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LIVELY CAPITAL

BIOTECHNOLOGIES, ETHICS, AND
GOVERNANCE IN GLOBAL MARKETS

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AIDS POLICIES FOR MARKETS AND WARRIORS

Dispossession, Capital, and Pharmaceuticals in Nigeria

Most of the literature on globalization that theorizes flexible capital, flows (media, migration, technology), global cities, cosmopolitanism, and local-global relationships proceeds from an analysis of finance and manufacturing capital.¹ Such paradigms account for accumulation, speed, and the migratory patterns of both people and technology via capital circulating among cybernetic and physical spaces. As one imagines the enormity of capital movement, what is said of the spaces and places that are emptied out, from which these voluminous forms of capital are originally extracted? As it is widely recognized that the African continent continues to provide raw material in the form of oil, minerals, and cash crops to the rest of the world in crumbling and nonreproducible ways, can there be an analysis of an emptied-out space as the left-behind effect of such movement? Can there be an accounting of this space that is connected but defies overlap with other spaces in the transnational realm, one that cannot always imagine how raw material and capital are transformed and consumed beyond its boundaries, yet one that is not parochial in the estimation of its own loss?

Dispossession and Its Organizational Strategies

When it comes to theorizing Africa's relationship to globalization, there is remarkably little said other than that Africa is simply marginalized in the global political economy.² However, Africa is being rigorously "reinscribed" in the world via trade, development, and economic policies, which suggests an importance greater than simple marginalization. How African states comply with the World Trade Organization, for example, will largely determine the role and activities of trade and global governance in ways that are yet to be imagined, and in ways that are alarmingly on the horizon, such as the slow and rigorous wiping away of the generic drug industry via legal measures found in numerous free-trade agreements.

This chapter assesses a form of "lively capital" that begins with the following assumptions: wealth accumulation as described by analyses of speculative and manufacturing capital, global cities, and so on cannot solely account for the contours or performance of global capitalism and Africa's relationship to it. Rather, Africa is an imperative and integral part of current processes of globalization that include the continent's cultural and economic representations, the building of new capital markets, and the redirected efforts of foreign aid that are increasingly being tied to global securitization. Instead of thinking about globalization as a unitary capitalism, I am more interested in theories of capital that may better capture and complicate Africa in the world, as more than one capitalism is at play and at stake here.³ In these paradigms, therefore, more attention needs to be paid to *wealth extraction* and *dispossession*, whereby the emptied-out material space is generated by both extractive industries and overlapping configurations of policymaking and capital mobility.⁴ This dispossessed space provides the ground in which emergent and competing kinds of capital, as well as social and institutional exchange, find their roots and growth. In this particular instance, they manifest as varying forms of pharmaceutical capital, whose circulation and existence are tied to oil, debt, and military economies.⁵

By describing the institution of pharmacy (defined as the discipline of drug dispensation and composition) and, to a lesser extent, drug manufacturing in Nigeria as exemplaries of emptied-out space, I am not referring to *terra nullius*, which would imply sheer absence in a colonial imaginary, the modern ghost of which is invoked by the pharmaceutical industry as "lack of infrastructure" and used as a prime reason to refuse adequate drug price reductions. Nor am I privileging the colonial state as a robust entity that extended its drug-distribution efforts beyond the citizen to the subject, a task

begging the attention of the postcolonial state. Rather, I am referring to two means of dispossession: The first is the structural adjustment program (SAP) of 1986 of the International Monetary Fund (IMF), which was strongly tied to a rise in militarism in Nigeria and to a protracted prodemocracy movement. The SAP initiated a massive emptying-out of existing health institutions and pharmacy, and it disabled drug manufacturing (via currency devaluation, wage decreases, state privatization, and dismantling, etc).⁶ New therapeutic institutions emerged, replacing dying institutions in a process in which professional and patient agencies, strategies, and subjectivities came into being, literally enveloping other ones. The second is a more refined form of dispossession that attempts to dismantle the generic drug industry's market viability through two routes: trade-related intellectual-property law and specific AIDS treatment policies, both of which emphasize and privilege proprietary transnational drug companies and the circulation of their products.

