# Profits over Patients:
## *Foreign Actors' Impact on South Africa's HIV/AIDS Epidemic*

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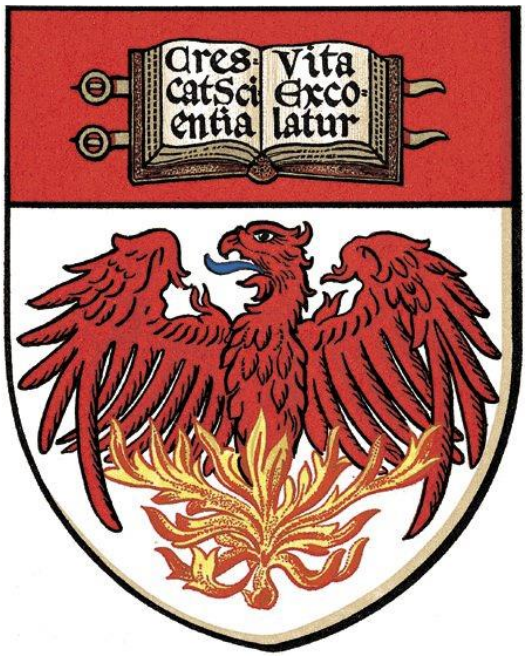


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**Introduction**[1]

In the twelve years following the end of Apartheid (1994-2006), South Africa witnessed a 500% surge in its HIV/AIDS epidemic. Despite the African National Congress's (ANC) introduction of a National AIDS Programme and the designation of the epidemic as a "Presidential Lead Project" in 1994, the country failed to mobilize[2] an effective response to the epidemic, leading to cases increasing from 1 million to 5 million infected citizens by 2006[3]. These cases were highly prevalent in pregnant women with 30% of this population HIV positive[4] and a resulting 80,000 infants born with HIV in 1998. South Africa was not alone in its HIV crisis, with the vast majority of countries in the global south unable to combat HIV/AIDS outbreaks. Interestingly, South Africa, as the most financially developed country in sub-Saharan Africa, had the existing resources to launch a campaign against this disease. Yet, South Africa soon became the country with the largest number of HIV-positive citizens[5], a surprising result when considering the lesser developed, civil war-wrought countries occupying its economic and social peerage. Previous scholars established that domestic[6] factors influenced South Africa's response to the disease. Some discuss how the ANC failed to address the socioeconomic gap brought on by the Apartheid regime, reinforcing a culture of preexisting racial healthcare

[1] For extensive guidance, feedback and comments, I deeply thank Dr. Renslow Sherer and Dr. Linnea Turco. With gratitude, I thank Dr. Matthias Staisch and my classmates in the Committee on International Relations Master of the Arts Program for their consistent and thorough advice on this project.

[2] Schneider, Helen. "Implementing AIDS Policy in Post-Apartheid South Africa." *Social Science & Medicine*, 52, no. 5 (2001): pp. 725. https://doi.org/10.1016/s0277-9536(00)00174-x.

[3] "South Africa." *UNAIDS*, December 26, 2021. https://www.unaids.org/en/regionscountries/countries/southafrica.

[4] McIntyre, James. "HIV in Pregnancy : A Review - UNAIDS." HIV in Pregnancy: a review. *Joint United Nations Programme on HIV/AIDS*, 1998, pp. 5.

[5] Simelela, Nono, W. D. Venter, Yogan Pillay, and Peter Barron. "A Political and Social History of HIV in South Africa." *Current HIV/AIDS Reports* 12, no. 2 (January 2015): pp. 256. https://doi.org/10.1007/s11904-015-0259-7.

[6] Schneider Geoffrey. "The Post-Apartheid Development Debacle in South Africa: How Mainstream Economics and the Vested Interests Preserved Apartheid Economic Structures." *Journal of Economic Issues*. Vol 52, 2018, pp. 313, https://doi.org/10.1080/00213624.2018.1469855

inequality. As a result, millions of low-income South Africans[7] lacked access to treatment or prevention options for the initial decades of the HIV/AIDS epidemic, allowing the disease to quickly spread and proliferate. While South Africa's HIV/AIDS epidemic is a domestic crisis, it cannot be observed without considering international factors influencing South Africa's healthcare and political spheres.

South Africa's HIV/AIDS campaign was complicated by the influence of foreign actors in its domestic politics and economic development. Institutions like the World Bank, which served as a vessel for Western interests, and countries like the United States had considerable stakes[8] in South Africa's post-Apartheid development. Between 1994 and 1998, these forces pressured the ANC to adopt the economic dogma of the global north: neoliberal economic globalization. Specifically advocating for deregulation and free trade[9], neoliberal economics had the potential to cultivate inventive and exciting business practices globally. However, when brought to countries in the global south, with less developed domestic industries and economic principles, neoliberal principles deteriorated[10] economic growth across industries. Recent scholarship finds that neoliberal economics resulted in South Africa's limited job availability, stagnating growth, and increasing poverty. These factors both contributed to South Africa's inequitable, underdeveloped healthcare structure and created the conditions for South Africa's reliance on foreign health aid to combat its HIV/AIDS epidemic.

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[7] Kenyon, Chris, and Sizwe Zondo. "Why Do Some South African Ethnic Groups Have Very High HIV Rates and Others Not?" *African Journal of AIDS Researc*h, vol. 10, no. 1, 2011, pp. 51, https://doi.org/10.2989/16085906.2011.575548.

[8] Appel, Hilary, and Mitchell A. Orenstein. "Why Did Neoliberalism Triumph and Endure in the Post-Communist World?" *Comparative Politics,* vol. 48, no. 3, 2016, pp. 313, http://www.jstor.org/stable/24886207.

[9] Ibid.

[10] World Trade Organization, "World Trade Report 2008: Trade in a Globalizing World", World Trade Report, June, 2008, pp. 41, https://doi.org/10.30875/e89f8212-en

South Africa's underdeveloped healthcare structure inhibited its research and manufacturing capabilities. Countries in the global north, consisting of the world's most developed, post-industrial countries, had broad access[11] to research and production channels. The United States, using its international system of production channels and internal resources, was able to provide HIV/AIDS treatment options to its citizens by the early 1990s. Countries able to afford these expensive treatments began to witness a decrease in HIV-positive tests in the same decade. However, World Health Director Jonathon Mann described a different picture in the global south with the disease, "rob[bing] societies of people who are in their most productive years"[12] in the 1990s. South Africa, amongst other countries of Sub-Saharan Africa, lacked the research resources and production pipelines to mass produce, let alone afford, the expensive treatments created in the global north. Even the countries with access to these resources were inhibited by trade agreements[13] from selling cheap generics to South Africa. South Africa's struggle to financially access the necessary treatment for its HIV-positive citizens indicates that it had to mitigate its efforts with international interests of the global north's pharmaceutical interests. Countries like Japan and the United States attempted to buttress[14] their economic gain in patented drugs at the expense of affordable treatment campaigns for HIV/AIDS in the global south. Even when the United States launched the President's Emergency Plan for AIDS Relief (PEPFAR), their bilateral foreign aid campaign in South Africa, it came with the caveat of

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[11] Boden, Mark. "Neoliberalism and Counter-Hegemony in the Global South: Reimagining the State." *Social Movements in the Global South*, 2011, pp. 84., https://doi.org/10.1057/9780230302044_4.

[12] Mann, Jonathan M. "Statement at an Informal Briefing on AIDS to the 42nd Session of the United Nations General Assembly." Journal of the Royal Statistical Society. Series A (Statistics in Society), vol. 151, no. 1, 1988, pp. 134, https://doi.org/10.2307/298218.

[13] Kacowicz, Arie M. "Globalization, Poverty, and the North-South Divide." *International Studies Review*, vol. 9, no. 4, 2007, pp. 566, http://www.jstor.org/stable/4621860.

[14] Watal, Jayashree, et al., "The Making of the TRIPS Agreement." *World Trade Organization*, World Trade Organization, pp. 31, https://www.wto.org/english/res_e/booksp_e/trips_agree_e/history_of_trips_nego_e.pdf.

funding being initially spent on expensive American name-brand pharmaceuticals over cheaper generics.

In this research paper, I aim to answer why South Africa was initially unable to both effectively slow the spread of HIV/AIDS and provide better healthcare resources to its citizens in the decade following the end of Apartheid. I will address this question by discussing how relevant actions of foreign players influenced South Africa's poor response to the epidemic. The prominence[15] of international actors in South Africa's economic and aid systems during and after Apartheid makes this lens particularly useful. I will first establish that previous literature identifies how neoliberal economic globalization led to the uncontrolled spread of the disease and restrictions on treatment campaigns. In doing so, I will illuminate a gap in the existing scholarship that fails to address and identify the strategic altruism of foreign players in the HIV/AIDS epidemic. I define strategic altruism as a behavior adopted by international players to promote a self-motivated agenda within a seemingly benevolent act. I will focus on the neoliberal economic tenants of free trade and economic openness to showcase how foreign actors, particularly the World Bank and the United States, manipulate the policies they pressure onto other countries. I will identify these actors and how their actions impacted South Africa between 1994 and 2004 through three external influences: western pressures on South Africa to adopt a neoliberal economic system, the self-interested threat from the United States of sanctions, and the strategic altruism of PEPFAR, the United States' bilateral foreign aid HIV/AIDS campaign in South Africa. I will argue that foreign actors placed their own interests before ensuring that South Africa had the most effective response to its HIV/AIDS epidemic.

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[15] Narsiah, Sagie. "Neoliberalism and Privatisation in South Africa." *GeoJournal*, vol. 57, no. 1/2, Springer, 2002, pp. 29, http://www.jstor.org/stable/41147695.

**Literature Review: South Africa's HIV/AIDS Epidemic**

This review will examine existing literature that identifies factors contributing to South Africa's devastating HIV/AIDS epidemic. A group of literature[16] identifies the lackluster response from the South African government as the prime domestic cause of the epidemic's rise. Other literature[17] associates the phenomena of neoliberal economics with the rise in HIV infections and shortcomings of aid campaigns. However, both categories fail to sufficiently hold specific international actors accountable for the epidemic. Without this central perspective, these articles are unable to flesh out a holistic, realist understanding of how foreign motivations and self-interest interfered with humanitarian aid campaigns. This review will explain the shortcomings in the existing literature, recognizing how scholars fail to dedicate enough attention to international actors who exacerbate the HIV/AIDS epidemic globally and locally. To accomplish this, I will first provide a discussion of scholarship on the domestic failures of governmental leadership in South Africa's post-Apartheid economic restructuring and HIV/AIDS crisis. I will then provide an overview of articles discussing the relationship between neoliberal economic tenants and the spread of the HIV/AIDS epidemic. I will show how these articles fail to extensively identify the foreign actors responsible for these policies. I will conclude with a review of proxy literature that successfully recognizes foreign actors and their motivations for involvement in HIV/AIDS epidemics outside of South Africa. In doing so, I will showcase the importance of distinguishing the roles of foreign actors and their motivations in South Africa's HIV/AIDS epidemic response.

