDS pandemic the object of significant foreign policy concern, conceptually, politically, and financially, attests to the mounting threat infectious diseases pose in a unipolar world.

The limited progress made to date against the devastating HIV/AIDS pandemic is, in the opinion of UNAIDS, inadequate²⁰² and, in the undiplomatic anger of the U.N. Special Envoy on AIDS in Africa, “the grotesque obscenity of the modern world.”²⁰³ Given this reality, the way in which HIV/AIDS, human rights, and U.S. foreign policy mix together may encourage people to see a vaccine for HIV/AIDS as the only viable option for mitigating the HIV/AIDS nightmare.²⁰⁴ Technological advances in vaccines and antibiotics have, in the past, allowed public health authorities to reduce infectious disease threats temporarily (e.g., tuberculosis) or permanently (e.g., smallpox) without radical changes in national and international governance responses to global health problems. A safe, effective, and globally accessible vaccine would indeed be a scientific *deus ex machina* for the global struggle against HIV/AIDS. In the absence of this technological fix, the prospects for effectively fighting the axis of illness as manifested in the HIV/AIDS pandemic remain, despite increased political attention, funding, and new initiatives,²⁰⁵ rather grim.²⁰⁶

201. In addition to the domestic and foreign policy problems triggered by HIV/AIDS, the United States has recently faced public health challenges from bioterrorism, West Nile virus, antimicrobial resistance, monkeypox, and SARS. For an overview of pathogenic problems bearing down on the United States today, see INSTITUTE OF MEDICINE 2003, *supra* note 19.

202. UNAIDS, *supra* note 52, at 10–14.

203. Quoted in Kessler and Stein, *supra* note 55, at A24.

204. International AIDS Vaccine Initiative, The World Needs an AIDS Vaccine, at <http://www.iavi.org/need/needs.htm> (last visited Oct. 6, 2003) (“Only an AIDS vaccine can end the HIV/AIDS pandemic.”). Leading experts on the global HIV/AIDS problem have recently issued a prominent call for HIV/AIDS vaccine research to be accelerated dramatically. R. D. Klausner et al., *The Need for a Global HIV Vaccine Enterprise*, 300 SCIENCE 2036 (2003).

205. The WHO announced in September 2003, for example, a new initiative to increase the number of people in the developing world who receive antiretroviral treatment to three million by 2005. Press Release, WHO, World Health Organization Says Failure to Deliver AIDS Medicines is a Global Health Emergency, at <http://www.who.int/mediacentre/releases/2003/pr67/en/> (Sept. 22, 2003).

206. UNAIDS, AIDS in Sub-Saharan Africa (Sept. 2003), at <http://www.unaids.org/en/in+focus/topic+areas/estimates+and+projections+-+epidemiology.asp> (last visited Oct. 6, 2003) (“Even if exceptionally effective prevention, treatment and care programmes take hold immediately, the scale of the epidemic means that the human and socioeconomic toll will be massive for many generations.”).