By exploring the near-death of an industry and the subsequent rise of neoliberal health policies, I show how wealth extraction and other forms of dispossession are preconditions for generating contradictory *imperatives of capital* as they relate to old battles over the social contract, but are largely being reterritorialized in these scenarios (Ferguson 2005). Marx described two competing forms of capital, one that perpetuates further production and the other that perpetuates further circulation (see Marx 1977 [1852]; Marx 1959). More recently, David Harvey's important insights on capital mobility, described as "accumulation by dispossession" (2003, 137–82), rethink the importance of primitive accumulation since 1973, a process that—in contrast to the formulations of Rosa Luxemburg (1968) and Marx, yet following Hannah Arendt (1968)—remains an important strategy for capitalist expansion in the twenty-first century.⁷ Using Marx and Harvey to frame the larger politics and stakes, I would argue that what we are seeing in these dispossession and reinvestment strategies is the combination of territorial and capital logics, with policy logics that specifically emerge in the context of AIDS.⁸

Here, I refer to the financial interaction among, and capital movement facilitated by, policy organizations as well as financial institutions overseeing the implementation of policy. In being "brought together" by AIDS, policy organizations, the state, corporations, and AIDS activists make *implicit agreements* with each other that generate particular kinds of capital flows. In this context, implicitness represents the crux of policy logics reacting to neoliberal strategies and reform. That is, healthcare systems are

increasingly overlooked in favor of policies that address "the gaps" in care, such as prevention and treatment for HIV, rather than comprehensive care. Nonexistent robust health-systems infrastructure is a prerequisite for implementing policy that addresses these infrastructure gaps. This has led to new ideas of health, bodies, and surveillance collated by myriad consenting actors and institutions that generate abstractions and analysis of "the gaps." As a result, the "gaps" in healthcare systems are transformed into the system itself, for which humanitarian and government organizations deploy millions of dollars dedicated to new infrastructure, while health systems are left to wither in neglect; it is a scenario wherein the logics of health and economic crises both presuppose and require each other. "Implicit agreements" thus points to how economic and health abstractions become naturalized as normative social and institutional exchange. The policy-driven capital form is thus simply a question of how capital naturalizes its own mobility and operation.

Until the 2003 implementation of the U.S. President's Emergency Program for HIV/AIDS Relief (PEPFAR) for select states, including Nigeria, most AIDS development agencies had favored HIV-prevention policies over widespread treatment. This means that in Nigeria, for example, HIV education and prevention programs function as an AIDS humanitarian apparatus that provides protectionist measures for the oil-extraction industry. That is, long-term and sustainable AIDS-treatment policies would require, first and foremost, converting oil wealth into funding for treatment for the nearly five million who are HIV-positive and many more who are infected with numerous other infectious diseases.⁹ Fundamentally, any attempt toward widespread treatment necessitates reconfiguring the relationship between African states and their corporate partners, between external debt and foreign aid, between African states and their creditors. Because Africa's creditors are also Africa's AIDS donors (the World Bank, Paris Club members, the United States), it is perhaps no coincidence that a very particular biopolitical regime manages both HIV bodies and relationships between the state and humanitarian, and international financial institutions.

In these interdependent contexts, the state's own role is to facilitate, orchestrate, and permit "accumulation by dispossession to occur without sparking a general collapse" (Harvey 2004, 115)—constituting the general gist of an IMF structural-adjustment program. While Janet Roitman (2005), Achille Mbembe (2000), Jean-François Bayart (1997), and Sean Brotherton (2008) have all demonstrated how the state in Africa does act in its own interests, turning dispossession into new kinds of accumulation, I would

furthermore suggest that the state's technological capacities are shifting into other technological priorities that inscribe new patterns of capital flow and formation.¹⁰ In such cases, the state and capital are not always at odds with one another; it is not always the case that the state erodes while capital flourishes. Certainly for Nigeria, the primary source of accumulation is not based on wage labor, but rather on government contracts and oil-rent politics, through which accumulation is fundamentally channeled via the state, so that the state and capital actually rearticulate each other.¹¹ If anything, stringent and lax laws can coexist in the same space to enable and disenfranchise certain capital manifestations, where at once the state's own interests are both fulfilled and erased. This is a contradiction that largely emerges in the aftermath of a state privatization as well as within Nigeria's current efforts to be more squarely inserted into global markets.