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[16] Schneider Geoffrey. "The Post-Apartheid Development Debacle in South Africa: How Mainstream Economics and the Vested Interests Preserved Apartheid Economic Structures." *Journal of Economic Issues*. Vol 52, 2018, pp. 313, https://doi.org/10.1080/00213624.2018.1469855

[17] Altman, Dennis. "Globalization, Political Economy, and HIV/AIDS." *Theory and Society*, vol. 28, no. 4, Springer, 1999, pp. 564, http://www.jstor.org/stable/3108562.

*Domestic Blame Games*

Previous literature identified domestic leadership's economic self-interest as the primary source of continued socioeconomic inequality in South Africa. Geoffrey Schneider finds that the ANC did not focus on economic or healthcare redistributions[18] following the end of Apartheid. He criticizes the black elite population of South Africa, including key ANC figures like President Cyril Ramaphosa, for seizing all capital available to them instead of promoting redistribution policies for the majority black population to access. Schneider fails to account for the English and Dutch institutions that encouraged and enabled the corruption of South Africa's wealth redistribution. Schneider's narrative casts a harsh judgment on the elite members of the ANC and Pan Africanist Congress while ignoring the foreign institutions, like the British-owned *Anglo-American Corporation*[19], that created the restrictive circumstances for an allied group in the exclusive black elite leadership.

Moreover, the existing literature blamed President Mandela's initial lackluster[20] response without considering the foreign influences preventing him from acting on the epidemic. Commentators described President Mandela as a "late-bloomer to the fight against AIDS[21]." Helen Schneider finds that while President Mandela's government launched a *National Aids Programme*, insufficient attention and oversight were directed to implementing[22] this program

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[18] Schneider Geoffrey. "The Post-Apartheid Development Debacle in South Africa." pp. 313.

[19] Vilakazi, Thando, and Teboho Bosiu. "Black Economic Empowerment, Barriers to Entry, and Economic Transformation in South Africa." *Oxford Scholarship Online*, Oxford University Press, Sept. 2021, pp. 195., https://oxford.universitypressscholarship.com/view/10.1093/oso/9780192894311.001.0001/oso-9780192894311-chapter-9

[20] Leclerc-Madlala, Suzanne. "Popular Responses to HIV/AIDS and Policy." *Journal of Southern African Studies*, vol. 31, no. 4, 2005, pp. 846, http://www.jstor.org/stable/25065050.

[21] Ernstes, Casey. *Nelson Mandela: Late Bloomer in the Fight Against HIV/AIDS*. Borgen Magazine, 19 Jan. 2014, https://www.borgenmagazine.com/nelson-mandela-late-bloomer-fight-hivaids/safrica-mandela-obit-files/.

[22] Schneider, Helen. "Implementing AIDS Policy in Post-Apartheid South Africa." Social Science & Medicine, 52, no. 5, 2001: pp. 725. https://doi.org/10.1016/s0277-9536(00)00174-x.

successfully. She addresses how although large funds had been raised domestically and internationally for addressing the epidemic, the *National AIDS Programme* did not have the experience or personnel to effectively distribute these funds and guides to provincial governments. Schneider fails to account for the motivations of international actors to give financial support but not guidance on how to use said resources to a newly-formed government. Similarly, Virginia van der Vliet addresses the failures of Mandela's response to the epidemic, noting that "personnel and finances were already overstretched[23]." Her article successfully accounts for the continued presence of unsupportive middle bureaucrats from the Apartheid-era Nationalist party[24], adding additional stress and instability to Mandela's response to the HIV/AIDS Epidemic. However, der Vliet neglects to consider the massive pressures from international actors on Mandela's government to act on foreign issues of pertinence, which included the adoption of a neoliberal economic system. This pressure was extreme when considering the global attention Mandela's government received to see whether they were capable of effectively running a country and guaranteeing South Africa's economic stability. Without acknowledging the actions of foreign actors during Mandela's presidency, scholars fail to paint an accurate depiction of why Mandela failed to undertake a strong response to the epidemic.

Similarly, scholars criticized President Thabo Mbeki's promotion of unproven domestically-made HIV treatments. Didier Fassin discusses President Mbeki's public endorsement of the South African-developed drug Virodine[25] as an HIV/AIDS treatment. Fassin

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[23] van der Vliet, Virginia. "AIDS: Losing 'The New Struggle'?" *Daedalus*, vol. 130, no. 1, The MIT Press, 2001, pp. 158, http://www.jstor.org/stable/20027683.
[24] Ibid.
[25] Fassin, D. "The Politics of AIDS in South Africa: Beyond the Controversies." BMJ, vol. 326, no. 7387, 2003, pp. 495, https://doi.org/10.1136/bmj.326.7387.495.

notes that this endorsement faced general criticism from the medical community due to the presence of dimethylformamide, a toxic industrial solvent, in Virodine. Similarly, Joseph Amon, notes how President Mbeki promoted other false treatments like an edible mixture of garlic, olive oil, beetroot, and lemon for HIV, finding antiretroviral therapy (ART) to be a "toxic[26]" treatment. However, these scholars do not indicate why President Mbeki, who previously[27] voiced the significance of addressing the ongoing epidemic and demanded foreign aid, promoted these treatments. They neglect to recognize factors like the exorbitant $20,300 per patient cost for American-made ART treatment and the threat of sanctions[28] from the United States for seeking out cheaper, generic alternatives[29].

*Neoliberal Globalization and Epidemics*

Neoliberal economic openness promoted the spread of disease by increasing global travel and the transnational movement of commerce. Dennis Altman discusses how the transformation of the modern world economy directly increased HIV/AIDS spreadability. Altman notes how economic globalization increases population and free trade movements around the world, leading to HIV/AIDS "link[ing] the least developed and the most developed regions of the world[30]." However, Altman does not immediately identify the regions or actors engaging in these international economic networks. This lack of identification leads to complications in identifying the harmful impact neoliberal economics can have on countries like South Africa. Similarly,

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[26] Amon, Joseph J. "Dangerous Medicines: Unproven Aids Cures and Counterfeit Antiretroviral Drugs." *Globalization and Health*, vol. 4, no. 1, 2008, p. 5., https://doi.org/10.1186/1744-8603-4-5.
[27] Mbeki, Thbabo. "Documents - Thabo Mbeki's Letter In the Age of AIDS." *Frontline*, Public Broadcasting Service, 30 May 2006, https://www.pbs.org/wgbh/pages/frontline/aids/docs/mbeki.html.
[28] Gellman, Barton. "A Conflict of Health and Profit." *The Washington Post*, WP Company, 21 May 2000, https://www.washingtonpost.com/archive/politics/2000/05/21/a-conflict-of-health-and-profit/bf7bd742-b153-46ee-a50a-666b2c4c30d6/.
[29] I will return to this pertinent topic in Case II of this paper to fully flesh out the external influences contributing to President Mbeki's AIDS denialism and his regime's inability to provide treatment for South African citizens.
[30] Altman, Dennis. "Globalization, Political Economy, and HIV/AIDS." pp. 564.

David Kotz theorizes that this connectivity forces political, economic, and physical borders[31] to open, yet does not identify specific cases of when and how this phenomenon occurs. The absence of identifiable actors and impacted nations in these works bring about a demand for more explicit case studies. Ultimately, existing scholarship fails to provide sufficient details on the actors promoting economic openness and the harm this has to local outbreaks of HIV/AIDS.

Economic openness also led to unprecedented levels of labor mobility in the early 2000s, increasing the infectivity of HIV. Steven Weine describes how labor mobility, brought on by neoliberal removal of trade barriers[32], is associated with increased percentages of HIV infections. His findings noted the frequency of "multiple partnering" and "limited condom use[33]" in migrant labor groups increased the chances of infection. Weine's methodology provides a global overview of cases, briefly touching upon anecdotes without sufficient details. In doing so, he shapes a narrative on a global phenomenon that misses essential details on these regional cases. Dennis Altman offers another brief scope of economic openesses, describing how tourism[34] from the global north to locations in the global south presented opportunities for infections to travel across national borders. Altman attempts to specify these tourist-based exchanges, noting[35] instances with visitors from the United States to Haiti. However, he only briefly mentions these instances, indicating demand for a closer observation that takes other pertinent externalities into account. David Stuckler expands on international labor mobility, highlighting how 30% of migrant miners in South Africa were "infected with HIV within 18 months of working on the

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[31] Kotz, David M. "Globalization and Neoliberalism." *Rethinking Marxism*, vol. 14, no. 2, 2002, pp. 65, https://doi.org/10.1080/089356902101242189.
[32] Weine, Stevan M, and Adrianna B Kashuba. "Labor migration and HIV risk: a systematic review of the literature." *AIDS and Behavior*, vol. 16,6 (2012): 1608. doi:10.1007/s10461-012-0183-4
[33] Ibid.
[34] Altman, Dennis. "Globalization, Political Economy, and HIV/AIDS." pp 573.
[35] Ibid.

mines[36].” This study accounts for a specific case on labor mobility and HIV transmission but does not provide sufficient details of the actors, including the international mining companies[37], involved in shaping the high prevalence of HIV/AIDS in these mines. This study would be greatly supplemented by details discussing how international demand for South African gold led to the expansion of these mines, removing male workers from their families and increasing instances of transactional sex[38]. While scholars propose how economic neoliberalism has increased the spread of HIV infections globally, they fail to flesh out well-rounded accounts of this phenomenon in each anecdote they observe.