In the rest of this chapter I describe the shrinkage of pharmacy and decline of drug manufacturing since the IMF structural adjustment, and the lack of quality drugs that has resulted. I also describe the excess of counterfeits, illegal drug markets, self-medication, and drug-labeling problems as produced materiality and practice in a "post"-IMF space. I then examine how two treatment policies (one in Nigeria, one in the United States) map onto these spatial environments. I pay special attention to the merging of security and health discourses in the implementation of these treatment policies. "Household security," in the context of AIDS, loses ground to "national security," giving rise to new policy logics that bypass the aftermath of healthcare infrastructure disposessions. Ultimately, I argue, the 1986 IMF SAP in Nigeria constitutes a particular historical moment that emptied out Nigerian and other African pharmacies while inaugurating new protectionist measures for the global circulations of pharmaceuticals, where new markets and security cultures thrive.

Frantz Fanon wrote, "It was not the organization of production but the persistence and organization of oppression which formed the primary social basis for revolutionary activity" (1966, 88, cited in Robinson 2001, 134).¹² In following Fanon, and in viewing *dispossession* as a form of *oppression*, I argue that dispossession is the primary organizational strategy that generates such protectionist measures, which alter health and medical practices, including drug production and consumption. The very drive of this dispossession are the implicit agreements among institutions that enable capital to thickly accumulate in ways that contradict the interests of public health. It may be counterintuitive to imagine that state and other forms of dispossession negate capital accumulation and wealth.¹³ Indeed, dispossession ulti-

mately curtails incentives for foreign direct investment when state services like electricity no longer function properly and social conflicts carry on amid scarce resources. But dispossession actually serves as a productive contradiction in a Marxist sense. The AIDS policy is a pivoting anchor that enables the subsidizing of new drug markets and, particularly for Nigeria, keeps the flow of oil wealth sustained in ways that continually reproduce national and international elites. In the process, the state both consumes and negates its own interests; and the population must negotiate a therapeutic economy and knowledge that edges on a dangerous medical pluralism.

Emptying-Out of Pharmacy, Dismantling Drug Manufacturing

In the mid-1980s the pharmaceutical-manufacturing industry comprised over fifty manufacturing firms that produced generics for malaria and other pertinent endemic parasites and diseases. By 1996, ten years after structural-adjustment implementation, nearly two-thirds of the industry bottomed out. Two IMF austerity measures (among others) impacted this decline. The first, a high tax placed on imported raw materials, was viewed as a step toward increasing local production of raw materials and justified by the IMF as addressing the need to wipe out "nonessential" state imports. The second was the devaluation of the currency, which cut earning power in half across the country within the first month of structural-adjustment implementation (and led to further declines after that).

The decline in earning power had two effects: 1) it eliminated purchasing power for local manufacturers, who could no longer invest or reinvest in raw-material production (as of today, 100 percent of all raw materials for drug manufacture are imported to Nigeria at extraordinary costs, undercutting the IMF's original claims that its impetus was to improve self-sustainability); 2) the purchasing power of the consumer was also devastated, whereby those who sought generic Nigerian drugs were left to either pay more or seek alternatives such as traditional medicines or practitioners who claimed to have a cure for AIDS. Traditional medicine has always comprised part of the therapeutic economy. It is estimated that 70 percent of the population seeks out traditional healers (due to cost and familiarity) as primary healthcare providers, which matches most estimates that 70 percent of the population lives on less than one U.S. dollar per day (Maiwada 2004).