Neoliberal globalization also created trade practices that harmed the global south’s ability to fight HIV/AIDS outbreaks. The International Labor Union’s (ILU) 2005 *HIV/AIDs and World in Globalizing World* report notes that some developing countries have seen improved growth and reduced poverty[39] in the face of free trade. It vaguely describes that the “economies of some countries in sub-Saharan Africa highly affected by HIV/AIDS are poorly integrated into the world economy.”[40] The report fails to specify these countries and their individual economic contextual systems. Moreover, the report does not provide details for what their “poor” integration is defined by, creating a vague depiction of inequality. Without detailing this integration or specifying the countries, the ILU’s report fails to properly demonstrate how global disconnection prevents these countries from accessing resources such as antiretroviral therapies

[36] Stuckler, David et al. “Introduction: 'dying for gold': the effects of mineral mining on HIV, tuberculosis, silicosis, and occupational diseases in South Africa.” *International Journal of Health Services*, vol. 43,4 (2013): 639. doi:10.2190/HS.43.4.c

[37] Vilakazi, Thando, and Teboho, Bosiu. “Black Economic Empowerment.” pp 5.

[38] Corno, Lucia and de Walque, Damien. "Mines, migration and HIV/AIDS in southern Africa," Policy Research Working Paper Series 5966, The World Bank. 2012, pp. 4.

[39] International Labor Office. *HIV/AIDS and Work in a Globalizing World*, pp 14.

[40] International Labor Office. *HIV/AIDS and Work in a Globalizing World*, pp 15.

for treating HIV patients[41]. While the ILO report discusses how disconnected trade practices can theoretically impact countries in sub-Saharan Africa, it does not specify how countries in the global north circumvent such disconnected trade practices through foreign aid endeavors in specific countries of sub-Saharan Africa.

Existing trends in globalization also establish exclusive free trade practices in the healthcare industry during the scope (1994-2006) of this project. Jill Fisher discusses how medical economic neoliberalism turned medical patients into consumers, commercializing[42] the health of a society. The article raises a theory that under the economic conditions in the early 2000s, medicine had turned into, "a set of commodities to which individual patients have different degrees of access[43]." However, the article fails to indicate specific cases of how this plays out, establishing a broad concept of healthcare commodification. Such healthcare commodification is notable in the international pharmaceuticals industry, where drugs are priced for the highest paying buyers. Fisher fails to specify relevant context on the patients and providers in her article. These consumers and companies are commonly found in the global north[44], leaving patients of the global south unable to secure expensive medicines for their health. This contextual information is essential for delivering a comprehensive understanding of the global health sector resource disparity. Patrick Bond and George Dor suggest that neoliberalism has resulted in the inaccessibility of medical equipment, drugs, and transport in Sub-Saharan Africa, directly impacting these countries' abilities to "deal with AIDS-related

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[41] Ibid.
[42] Fisher, Jill A. "Coming Soon to a Physician Near You: Medical Neoliberalism and Pharmaceutical Clinical Trials." *Harvard Health Policy Review*, vol. 8,1. 2007, pp. 64.
[43] Ibid.
[44] Legge, David G. "Covid-19 Response Exposes Deep Flaws in Global Health Governance." *Global Social Policy*, vol. 20, no. 3, 2020, pp. 384., https://doi.org/10.1177/1468018120966659.

illnesses[45].” Yet Bond fails to mention the role of foreign aid in these countries’ campaigns against the HIV/AIDS epidemic, missing a crucial discussion of how countries and institutions in the global north can bring in otherwise inaccessible medications to places like South Africa. Ultimately, the discussion around medical economic neoliberalism in the international scope misses the distinction of actors involved in this exchange.

*Regional Case Studies*

In this section, I will provide a review of literature that successfully establishes a holistic view of HIV/AIDS epidemics outside of South Africa by identifying foreign actors and their motivations for involvement in the outbreak. By discussing this literature, I will show the importance and potential of identifying foreign actors and their motivations when studying the growth of the HIV/AIDS epidemic in South Africa.

Previous literature established a precedent for identifying the sources of oppressive neoliberal economic policies which exacerbate the HIV prevalence in a country. Jason Hickel explores the factors influencing the high transmissibility of HIV/AIDS in Swaziland, discussing domestic conditions of “deteriorating healthcare services[46].” However, he does not just account for domestic sources of Swaziland’s lackluster medical resources; Hickel also provides scope on key foreign influences. His article associates Prime Minister Margaret Thatcher and President Ronald Reagan’s promotion of neoliberal economic globalization through specific deregulations of international trade practices[47] with increased global HIV transmission. He then applies the impact of these neoliberal economic policies to Swaziland, giving specific examples of how they

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[45] Bond, Patrick, and George Dor. “Uneven Health Outcomes and Political Resistance under Residual Neoliberalism in Africa.” *Neoliberalism, Globalization, and Inequalities*, 2020, pp. 345., https://doi.org/10.1201/9781315231082-25.

[46] Hickel, Jason. “Neoliberal Plague: The Political Economy of HIV Transmission in Swaziland.” *Journal of Southern African Studies*, vol. 38, no. 3, 2012, pp. 517., https://doi.org/10.1080/03057070.2012.699700.

[47] Hickel, Jason. “Neoliberal Plague” pp. 513.

shaped the healthcare sector and increased domestic "labor migration and transactional sex[48]." This distinction shapes an understanding of foreign actors' impact on the spread of HIV infections in Swaziland and the country's inability to mitigate the epidemic, establishing a comprehensive scope of the epidemic's prominence. Hickel's case study successfully builds a multi-faceted lens on domestic and foreign actors' ability to advance domestic epidemics that I will use to accurately depict the nuanced factors impacting South Africa's HIV/AIDS outbreak.

Additionally, literature written about Haiti's HIV/AIDS outbreak reveals the necessity of using both primary and secondary discussions of the epidemic to correctly show foreign players' relevant actions and shortcomings. The 2001 Cange Declaration was a call from patients with HIV in Cange, Haiti, publicly declaring a demand for affordable treatment and accessible care. The declaration notes, "For HIV treatment, for example, we see in the newspaper that it should cost less than $600 per year. Although that is what is quoted in the press statements, here in a poor, small country like Haiti, it costs twice as much[49]." The declaration depicts how neoliberal free trade[50] created variable drug pricing that made countries, like Haiti, dependent on foreign aid campaigns for otherwise unaffordable HIV treatments. The declaration follows up on this vague statement by naming the foreign actors providing supposed aid and the fallacies of their actions. It calls on the World Bank, an institution of neoliberal globalization that enabled disparate global drug pricing, to "stop wasting critical funds[51]." However, the declaration lacks a detailed explanation of how the World Bank has created a lacking response to the epidemic.

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[48] Ibid.

[49] "Cange Declaration: PIH's First HIV Patients Advocate for Equal Access to treatment." *Partners In Health*, 2013, pp. 1, https://www.pih.org/article/cange-declaration-pihs-first-hiv-patients-advocate-for-equity-in-access-to.

[50] Legge, David G. "Covid-19 Response Exposes Deep Flaws in Global Health Governance." pp. 385.

[51] "Cange Declaration," pp. 2.

Secondary literature reveals how the World Bank's Multi-Country AIDS Program[52] developed ineffective and inequitable distributions of funding. Christopher Simms elaborates on the declaration by noting that Brazil's HIV funding was half[53] as much as the African continent's, despite Brazil having an extremely low HIV prevalence rate. Simms also notes that in 1999 the World Bank's Health, Nutrition, and Population Unit had a dismally low number of AIDS projects in all of Africa, all of which were phased out[54] by the turn of the century. When combined, the Cange Declaration and secondary sources accurately demonstrate how the World Bank provided unequal, poorly-organized aid programs that misrepresented the combat against the HIV/AIDS epidemic. This approach is pertinent to my project due to the relevant role the World Bank had in shaping inequitable, healthcare conditions in South Africa during the transitionary period (1994-1998) following the end of Apartheid.

Importantly, the insights of primary stakeholders in Haiti's HIV/AIDs epidemic reveal essential externalities influencing foreign actions towards the epidemic. Paul Farmer, the founder of *Partners in Health*, a leading American HIV/AIDS organization, describes how foreign aid campaigns for the HIV/AIDS outbreak in Haiti initially excluded treatment and antiretroviral medication (ARV) programs. Farmer, through his work with *Partners in Health*, transformed the domestic and international response to Haiti's growing HIV/AIDS epidemic. Moreover, Farmer used his insight to show why countries of the global north favored cheaper prevention campaigns[55] over promoting the use of effective highly active antiretroviral therapy (HAART).

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[52]Harman, Sophie. "The World Bank: Failing the Multi-Country AIDS Program, Failing HIV/AIDS." *Global Governance* 13, no. 4 (2007): pp. 487. http://www.jstor.org/stable/27800678.

[53] Simms, Chris. "The World Bank and sub-Saharan Africa's HIV/AIDS crisis." *Canadian Medical Association Journal*, vol. 176, 12, 2007, pp. 1728. doi:10.1503/cmaj.061661

[54] Ibid.

[55] Farmer, Paul, et al. "Community-Based Approaches to HIV Treatment in Resource-Poor Settings." *The Lancet*, vol. 358, no. 9279, 2001, pp. 404., https://doi.org/10.1016/s0140-6736(01)05550-7.

Farmer provides the context that the existing substandard Haitian healthcare infrastructure served as an excuse for both Haiti's government and international aid organizations to avoid providing these treatments. However, Farmer's team ran a trial, proving the effectiveness of HAART treatment in a "poor community in rural Haiti[56]," thus suggesting that existing aid campaigns were not providing the most successful programs. These campaigns included funding and oversight from PEPFAR, which largely went towards abstinence-based prevention education rather than the financing of essential STI barrier devices like condoms. Farmer's firsthand work with *Partners in Health* in Haiti emphasizes a human rights-based approach that demands the engagement and active involvement of affected communities. His article suggests the importance of including the perspective of primary individuals, including doctors, patients, and local activists, in studies on domestic epidemics. Moreover, his study and personal experiences show that foreign aid providers were cost-motivated to implement less-effective, cheaper prevention campaigns over more costly treatment campaigns. Understanding the motivations of these foreign actors shapes essential context on why foreign aid campaigns failed to deliver the most effective resources to Haiti's HIV/AIDS epidemic. Ultimately, a holistic depiction of a country's HIV/AIDS epidemic is enhanced by the inclusion of insights from communities and individuals working against the disease.

This literature review reveals that there is an importance in identifying the international actors that impact South Africa's HIV/AIDS epidemic. Scholars are quick to criticize governments and national public health authorities, vaguely citing neoliberal economics as exacerbating HIV/AIDs infections and aid campaigns without accounting for the massive influence of international players. Without extensively noting the role of international actors,

[56] Ibid.

these scholars fail to depict an accurate and comprehensive outlook on why South Africa's epidemic has become so devastating. My discussion of proxy literature reveals that it is essential to document how foreign actors engaged in strategic altruism during the South African HIV/AIDS outbreak from 1994 to 2006. I aim to identify these foreign actors and how their motivations influenced South Africa's HIV/AIDS epidemic by using a combined scope of primary and secondary literature. This project will orient around South Africa's outbreak during the twelve years following Apartheid (1994-2006) due to the 500% increase[57] in cases in this timeframe and the wide-sweeping efforts of international players to involve themselves in the epidemic. I will illuminate a key element of how foreign interests initially failed to balance their altruistic efforts with their self-interested behavior in aid campaigns against South Africa's HIV/AIDS epidemic.

**Case I: Economic Reinforcement for Healthcare Inequality**

Between 1994 and 2006, both social and economic inequality increased in South Africa. Despite introducing policy efforts to increase welfare and having one of the largest government social grant programs in the world, South Africa remains to have the world's highest[58] Gini coefficient[59]. South Africa's inequality growth covers many areas of life in the country; it is particularly strong in the country's healthcare domain. Additionally, this inequality fits pre-Apartheid demographic trends, largely being found in the majority black population of South

[57] "South Africa." *UNAIDS*, December 26, 2021. https://www.unaids.org/en/regionscountries/countries/southafrica.
[58] Schneider Geoffrey. "The Post-Apartheid Development Debacle in South Africa: How Mainstream Economics and the Vested Interests Preserved Apartheid Economic Structures." *Journal of Economic Issues*. Vol 52, 2018, pp. 313, https://doi.org/10.1080/00213624.2018.1469855
[59] A measurement showing the statistical distribution of income inequality across a country.

Africa. Noteworthy, South Africa's maternal mortality rate increased[60] between 2000 and 2005, going from 160 to 201 deaths per 100,000 live births. This is concerning when compared to decreasing trends[61] for maternal mortality rates in countries of the global north and is attributed to the prevalence of HIV in pregnant South African mothers[62]. Many economists find that South Africa's post-Apartheid adoption of a neoliberal, open-market trade economy[63] is a defining source of this healthcare inequality, yet fail to provide a comprehensive evaluation of why South Africa adopted this system. To understand how the country's post-Apartheid economic system has influenced capabilities and responses to the epidemic, I will look to the comprehensive influence of foreign actors on South Africa's economic development. As one of the top five growing economies in the 1990s[64], South Africa was a target for economic attention from foreign investors and governments. In this section, I will argue how foreign pressure for pursuing neoliberal economics exacerbated South Africa's existing racially disparate response to the HIV/AIDS epidemic, rather than offering a solution to the ongoing health crisis.

South Africa's society was defined by racially-segregated systematic inequality through the Apartheid state. In the approximate forty years of Apartheid (1950-1994), South Africa's black population was stripped of socio-political and economic autonomy. Measures during the regime included the forced relocation of black South Africans into established bantustans or

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[60] Jamison, Dean T., et al. "Chapter 16 Maternal Mortality." *Disease and Mortality in Sub-Saharan Africa*, 2nd. ed., World Bank, Washington, D.C, 2006.

[61] Nour, Nawal M. "An Introduction to Maternal Mortality." *Reviews in Obstetrics & Gynecology* vol. 1,2 (2008): pp. 78.

[62] McIntyre, James. "HIV in Pregnancy : A Review - UNAIDS." pp. 5.

[63] Smis et al. "EU South African Trade, Development and Cooperation Agreement: Bane or Boon for Socio-Economic Rights under the South African Constitution?." *European Law Journal*. Vol 20. No 6. 2014, pp. 795, http://dx.doi.org/10.1111/eulj.12106

[64] O'Neill, Aaron. "Topic: BRICS Countries." *Statista*, Statista, https://www.statista.com/topics/1393/bric-countries/#:~:text=The%20BRICS%20countries%2C%20namely%20Brazil,emerging%20economies%20in%20the%20world.

townships[65], limitations on the occupations and income of black South Africans, and the restriction of voting rights[66]. These factors, among others, led to the extremely disparate healthcare resources and facilities for South Africa's black population. Hospitals for black South Africans were dismally operated, lacking the personnel and resources to serve communities[67]. These disproportionate conditions translated to the Apartheid regime's response to the rising epidemic in the early 1990s: "white patients receive state-of-the-art intensive care unit and AZT treatment… In contrast, the state's response to the AIDS problem in the Black community is described as irresponsible and ineffectual.[68]" South Africa's Apartheid state created the foundations for a racially-unequal response in the initial years of the HIV/AIDS epidemic. This foundation meant that only the wealthiest in South Africa, the white elite most unlikely to contract HIV, were able to afford treatment for the virus. The Apartheid regime established a precedent for racial healthcare inequality that needed to be dismantled.

Following the end of Apartheid, the ANC failed to address the country's healthcare inequality due to foreign pressures for the country to adopt an open market neoliberal economy. While the ANC initially had a "socialist" economic proposal, including provisions for expanded healthcare accessibility, South African leaders were pressured by "multilateral institutions such as the World Bank,"[69] to pursue a neoliberal open market trade system. The World Bank is

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[65] Roberts, Margaret. "The Ending of Apartheid: Shifting Inequalities in South Africa." *Geography*, vol. 79, no. 1, Geographical Association, 1994, pp. 54, http://www.jstor.org/stable/40572386.
[66] Skovsholm, Klavs. "The Right to Vote in South-Africa - A Hundred Years of Experience." *Law and Politics in Africa, Asia and Latin America*, vol. 32, no. 2, 1999, pp. 238, http://www.jstor.org/stable/43110246.
[67] Seftel, David. "AIDS and Apartheid: double trouble." Africa report (1988), 17.
[68] Toms, Ivan. "AIDS in South Africa: Potential Decimation On the Eve of Liberation." *Progress Reports On Health & Development in Southern Africa*, 1990, pp. 13.
[69] Narsiah, Sagie. "Neoliberalism and Privatisation in South Africa." pp. 29.

dominated by the influence of majority shareholders[70] from the United States and other countries of the global north, with a distinct agenda to broaden the reach of economic globalization into new markets. This agenda is demonstrated by the World Bank sending advisors to South Africa and having ANC leadership travel to Washington D.C. for education on the principles of neoliberalism. Moreover, the ANC inherited the budget deficits, debts, and economic shortfalls[71] of the preceding Nationalist party, leading to leaders quickly defaulting on their original economic plan. Rather than helping the ANC with its inherited debt, countries like the United States used this economic circumstance to pressure South Africa into pursuing a neoliberal economic model. South Africa was thus inhibited by international influences and pre-existing domestic circumstances from pursuing the inclusive economic system and accessible healthcare structure initially sought by the leaders of the ANC. By continuing the economic agenda of the preceding Nationalist party, the ANC built upon the foundation of Apartheid's rampant economic and healthcare inequality.

The international and domestic pressure to pursue a neoliberal economic system combined with initial efforts to preserve some ANC economic goals resulted in South Africa's convoluted economic structure. South Africa's economic characteristics fluctuate between the established coordinated market economy (CME), liberal market economy (LME), and state-permeated market economy models: "South Africa has the strong trade unions and welfare system of CMEs but the deregulation for financial markets and businesses of LMEs."[72] These conditions established contradictory and uncoordinated economic practices of strong labor and

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[70] "Member Countries." *World Bank*, 20 Nov. 2020, https://www.worldbank.org/en/about/leadership/members#:~:text=The%20organizations%20that%20make%20up,policy%2C%20financial%20or%20membership%20issues.

[71] Davies, Matthew. "Nelson Mandela: His Economic Legacy." *BBC News, BBC*, 9 Dec. 2013, pp. 2., https://www.bbc.com/news/business-23041513.

[72] Schneider, "The Post-Apartheid Development Debacle", pp. 317.

business power, resulting in the stagnation and decomposition of domestic development and existing healthcare structures. The stagnation of the existing Apartheid-era healthcare system contributed to South Africa's weak foundation for HIV prevention and care of its Black population. Additionally, this deterioration is further provoked by South Africa sharing the "leading central state-business coordination"[73] of state-permeated market economies. This economic system would ideally be suitable for South Africa, placing it in a group of emerging markets like China, Brazil, and India, garnering prominent attention and funds from foreign investors. However, South Africa did not entirely operate in this model due to a state-led "promotion of short term profit-seeking over long term development of new job-creation"[74] and the pressure from western powers to adapt to their existing trade structures and development. These mechanisms led to South Africa's disastrously high unemployment and industry stagnation, making it difficult for the country to provide essential health welfare programs on its own in the twelve years post-Apartheid. As a result of South Africa's disparate economic system, the country has to rely on major foreign aid providers and foreign manufacturers to mitigate the health crisis of its ongoing HIV/AIDS epidemic.

ANC leadership failed to implement reforms to reverse the vast economic inequality between the Black and white South African populations from Apartheid. The ANC's work to foster black representation in South African economic institutions resulted in their joint effort with the established and dominant white business interests to launch the Black Economic Empowerment program[75] (BEE). While this program aimed to divest economic control and interests into the country's majority economically disadvantaged Black population, its agenda

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[73] Ibid.
[74] Ibid.
[75] Southall, Roger. "Ten Propositions about Black Economic Empowerment in South Africa." *Review of African Political Economy*, vol. 34, no. 111, 2007, pp. 67., https://doi.org/10.1080/03056240701340365.

was controlled by the elite white domestic population and European investors, who previously dominated South Africa's business industries. *Anglo-American Corporation*, a British company, was the primary private company to construct the BEE and "transferred the assets of small subsidiaries to well-connected members of the ANC and Pan Africanist Congress leadership, making them wealthy overnight."[76] Although the BEE required partial black ownership in corporations, few black businesses or people had the capital necessary to buy shares of major companies, leading to only a handful of people "emerging as leading black partners for various deals."[77] This small group of black economic leaders overlapped with the political leadership of the country, notably including politicians like President Cyril Ramaphosa. Ultimately, the regime transition following Apartheid enabled the white elite, backed by their foreign overseers in Europe, to create restrictive conditions for the BEE by allying[78] with a minority black elite group and thus limiting the majority black population's access to economic opportunities. The ANC, and other black leaders in South Africa, failed to work against the neoliberal interests of the established white elite and their foreign allies, prioritizing their own profits over diversifying economic and healthcare resources to the country's majority black population.