Both private capital flight and the debt repayment are derived almost exclusively from oil wealth, and both represent primary forms of wealth extrac-

tion.¹⁴ State privatization, trade liberalization, the removal of petroleum subsidies, and the devaluation of the naira led to decreased earnings, and food prices nearly quadrupled. Nigeria faced increased black-market expansion, heightened poverty, increased crime, food riots, and worker strikes. Primary healthcare services collapsed, which, again, impeded the IMF's stated goal of building self-reliance, as the fund envisioned total cost recovery from patients who could not afford even basic food commodities (Salako 1997). In Nigeria capital investments and recurrent payments, such as salaries and essential drugs, and facilities maintenance were suspended (Samba 2004). With the introduction of user fees and the sale of drugs liberalized, the public consumption of drugs drastically declined. By 1990 the domestic production of pharmaceuticals had ceased almost entirely throughout Africa; most pharmaceutical and medical-supply industries were pushed into bankruptcy, and medical workers fled to the private sector both within and outside of Africa (*ibid.*).

The SAP also affected drug-distribution systems, which were already facing great difficulties and challenges. The original drug-dispensation program was based on a colonial administrative system whereby drugs were transported to central stores and dispensed by government pharmacists. After the Nigerian civil war (1967-70) and the oil boom of the 1970s, there was massive hospital and healthcare expansion. Additionally, overseas manufacturers found the seventy-million-person market to be highly lucrative, and started to pack and distribute imported drugs in Nigeria. Companies such as Pfizer, Abbott, Glaxo, Wellcome, and Roche came to Nigeria and manufactured drugs (Ovbiagele 2000). The colonial system of drug dispensation could not meet the needs of an expanding healthcare system, and the government was slow to react. Steeped in postwar reconstruction efforts, the government was unable to reconstitute or expand the regulatory structures quickly enough to forestall the growing chaos of drug distribution (*ibid.*). With an oil bust producing a severe economic crisis, the government took a desperate measure, liberalizing drug-import policies via an "import license" that allowed nonpharmacists to freely import and sell drugs at huge profits. As a result, massive quantities of fake drugs entered the country, and military and civilian counterparts together assumed control of drug markets. It was not until 1990 that the National Drug Policy was executed, which gave rise to the National Agency for Drug Administration and Control (NAFDAC), Nigeria's drug regulatory agency, which remains to this day highly underfunded.

By 2005 Nigeria had accumulated a total debt of 36 billion USD, at which

point the country threatened to repudiate what it deemed an illegitimate accumulation of debt by former corrupt military leaders who did not pay as scheduled; late-payment fines and arrears amounted to billions, even though the principal had been paid off at least three times. By 2001, with the end of military rule, annual payments to foreign creditors amounted to \$2 billion, while only \$300 million was allocated toward the entire national healthcare budget, designated for 120 million people. The health budget of 2001 was 1.9 percent of the total national budget (or U.S.\$7 per capita) (World Health Organization Statistical Information System 2001).¹⁵

In the same year, *nearly half* of all drugs in circulation were found to be counterfeit or substandard, and such drugs are mostly found in thousands of drug markets across the country (R. B. Taylor et al. 2001). The 2001 statistic on fake and substandard drugs may be declining, as Dora Akunyili, the former director of Nigeria's drug regulatory agency, NAFDAC, started a campaign to confiscate and burn fake drugs in great media and public displays. As a result, she and many NAFDAC workers were attacked in markets; several car bombs were detonated; various assassination attempts were made on their lives; and the NAFDAC headquarters were burned down in 2003. Market sellers in open drug markets have been rarely prosecuted in the past despite good laws on the books, and in using their own union protection, they are fighting the prospect of unemployment. Whether or not Akunyili's efforts were effective, the public attention brought to fake and counterfeit drugs marks a shift in consciousness with regard to the presence of fake drugs in the country.

In contrast to the numerous illegal drug markets, very few pharmacies exist, and over 90 percent of those pharmacies are in the urban areas, 30 percent of which are concentrated in the city of Lagos. Out of the thirty-six states, only six have more than a hundred pharmacies and five states have fewer than fifteen, which are intended to serve potentially millions of people, given a population of 130 million (Pharmacists Council of Nigeria 2000).¹⁶ There are nearly four times the number of registered pharmacists as there are pharmacy premises, perhaps pointing to the problems of gaining start-up capital, unstable electric supplies, and unemployment. Moreover, doctors dispense drugs themselves and are not eager to hand over dispensing responsibilities to pharmacists—a state of things to which many regulatory officials, some of whom spoke to me, have resigned themselves.

As the profession has declined, pharmaceutical practice has itself changed. Even in the urban areas where pharmacies are accessible, how pharmacists dispense drugs is highly mystified for many patients, the names and dosages

of drugs prescribed, for example, rarely being labeled (O. Taylor 1998). Indeed, to omit such information is a common practice and even the policy of many hospitals and pharmacies. When I was in Owerri, in the eastern part of the country, with Mary, a nurse and AIDS activist, we visited her family in a nearby village and found that her mother-in-law was ill. After taking her to the doctor, we walked with her to the hospital pharmacy, where she picked up her prescribed medication. A sign posted next to the pharmacy window, in both English and Igbo, encouraged patients to ask questions about the drugs they were receiving. Mary's mother-in-law received her drugs in a plastic bag, which, marked in pen, stated how many pills she should take per day. Neither the name nor dosage of the drug was listed. Mary went back to the pharmacy and asked them to label it "correctly." The conversation escalated in the street, with Mary yelling at two hospital administrators about their nonlabeling policy and a couple dozen patients who had gathered around to listen. The administrators calmly told Mary that they could not label prescriptions because too many patients self-medicate, which Mary countered with, "And what happens when your patients have adverse side effects or allergic reactions to prescribed drugs? How will any medical worker ever know what was prescribed when the patient has no idea? And what if the patient dies? Then what?" To these questions, there was no response.

Indeed, concern about self-medication with controlled drugs—which is, after all, the most common method of treatment—is the most common justification pharmacists give for nonlabeling. But conversations I had with pharmacists indicate that something else is at work: the desire to keep drug knowledge circulating only among pharmacists. Many articulated what seemed like a mantra of using self-medication as an excuse for non-labeling. Very few wanted to explore the notion of assisting a very large self-medicating population through labeling.¹⁷ The profession of pharmacy, long held in esteem, has been increasingly devalued, due to the inhospitable climate of drug distribution and difficulties in competing against "illegitimate" businesses. Perhaps nonlabeling acts as a reconfiguration of expertise wherein making certain knowledge secret confers a sense of authority on a profession struggling to regain legitimacy or status. Indeed, one of the newsletters of the Pharmacists' Council of Nigeria stated at the 1999 annual meetings that a newly institutionalized honorific, "Pharm," would precede the honorifics Mr. and Mrs. The use of this honorific is now common practice among pharmacists. Together, the mystification of drug knowledge and the implementation of the new titles establish a sense of control over professional loss.

Of course, the control of knowledge does not preclude patients from seeking the information they want. Patients often obtain their knowledge of drugs from market sellers, most of whom are not trained as pharmacists. I have walked through the Lagos drug markets, where the conditions for storing drugs are generally not ideal, and found both controlled and uncontrolled substances. I have watched buyers give sellers lists of symptoms, for which the seller proceeds to find the appropriate medications in his supply. Moreover, hospitals and clinics also get their supplies from these markets, and pick-up trucks with hospital logos regularly pull up to restock their supplies. Not only do patients prefer to buy in markets, but so do physicians. In Lagos, a report estimated that 58 percent of all physicians identify drug markets as their vendors of choice, because of availability and ease, despite the fact that substandard and counterfeit drugs are to be found in some of these markets (Pharmaceuticals Manufacturing Group, Manufacturing Association of Nigeria, 2001).