The lack of economic redistribution resulted in reduced development and economic opportunities in South Africa. By maintaining the existing foreign, white-dominated economic system, the ANC reinforced a post-Apartheid economy with, "no significant redistribution… opening of financial markets and elimination of foreign exchange controls.... dramatic reduction of tariffs and implementation of free-trade policies."[79] These policies resulted in the increased

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[76] Ibid.
[77] Vilakazi, Thando, and Teboho Bosiu. "Black Economic Empowerment." pp. 190.
[78] Ngwane, Trevor, and Patrick Bond. "South Africa's Shrinking Sovereignty: Economic Crises, Ecological Damage, Sub-Imperialism and Social Resistances." Vestnik RUDN. International Relations, vol. 20, no. 1, 2020, pp. 73., https://doi.org/10.22363/2313-0660-2020-20-1-67-83.
[79] Schneider, "The Post-Apartheid Development Debacle", pp. 311.

domination of international imports, reducing the demand for domestic development and manufacturing. As a result, many of South Africa's low-skilled labor industries, which were typically labor opportunities for the Black population, shrunk dramatically while financial capital rose. Alongside this, South Africa became dependent on other countries' manufacturing capabilities for service industries including their healthcare practices. These policies ensured that South Africa's majority Black population, one of the most susceptible groups to healthcare risks, did not have the financial means or domestic access to treatment or prevention options. This stark inaccessibility contributed to the disastrous observation in 2004 that 19.9% of Black South Africans tested positive for HIV[80] compared to the 0.5% of HIV infections in the country's white population. As a result, South Africa became dependent on the aid and efforts of foreign actors to subsidize the racial disparity of its HIV infections, complicating its ability to independently lead a response to the epidemic.

**Case II: The Threat of Economic Sanctions and Access to HIV/AIDS Treatment**

In this section, I will examine the use of international economic sanctions on South Africa. Economic sanctions are tools used to promote a country's international agenda. Typically, they are used by an advantageous[81] country, or coalition of countries, against a lesser power to force their hand. These instances are common in contemporary international relations, where countries employ sanctions to address security threats or to punish other nations for unjust

[80] Kenyon, Chris et al. "HIV prevalence by race co-varies closely with concurrency and number of sex partners in South Africa." *PlOS one* vol. 8,5 21 May. 2013, pp. 4, doi:10.1371/journal.pone.0064080

[81] Masters, Jonathan. "What Are Economic Sanctions?" *Council on Foreign Relations*, Council on Foreign Relations, 12 Aug. 2019, https://www.cfr.org/backgrounder/what-are-economic-sanctions.

actions. Sanctions have a history of effectiveness, especially in the African continent[82]. In 1978, several western countries launched trade bans[83] against Uganda due to human rights violations of then-president Idi Amin's regime. These trade sanctions crippled Uganda's economy, resulting in Amin's loss of popularity[84] and eventual downfall. Relevant to this project, several international economic organizations and countries placed sanctions on South Africa from the 1970s to the 1990s to pressure an end[85] to the Apartheid regime. In this section, I will provide a discussion of these initial[86] sanctions, analyzing their effectiveness. I will then analyze how the effectiveness of the sanctions placed in response to Apartheid set an effective precedent for countries to use the threat of economic sanctions against South Africa.

Initial efforts to promote widespread sanctions against South Africa failed due to international interests in South Africa's economy. In 1962, The United Nations established Resolution 1761, an effort to promote divestment from South Africa's economy. However, this resolution was passive[87] in nature, serving as an international declaration of South Africa violating the United Nations charter. While the resolution requested member states to break, "off diplomatic relations with the Government of the Republic of South Africa,"[88] and to boycott, "all South African goods and refraining from exporting goods, including all arms,"[89] its resolution

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[82] Lyman, Princeton N. "U.S. Sanctions Policy in Sub-Saharan Africa: Testimony Before the Senate Foreign Relations Subcommittee on Africa and Global Health Policy." *United States Institute of Peace*, 29 Dec. 2016, https://www.usip.org/publications/2016/06/us-sanctions-policy-sub-saharan-africa.
[83] Miller, Judith. "When Sanctions Worked." *Foreign Policy*, 15 Mar. 1980, https://foreignpolicy.com/1980/03/15/when-sanctions-worked/.
[84] Ibid.
[85]Rodman, Kenneth A. "Public and Private Sanctions against South Africa." *Political Science Quarterly*, vol. 109, no. 2, 1994, pp. 314, https://doi.org/10.2307/2152627.
[86] Kaempfer, William H., and Anton D. Lowenberg. "The Theory of International Economic Sanctions: A Public Choice Approach." *The American Economic Review*, vol. 78, no. 4, American Economic Association, 1988, pp. 788, http://www.jstor.org/stable/1811175.
[87] *United Nations Resolution 1761*. United Nations, https://undocs.org/pdf?symbol=en/A/RES/1761(XVII).
[88] Ibid.
[89] Ibid.

failed to gain traction in any nations. The resolution had no requirements for divestment or political consequences for South Africa, effectively failing to hold member nations accountable. Moreover, influential countries refused to take action, with many having business stakes in South Africa's economy. "Standard Bank Group, First National Bank, Absa Group, and Nedbank Group" were "most in control of the financial sector"[90] in post-Apartheid South Africa. Both Standard Bank Group and First National Bank are "London-based firms," and Nedbank Ground is a "Dutch-owned"[91] firm, indicating that South Africa's financial gains were for the benefit of British and Dutch interests. Firms from the United States and then West Germany took advantage of the low labor costs[92] associated with non-white labor in South Africa during this time period. Alongside these economic incentives, many "political groups"[93] in western countries continued to sympathize or align themselves with the Apartheid regime. Such economic and cultural investments in South Africa's Apartheid state created incentives for influential countries to ignore United Nations Resolution 1961. Without the action and support of these western countries against Apartheid, initial sanctions failed.

When western hegemonic powers finally sanctioned South Africa, South Africa's economic and soft power declined. In the 1970s, pressure from American anti-Apartheid movements[94] led to major investors evaluating business reputations and redirecting their money from companies with ties to the Apartheid regime. Alongside these financial campaigns, students

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[90] Schneider, "The Post-Apartheid Development Debacle", pp. 310.
[91] Schneider, "The Post-Apartheid Development Debacle", pp. 314.
[92] Clark, Nancy L., and William H. Worger. *South Africa: The Rise and Fall of Apartheid*. Routledge, 2022, pp. 120.
[93] Miller, Judith. "When Sanctions Worked", pp. 4.
[94] Culverson, Donald R. "The Politics of the Anti-Apartheid Movement in the United States, 1969-1986." *Political Science Quarterly*, vol. 111, no. 1, 1996, pp. 129, https://doi.org/10.2307/2151931.

pressured American universities[95] to pull investments from companies associated with South Africa. These social and business efforts eventually resulted in the Comprehensive Anti-Apartheid Act of 1986[96], ending American investments in South African steel and coal. Simultaneously, the United Kingdom and the European Community (EC) imposed limited[97] sanctions, and voluntary tourism bans on South Africa. These sanctions from western hegemons resulted in capital outflows from South Africa, leading to economic instability and over $20 billion[98] in losses. Moreover, South Africa's international reputation began to decline, with fewer countries[99] and organizations willing to engage with the Apartheid regime or related businesses. The economic uncertainty and fallout eventually led to the Apartheid regime releasing Mandela from prison[100] and beginning the eventual transition in South Africa's governing body. Scholars note that the sanctioning from American universities had a particularly prominent impact[101], raising the notion that economic sanctions from even a singular western hegemony can pressure South Africa into political alignment.

The use of sanctions on South Africa's Apartheid regime set a precedent for their effectiveness at the unilateral level. It is reasonable to grant that South Africa was seen as faltering to the impact of sanctions at the end of Apartheid in 1994. This faltering can be attributed to its economic dependence on foreign nations, particularly the United Kingdom and

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95 "How Students Helped End Apartheid." *University of California News*, University of California, 4 May 2018, https://www.universityofcalifornia.edu/news/how-students-helped-end-apartheid.
96 "Comprehensive Anti-Apartheid Act." *H.R.4868 - Comprehensive Anti-Apartheid Act of 1986*, 99th Congress (1985-1986), https://www.congress.gov/bill/99th-congress/house-bill/4868.
97 Lewis, Paul. "European Nations Order Sanctions on South Africa." *The New York Times*, The New York Times, 11 Sept. 1985, https://www.nytimes.com/1985/09/11/world/european-nations-order-sanctions-on-south-africa.html.
98 Edgar, Robert E., and Richard Knight. "Sanctions, Disinvestment, and U.S. Corporations in South Africa." *Sanctioning Apartheid*, Africa World Press, Trenton, NJ, 1990.
99 Ibid.
100 Prokesch, Steven. "Mandela Urges Support for Sanctions." *The New York Times*, The New York Times, 17 Apr. 1990, https://www.nytimes.com/1990/04/17/world/mandela-urges-support-for-sanctions.html.
101 "How Students Helped End Apartheid." *University of California News.*

the United States. In the following section, I will examine how the precedent of sanctioning South Africa led to foreign coercion for South Africa to adhere to neoliberal economics in the international pharmaceutical industry.

While neoliberal economics seemingly promotes free trade, the global north uses its tenants to protect their own international business interests against the competition. In 1994, the WTO launched the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The United States, European Union, and Japan[102] lobbied the WTO to launch TRIPS, securing their businesses protection abroad against patent infringements. Although these global north countries promoted the advancement of TRIPS, global south countries like Brazil, Thailand, and India advocated against the agreement[103]. TRIPS favors the business interests of first-mover manufacturers[104], securing them premium-selling advantages of their product. More importantly, it allows first-mover manufacturers to gain vast control over pricing by eliminating the opportunity for competitors to sell generic versions[105] of the product. This agreement had a powerful impact on the pharmaceutical industry, where countries like India[106] were noteworthy for supplying international markets with affordable, generic versions of drugs in the 1990s and early 2000s. Neoliberal globalization would seemingly promote generic drugs' favorability through the assurance of free trade[107]. However, TRIPS created a dual-win economic playing field for global north companies. In the years after TRIPS' launch, critics noted that it, "provides unnecessarily strong protection of intellectual property rights which serves to prevent the ill in

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[102] Watal, Jayashree, et al., "The Making of the TRIPS Agreement." pp. 31.
[103] Ibid.
[104] Subhan, Junaid., "Scrutinized: the TRIPS agreement and Public Health." *McGill Journal of Medicine,* vol. 9,2 (2006): pp 153.
[105] Subhan, Junaid., "Scrutinized: the TRIPS agreement and Public Health." pp. 158.
[106] Mcneil, Donald G., "Indian Company Offers to Supply Aids Drugs at Low Cost in Africa."
[107] Bond, Patrick., "Uneven Health Outcomes." pp. 345.

developing nations from having access to affordable essential medications."[108] The TRIPS Agreement enabled the global north to use free trade to its benefit while simultaneously protecting the pharmaceutical companies in these countries from the competition of the global south's generic drug production.

However, the TRIPS Agreement allows the promotion of parallel imports, encouraging accessible drug pricing despite patent protections. These imports, "are products marketed by the patent owner… or with the patent owner's permission in one country and imported into another country without the approval of the patent owner."[109] The movement of parallel imports has the potential to stifle the pricing agendas of global north pharmaceutical companies. As the Haiti Cange Declaration noted, HIV treatments in other countries "should cost less than $600 per year,"[110] but cost "twice as much" in Haiti. This price difference is associated with the international pricing mechanisms of pharmaceutical companies, which often change "price differentials"[111] for drugs based on demand in a country. Under TRIPS, countries can secure access to cheaper drug options with lower manufacturing fees, reducing the costs associated with the importation and sale of drugs. This benefit has wide-sweeping advantages for those seeking HIV/AIDS treatment, as parallel importing can make treatment options more economically and politically accessible[112] to the general populace of a country. The WTO provided an

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[108] Subhan, Junaid., "Scrutinized: the TRIPS agreement and Public Health." pp. 152.

[109] "TRIPS and Pharmaceutical Patents: Obligations and Exceptions." WTO, World Trade Organization, https://www.wto.org/english/tratop_e/trips_e/factsheet_pharm02_e.htm.

[110] "Cange Declaration," pp. 2.

[111] Du Plessis, Esme. "The TRIPS Agreement and South African Legislation: The Case of the Parallel Importation of Medicines." *Law, Democracy & Development: University of Western Cape*, vol. 3, no. 1, 1999, pp. 57.

[112] Abbas, Muhammad Zaheer. "Parallel Importation as a Policy Option to Reduce Price of Patented Health Technologies." *Journal of Generic Medicines: The Business Journal for the Generic Medicines Sector*, vol. 17, no. 4, 2021, pp. 214., https://doi.org/10.1177/1741134321999418.

economically-equitable clause in the TRIPS Agreement, seemingly looking out for smaller, developing countries.

The actual use of the parallel-importing clause in TRIPS is often stifled by the agendas of economic hegemonies in the global north. Through the patent protections of TRIPS, The United States had the potential to, "receive rent (royalties) in the range of billions a year."[113] Parallel importation directly interferes with the United States' efforts to secure these capital gains, resulting in American efforts to coerce other countries into avoiding the parallel importation clause. In the following section, I will discuss how the United States threatened South Africa into avoiding a drug importation policy that would damage their profitability in the international pharmaceutical industry between 1998 and 2001.

In the late 1990s, South Africa attempted to create a legislative backbone for parallel importations of pharmaceuticals, launching the Medicines and Related Substances Control Amendment Act 90 (Medicines Act). The Medicines Act was a governmental effort to secure affordable and accessible healthcare[114] for the people of South Africa during the HIV/AIDS epidemic, giving South Africa's executive the ability to override[115] patent protections and trade agreements to secure access to cheaper drugs. The Medicines Act indicated that South Africa seemingly broke the TRIPS Agreement, however, TRIPS also highlights in Article 8 that, "members may… adopt measures necessary to protect public health and nutrition."[116] South Africa's Medicines Act came at a crucial time in the HIV/AIDS epidemic when treatment

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[113] Harris, Donald P. "TRIPS' Rebound: An Historical Analysis of How the TRIPS Agreement Can Ricochet Back against the United States." *Northwestern Journal of International Law and Business*, vol. 25, no. 1, 2004, pp. 109.
[114] Du Plessis, Esme. "The TRIPS Agreement and South African Legislation." pp. 62.
[115] Ibid.
[116] "Agreement on Trade-Related Aspects of Intellectual Property Rights as Amended by the 2005 Protocol Amending the TRIPS Agreement: Article 8." *WTO*, World Trade Organization, https://www.wto.org/english/docs_e/legal_e/trips_e.htm#art8.

options were becoming increasingly available and cheap in the global north, while the global south[117] remained without affordable or accessible drug options. Under the Medicines Act, South Africa would be able to both create their own drugs and seek out cheaper, generic options from competitors outside of their initial trade agreements. The Medicines Act promoted South Africa's healthcare system while also upholding the neoliberal tenant of free trade.

However, the United States, a prominent neoliberal economics promoter, prevented the implementation of the Medicines Act. In 2000, U.S. trade officials placed South Africa on Special 301 Watch List[118] to protect the business interests of their pharmaceutical industry. Placement on this watchlist is a warning to countries of potentially risking sanctions[119]. The Special 301 Watch List and Report are commonly regarded as public mechanisms for the promotion of corporate interests, indicating the government's efforts to protect private pharmaceutical interests. This was accompanied by the United States "backing"[120] companies that were suing South Africa for pharmaceutical trade deal violations. The United States' actions indicate a rejection of free trade; the American government attempted to use its economic influence to discourage South Africa's use of free trade in their pursuit of affordable HIV/AIDS treatment. Moreover, the United States' threat of sanctions, in the context of South Africa, is particularly effective when considering the severe economic impact sanctions had previously on the Apartheid regime in the preceding decade. The threat of new sanctions, when only five years

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[117] Ford, Nathan, et al. "The First Decade of Antiretroviral Therapy in Africa." *Globalization and Health*, vol. 7, no. 1, 2011, p. 33., https://doi.org/10.1186/1744-8603-7-33.
[118] "U.S. to South Africa: Just Say No." *Wired, Conde Nast*, 25 Apr. 2000, pp. 1, https://www.wired.com/2000/04/u-s-to-south-africa-just-say-no/.
[119] Gellman, Barton. "A Conflict of Health and Profit." *The Washington Post*, WP Company, 21 May 2000, https://www.washingtonpost.com/archive/politics/2000/05/21/a-conflict-of-health-and-profit/bf7bd742-b153-46ee-a50a-666b2c4c30d6/.
[120] "U.S. to South Africa: Just Say No." pp. 1.

prior (1995) were all American sanctions from the Apartheid era lifted[121], sent a clear message to South Africa that it would be punished for breaking from the expectations and economic agenda of the United States. The combination of these warnings and threats indicates that the United States was willing to default from its adamant promotion[122] of neoliberal economics globally in a circumstance that benefited its business interests.

The United States' efforts to limit South Africa's access to free trade indicate hypocrisy and extreme self-interested motivations in the American promotion of international neoliberalism. While South Africa suffered from one of the largest and fast-growing HIV/AIDS epidemics, the United States put its corporate economic gain before the health and welfare of the South African people in the 1990s. This not only contributed to the growing number of HIV cases in South Africa but set a message to other countries in the Global South that advocating for their citizens' health would be a secondary matter in the global economy.

**Case III: American Protection of Pharmaceutical Interests and PEPFAR**

By 2001, the AIDS epidemic had infected over 40 million people, with 20 million of those cases in sub-Saharan Africa, and 3 million people in South Africa. The rapid rise in cases led to an intervention from the global north in the form of multilateral and bilateral health campaigns. While many nations banded together in efforts like the *Global Fund to Fight HIV, Tuberculosis, and Malaria* (Global Fund), some countries launched their own campaigns.

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[121] "Remarks on Signing the South African Democratic Transition Support Act of 1993." *The American Presidency Project*, 23 Nov. 1993, https://www.presidency.ucsb.edu/documents/remarks-signing-the-south-african-democratic-transition-support-act-1993.

[122] Kentikelenis, Alexander E., and Sarah Babb. "The Making of Neoliberal Globalization: Norm Substitution and the Politics of Clandestine Institutional Change." *American Journal of Sociology*, vol. 124, no. 6, 2019, pp. 1720., https://doi.org/10.1086/702900.

President Bush initiated the United States's bilateral[123] campaign: the *President's Emergency Plan for AIDS Relief* (PEPFAR). PEPFAR, with an initial focus on the African continent[124], enabled the United States to shape its own campaign and policy response to the international HIV/AIDS epidemic without the influence or control of a multilateral organization. PEPFAR can be viewed as a benevolent effort to help other nations fight against the HIV/AIDS Epidemic, however, it simultaneously created a strategic space to promote American business[125] interests. While PEPFAR's unrestricted nature allowed the United States to forgo the bureaucratic slowdown associated with other large-scale HIV/AIDS aid campaigns, it also gave the United States complete jurisdiction over the organizational and implementation aspects of an international health campaign. In this section, I will explore how the creation of PEPFAR enabled the United States to promote its pharmaceutical businesses through PEPFAR's use of name-brand drugs over accessible generic alternatives and the consequences of this strategic altruistic approach to aid.

PEPFAR's bilateral nature gives the United States direct and complete control over the nature of its HIV/AIDS campaign. In the early 2000s, multilateral organizations like the World Bank and Global Fund provided the environment and mechanisms[126] for countries to invest in campaigns against HIV/AIDS. These organizations have diverse resources, knowledge, and human capital[127], making a strong case for the effectiveness of multilateral health aid campaigns.

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[123] "The United States President's Emergency Plan for AIDS Relief." PEPFAR, U.S. Department of State, 2 Feb. 2022, https://www.state.gov/pepfar/.
[124] Chin, Roger J et al. "PEPFAR Funding and Reduction in HIV Infection Rates in 12 Focus Sub-Saharan African Countries: A Quantitative Analysis." International journal of MCH and AIDS vol. 3,2 (2015), pp. 150.
[125] Stirrups, Robert. PEPFAR: Promises and Pitfalls . The Lancet, 2 Nov. 2021, pp. 1 https://www.thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018(21)00293-9.pdf.
[126] "Bilateral and Multilateral Financing of HIV/AIDS Programs: The World Bank, the International Monetary Fund, the Global Fund, Bilateral Donors and the Private Sector." Global Lessons from the AIDS Pandemic: Economic, Financial, Legal and Political Implications (2008): pp. 218. doi:10.1007/978-3-540-78392-3_7
[127] Ibid.

However, multilateral initiatives can become bogged down[128] in the demands, politics, and expectations of the various member nations, creating bureaucratic inertia and inaction. While the *Global Fund* distributed[129] $2.9 billion for HIV prevention and treatment within its first five years, PEPFAR distributed[130] $15 billion in the same timeframe. PEPFAR created the means for the United States to have complete control over the messaging, outreach, and implementation of an HIV/AIDS campaign. This authority enabled the initial condition that PEPFAR prevention funding was exclusively used for abstinence-only education initiatives[131], which the WHO and other multilateral health authorities previously abandoned due to the proven ineffectiveness of abstinence-only programs preventing HIV transmission. PEPFAR even withheld funds from countries that promoted condom education and accessibility campaigns, indicating the potential harm a single-authority campaign can have on a domestic HIV/AIDS epidemic. Moreover, while PEPFAR enhanced the United States' soft power[132] with target nations for aid, the campaign also gave the United States autonomy over which pharmaceuticals to use in their campaign. This autonomy meant that the United States could reject the rulings[133] of WHO, a multilateral organization, on which drugs and companies were suitable for an HIV/AIDS campaign. In

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[128] Biscaye, Pierre E., et al. "Relative Effectiveness of Bilateral and Multilateral Aid on Development Outcomes." *Review of Development Economics*, vol. 21, no. 4, 2016, pp. 1425–1447., https://doi.org/10.1111/rode.12303.

[129] "The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background." *EveryCRSReport.com*, Congressional Research Service, 26 Apr. 2006, https://www.everycrsreport.com/reports/RL31712.html.

[130] "H.R.1298 - United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003." *Congress.gov*, 108th Congress, https://www.congress.gov/bill/108th-congress/house-bill/1298.

[131] Santelli, John S et al. "Abstinence promotion under PEPFAR: the shifting focus of HIV prevention for youth." *Global public health* vol. 8,1 (2013): pp 2. doi:10.1080/17441692.2012.759609

[132] "U.S. Should Continue To Use 'Soft Power,' Invest In PEPFAR To Improve Global Health, U.S. National Security." *KFF Daily Global Health Policy Report*, Kaiser Family Foundation, 7 July 2017, https://www.kff.org/news-summary/u-s-should-continue-to-use-soft-power-invest-in-pepfar-to-improve-global-health-u-s-national-security/.

[133] World Health Organization. "Removal of Antiretroviral Products from the WHO List of Prequalified Medicines." *World Health Organization Pres*s; 2004. pp. 2.

launching PEPFAR, the United States created a foreign aid campaign that had a strategic basis for serving its economic and business interests.

PEPFAR's initial selection of approved ART treatments indicated the United States' willingness to circumvent the benefits of free trade. The Doha Agreement enabled countries in the global south to evade the patent protection of TRIPS, giving them access[134] to cheaper generic drugs from foreign markets in times of crisis. However, as noted earlier, South Africa could not afford to mass import enough drugs to treat all their HIV-positive patients and was previously threatened with sanctions for seeking to import licensed generics. Foreign aid campaigns provided the means to access treatment and prevention resources at a volume[135] that would be otherwise impossible. While these campaigns are most financially efficient when using cheaper, generic drugs over name-brand pharmaceuticals, PEPFAR originally only permitted[136] the use of name-brand, patented drugs. Name-brand ART therapies were researched and manufactured primarily in the global north, with initial treatments costing[137] approximately $10,000 (USD) a patient in the 1990s. Generic drugs are commonly[138] manufactured in the global south, with generic pharmaceuticals serving as a backbone of the economies of India and Brazil. These drugs reduce the cost of therapies to a fraction of their original value, demonstrating distinct competitiveness in the global economy. The United States' plan to use its

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[134] "The Separate Doha Declaration Explained." TRIPS and Public Health, World Health Organization, https://www.wto.org/english/tratop_e/trips_e/healthdeclexpln_e.htm.

[135] Schneider, Matthew T et al. "Tracking development assistance for HIV/AIDS: the international response to a global epidemic." AIDS (London, England) vol. 30,9 (2016): pp. 1475. doi:10.1097/QAD.0000000000001081

[136] Schneider, Matthew T et al. "Tracking development assistance for HIV/AIDS." pp. 1476.

[137] Chorev, Nitsan. "Changing Global Norms through Reactive Diffusion: The Case of Intellectual Property Protection of AIDS Drugs." American Sociological Review, vol. 77, no. 5, 30 Sept. 2012, pp. 831., https://doi.org/10.1177/0003122412457156.

[138] Horner, Rory. "Pharmaceuticals and the Global South: A Healthy Challenge for Development Theory?" *Global Development Institute Blog*, University of Manchester, 19 Apr. 2017, pp. 1. http://blog.gdi.manchester.ac.uk/pharmaceuticals-global-south-healthy-challenge-development-theory/.

own pharmaceutical resources over cheaper, more accessible drugs promoted domestic business interests over using the most financially effective options. PEPFAR demonstrates the United States' efforts to promote their interests over shaping the most effective HIV/AIDS campaign, by giving them a basis for purchasing expensive, otherwise inaccessible treatment over the most economically attractive option on the market.

The use of name-brand drugs in PEPFAR had the potential to disrupt and deteriorate the mechanisms of the global fight against HIV/AIDS in the early 2000s. Immediate criticism arose, with "advocates, healthcare providers, and other HIV/AIDS care groups actively expressed concern that this requirement, instead of aiding PEPFAR, would subsidize pharmaceutical companies."[139] In doing so, the United States set a precedent for the use of foreign aid campaigns for the economic benefits of an aid-giving country. This economic gain comes at the expense of the global south, harming the economic success of the generic pharmaceutical industry and the reducing most effective response to the global HIV/AIDS campaign. PEPFAR established an economic loophole that gave other countries a way to evade free trade in the pharmaceutical industry. Moreover, the promotion of name-brand drugs by a hegemonic power brought into question the effectiveness[140] of other HIV/AIDS foreign aid campaigns by rejecting the authenticity and effectiveness of their commonly promoted "three-in-one" generic drug combinations. If other countries followed suit, this would "generate insurmountable barriers to the purchase of generic drugs, and significantly limit PEPFAR's reach[141]." The United States'

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[139] Quiñones-Rivera, Andrea. "The Untold Story of How High Quality and Low Cost Drugs Were Incorporated into PEPFAR." Annal for Forum for Collaborative HIV Research, The Forum for Collaborative HIV Research, 2013, pp. 2 https://forumresearch.org/storage/documents/annals-pdf/2013v15n1_quinones-rivera.pdf.

[140] Ismail, M. Asif, and Center for Public Integrity. "PEPFAR Policy Hinders Treatment in Generic Terms." *Public Integrity*, Center for Public Integrity, 8 Jan. 2022, pp. 3. https://publicintegrity.org/health/pepfar-policy-hinders-treatment-in-generic-terms/.

[141] Quiñones-Rivera, Andrea. "The Untold Story of How High Quality and Low Cost Drugs." pp. 2.

strategic altruism created the standard for other countries to promote domestic industries over effectively addressing the global HIV/AIDS crisis. This both selectively harms the business interests of the global south and inhibits the most powerful and efficient response to the HIV/AIDS epidemic.

Moreover, the effectiveness of name-brand ARTs is reduced in the context of the South African HIV/AIDS epidemic. *Gilead Sciences* is an American pharmaceutical company that was given the contract to provide *Truvada*[142], an HIV antiviral, for PEPFAR. With an altruistic angle, *Gilead* promoted an "at-cost" pricing[143] of 99 cents (USD) in 68 countries struggling to respond to their domestic HIV/AIDS epidemics. Although this price is seemingly a barebones cost, *Truvada* cannot be used on its own, requiring[144] additional drugs to treat HIV and additional costs for patients. The *Treatment Action Group of South Africa's* findings indicates that the average worker in 45 of the 68 countries earned $1 per day (USD), making[145] the 99-cent cost of *Truvada* financially inaccessible to them. In response to the questioning of generic drugs, a purity analysis[146] was run in Liverpool, finding that generic *Truvada*, already available in India in a three-in-one pill, was compositionally identical to the name-brand drug. Although three-in-one pills are the most effective and practical treatment option for South Africans, PEPFAR restricts products that combine HIV antivirals like "abacavir, lamivudine, emtricitabine or

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142 "Medicines: HIV/ AIDS." *Science and Medicine*, Gilead , https://www.gilead.com/science-and-medicine/medicines.

143 "FDA Approves Gilead, GlaxoSmithKline Fixed-Dose Combination AIDS Drugs." Kaiser Health News, Kaiser Health, 3 Aug. 2004, https://khn.org/morning-breakout/dr00025081/.

144 "Preventing HIV by Taking One Pill Once a Day: Pre-Exposure Prophylaxis (PrEP)." *Department of Health*, Department of Health New York State, Jan. 2020, https://health.ny.gov/diseases/aids/general/prep/faqs.htm.

145 "Brand-Name Fdcs and PEPFAR, 2004." *Treatment Action Group*, 11 Feb. 2020, https://www.treatmentactiongroup.org/publication/brand-name-fdcs-and-pepfar-2004/.

146 Rosenberg, Tina. "Britons Pay Hundreds for H.I.V. Drugs. Why Do Americans Pay Thousands?" New York Times, New York Times, 25 Sept. 2018, https://www.nytimes.com/2018/09/25/opinion/britons-pay-hundreds-for-hiv-drugs-why-do-americans-pay-thousands.html.

tenofovir"[147] due to "data exclusivity" in the United States's pharmaceuticals industry. The restrictions in PEPFAR, while benefiting American pharmaceutical interests, ultimately inhibited a productive campaign for HIV treatment in South Africa.

It is important to acknowledge that some figures in the pharmaceutical industry argue that PEPFAR's restriction of generic drugs stems from health and safety concerns. PEPFAR's legislation notes that pharmaceuticals promoted in the program are required to be "approved by a stringent regulatory authority or otherwise demonstrate quality, safety, and efficacy at the lowest possible cost[148]." While criticism regarded these measures as restrictive to the generics industry, the World Health Organization (WHO) eventually had to "[revoke] 17 of the 25… prequalified antiretrovirals[149]," on their initial list of usable treatments. However, even when generics were eventually deemed chemically identical to name-brand drugs, PEPFAR continued to promote name-brands that could cost up to $12,000 (USD) annually per patient. Yusuf Hamied, Chairman of the Indian generics company *Cipla*, noted that PEPFAR leadership, particularly Randall L. Tobias[150], a former CEO of *Eli Lilly*, an American pharmaceutical company, "put in a lot of hurdles [to ensure] that the PEPFAR money wouldn't go to the generics[151]." PEPFAR restricted the use of generic "Triomune — a combination of the drugs stavudine, lamivudine, and nevirapine[152]," a $400 (USD) per patient treatment for HIV. Pharmaceutical leaders', like

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147 "Brand-Name Fdcs and PEPFAR, 2004." *Treatment Action Group*, 11 Feb. 2020,

148 Quiñones-Rivera, Andrea. "The Untold Story of How High Quality and Low Cost Drugs." pp. 2.

149 "Removal of Antiretroviral Products from the WHO List of Prequalified Medicines." *3 By 5 Initiative*, World Health Organization, 1 Dec. 2010, pp. 1, https://www.who.int/3by5/news22/en/.

150 "An Interview with Randall L. Tobias- Spearheading the U.S. Response to Global AIDS." AmfAR, AmfAR, 2004, https://www.amfar.org/articles/around-the-world/treatasia/older/an-interview-with-randall-l--tobias%E2%80%94spearheading-the-u-s--response-to-global-aids/.

151 Ismail, M. Asif. "PEPFAR Policy Hinders Treatment in Generic Terms." International Consortium of Investigative Journalists, 9 June 2020, https://www.icij.org/investigations/divine-intervention/pepfar-policy-hinders-treatment-generic-terms/.

152 Ibid.

Hamied and Tobias, actions reveal the business influences vying for control of the resources needed for PEPFAR. While the quality of generics approved by WHO was briefly invalidated, even when generics were ensured to be quality and cheaper products for PEPFAR, key leadership promoted measures to protect American pharmaceutical interests over ensuring the best treatment campaign.

Eventually, PEPFAR began advancing the use of generic drugs but inhibited economic openness to ensure that these drugs did not reach wealthier markets in the global north. By 2005, a new antiretroviral fixed-dose combination (FDC) drug review process[153] was promoted to generic pharmaceutical companies in the global south. This process was implemented for these companies to develop or enhance[154] generic fixed doses three-in-one pill forms. The approval of these drugs meant that PEPFAR's patients had access to cheap, three-in-one treatment options, which were more effective and tailored to their socio-economic lifestyle. However, there were concerns that these drugs "would be sold back to Europe or the US[155]," the highest profit margin markets for pharmaceutical companies, and create a pricing war with name-brand products. As a result, "legal restraints" were initiated to protect the economic interests of American pharmaceutical companies. These measures, including repeated clinical trials, initial market exclusivity for name-brand manufacturers, and distinct labeling for generic products[156], demonstrate the United States' efforts to ensure the protection of their business interests. Moreover, these measures came at a cost, slowing the process of generic approval for PEPFAR

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[153]"Guidance for Industry on Fixed Dose Combinations, Co-Packaged Drug Products, and Single-Entity Versions of Previously Approved Antiretrovirals for the Treatment of HIV." *Federal Register*, Food and Drug Administration., 18 Oct. 2006, https://www.federalregister.gov/documents/2006/10/18/E6-17324/guidance-for-industry-on-fixed-dose-combinations-co-packaged-drug-products-and-single-entity.

[154] Ibid.

[155] Quiñones-Rivera, Andrea. "The Untold Story of How High Quality and Low Cost Drugs." pp. 4.

[156] Gupta, Ravi et al. "Generic Drugs in the United States: Policies to Address Pricing and Competition." Clinical pharmacology and therapeutics vol. 105, 2 (2019): pp. 329. doi:10.1002/cpt.1314

and leading to only 11% of PEPFAR-approved drugs consisting of generics. As previously noted, economic openness initially created barriers to the global south accessing essential treatment resources in the HIV/AIDS epidemic. When such economic openness began to offer accessible and cheaper treatment options, the United States protected its pharmaceutical companies' domestic sales. This is proven by the measures taken to prevent generic drugs promoted through PEPFAR from reaching patients in the global north.

The United States' PEPFAR campaign, while seemingly a domestic effort to promote a bilateral foreign aid campaign, indicates American willingness to protect and advance their business interests. PEPFAR enabled the United States to increase the profits of their domestic pharmaceutical companies by rejecting the best drugs available through free trade, even when it came at the expense of having the most fruitful international campaign against HIV/AIDS. Additionally, this promotion of domestic industry had the potential to disrupt international multilateral campaigns' use of generic drugs, having a further adverse impact on HIV/AIDS foreign aid. Ultimately, even when the United States began to encourage the use of generics in PEPFAR, the country took measures to block economic openness and protect the profits of their domestic pharmaceutical industries. These efforts, spanning the first five years of PEPFAR, show how the United States initially placed its economic security over providing the best quality aid to South Africa. Such foreign strategic altruism led to a lowered potential for the effectiveness of PEPFAR and contributed to the rise in HIV infections in South Africa.

## Conclusion

In the twelve years following Apartheid, South Africa was a frontier for foreign actors to learn how to balance humanitarian aid efforts with their strategic altruism. South Africa with

postcolonial economic and cultural ties to Europe existed as a singularity of development when compared to peer countries on the African continent. The advanced state of South Africa's economy led to its designation as one of the five major emerging markets[157] by western financial institutions. However, despite the prominence of its economic state, South Africa was unable to prevent the rapid spread of infection in its HIV/AIDS epidemic. The enigma of South Africa's severe HIV/AIDS epidemic serves as the focus of this project. This paper has demonstrated that actors like the United States and the World Bank provided wide-sweeping financial and medical resources to South Africa during the height of its HIV/AIDS epidemic. This paper explores how these seemingly altruistic actions cannot be studied without considering the international pressures that led to South Africa's rapid spread and extremely high prevalence of HIV. These pressures include the failure of foreign and domestic players to redistribute socioeconomic resources in South Africa and the influence of neoliberal globalization on the spread of the disease. Such conditions left South Africa dependent on foreign interventions to combat its HIV/AIDS epidemic. These international aid campaigns were nuanced by their strategic altruism, with the United States exclusively providing contracts to domestic pharmaceutical companies over cheaper, more effective generic manufacturers. Ultimately, South Africa's HIV/AIDS epidemic, while a domestic problem, cannot be viewed without considering the paramount influence of foreign actors. Rather than acting on goodwill alone, PEPFAR engaged in a form of strategic altruism, highlighting a pattern of self-interested behavior in the international aid domain. South Africa's HIV/AIDS epidemic is not an anomaly of foreign actors' self-motivation; the United States, World Bank, and other institutions have all engaged in international affairs with seemingly benevolent intentions. Further research could extend

[157] O'Neill, Aaron. "Topic: BRICS Countries."

strategic altruism to the ongoing issue of COVID-19 Vaccines Global Access and cases of tactical vaccine diplomacy.

After the epidemic reached its peak in 2006, it began to subside[158] in the following decade due to the effective initiatives and advocacy from both domestic and foreign actors. Domestic activism in South Africa led to the South African government securing access to treatment for HIV patients. *The Treatment Action Plan* led a national campaign to ensure the South African government made nevirapine, a drug preventing HIV transmission from mother to child, widely available and affordable[159]. Additionally, in the subsequent decade, PEPFAR and the Global Fund provided[160] over $10 billion in aid to South Africa, providing affordable and effective generic treatments to HIV patients. These efforts led to South Africa's rebounding health metrics, such as over "2.8 million babies of mothers with HIV… born HIV-free[161]." Importantly, institutions like the World Bank went on to recognize and mitigate[162] the shortcomings of pushing neoliberal economic tenants onto developing nations including South Africa. This enabled these countries to establish their own domestic systems to further economic and healthcare equity, which is evident in South Africa's formation[163] of a Department of Small Business Development. In doing so, South Africa directly addressed its massive socioeconomic

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[158] "HIV and AIDS in South Africa." *Avert*, Avert, 15 Apr. 2020, https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa#:~:text=The%20future%20of%20HIV%20in%20South%20Africa&text=New%20HIV%20infections%20overall%20have,is%20hampering%20HIV%20prevention%20efforts.

[159] Annas, George J. "The Right to Health and the Nevirapine Case in South Africa." *New England Journal of Medicine*, vol. 348, no. 24, 12 Feb. 2003, pp. 2472., https://doi.org/10.1056/nejm200306123482421.

[160] "Global Fund Grants in South Africa." *Global Fund*, Global Fund, https://www.theglobalfund.org/media/11824/oig_gf-oig-22-004_report_en.pdf.

[161]"PEPFAR." *HIV.gov*, Minority HIV/AIDS Fund, 8 Dec. 2021, https://www.hiv.gov/federal-response/pepfar-global-aids/pepfar.

[162] Adhikary, Rino Wiseman. "The World Bank's Shift Away from Neoliberal Ideology: Real or Rhetoric?" *Policy Futures in Education*, vol. 10, no. 2, 2012, pp. 191., https://doi.org/10.2304/pfie.2012.10.2.191.

[163] *Department of Small Business Development*, Republic of South Africa, http://www.dsbd.gov.za/.

disparity. Importantly, the United States began promoting[164] the use of cheaper, three-in-one generic treatments in its PEPFAR campaign, providing effective aid to larger numbers of HIV patients in South Africa.

Today, the efforts of domestic activists and international aid campaigns have accomplished tremendous victories in South Africa's ongoing HIV/AIDS epidemic, promising resources that would otherwise be impossible. Yet, recognizing these victories must be balanced with an awareness of the strategic altruism of foreign players in the economic and healthcare systems of South Africa to ensure that profits are never placed above the welfare of patients.

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[164] Venkatesh, Kartik K., et al. "Low-Cost Generic Drugs under the President's Emergency Plan for AIDS Relief Drove down Treatment Cost; More Are Needed." *Health Affairs*, vol. 31, no. 7, 2012, pp. 1429., https://doi.org/10.1377/hlthaff.2012.0210.

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Department of Small Business Development, Republic of South Africa, http://www.dsbd.gov.za/.

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