Many people I interviewed preferred to buy their drugs in the markets, to save money by avoiding the additional costs generated by seeing a doctor for treatment and care. Drug availability extends even to roadside "hawkers" who sell medications of all sorts in traffic jams and along busy and commercial roads, literally appearing and disappearing with the traffic itself. Sellers can also be found on public transport. While riding on buses, I encountered traveling drug salesmen who took turns wooing the crowds by offering candy and lame jokes about gender relations before launching into pitches about the efficacy of their goods. The attitude of the crowds on such bus rides often evolved from boredom and annoyance into enthusiasm and consumer passion. Pain pills, antibiotics, acne busters, and aloe vera were offered for sale at various times, and I myself bought some imported Indian Neem toothpaste.

Manthia Diawara has argued that "West African markets provide a serious challenge to the scheme of globalization and structural adjustment fostered by the World Bank and other multinational corporations that are vying to recolonize Africa. . . . [W]hat makes these traditional schemes of globalization special is the structural continuity they maintain with contemporary markets in opposition to the forms and structures of modernism that the nation-states have put in place in West Africa since the 1960s" (1998, 114–15). Indeed, economies are largely controlled and determined inside the markets (stationary and mobile), not by the banks. Diawara rightly claims that this poses a challenge to financial institutions that see the nation-state as the only legitimate vehicle to conduct business (ibid. 116). Diawara de-

scribes a typical scenario: to cope with the struggling economy, state officials depend on markets, where currency can be exchanged at higher rates than what banks offer, where low civil-service wages can be enhanced by bribes, and where forms of emergency cash may even be provided to a strapped government (*ibid.*). This is a system of recycling indebtedness that actually helps to stabilize a financial crisis and is tied to a conglomeration of state practices where notions of the public and private are blurred (*ibid.* 117).

The extent of counterfeit, fake, and substandard drugs located in the markets and on the streets actually represents a remarkable contradiction. On the one hand, the dispossession of the Nigerian pharmaceutical industry's capacity to, at best, carry out good manufacturing practices freed up space for new, mostly imported drug products to take root—drugs that can bypass regulatory organs of the state. During the 1990s these drugs especially competed with global company products that had distribution outlets in the country. In the process of an IMF-generated dispossession that would lay the ground for new proprietary pharmaceutical capital, counterfeit drugs, which made upward of 80 percent of the national drug market, became the thorn in the proprietary distribution agenda. In this sense, the drug markets provided the very challenge to state privatization and neoliberal reform that Diawara claimed.¹⁸ For Diawara, "As postmodern reality defines historicity and ethics through consumption, those who do not consume are left to die outside of history and without human dignity. The traditional markets are the only places where Africans of all ethnic origins and classes, from the country and the city, meet and assert their humanity and historicity through consumption" (1998, 120–21). On the other hand, there are a great number of counterfeits and fakes that can create severe side effects and injury, which puts the "right to consume" in jeopardy and thus the role of both the state and market in question. The "right to consume" needs to be situated in the context of the "right to produce" and the "right to regulate"—a messy configuration. As these rights of the individual and the nation-state surface as out of joint, these forms of medical pluralism continue to thrive.

At the very same time that fake and counterfeit drugs were substantially outcompeting the global proprietary drugs in Nigeria (and counterfeits of all sorts were doing the same in other parts of the world), demands for increased intellectual-property protection were being issued by private industry and Western governments via the World Trade Organization. While NAFDAC has made moves to break down drug markets in the interest of both protecting proprietary drug businesses (something explicitly emphasized to me) and public health, and this certainly does protect the intellectual-

property rights of the global proprietary industry, it is also giving an unexpected boost to the local generic industry, whose products were also largely copied during the 1990s. In the context of this rebirth, a different form of dispossession is creeping in, one that poses threats to the local manufacturing industry. This clearing is making room for U.S.-subsidized proprietary antiretroviral drugs via the politics of trade-related intellectual-property law as well as AIDS treatment policies. But this more refined emptying-out may actually destabilize the very new capital forms that are just beginning to be cultivated in this dispossessed drug landscape.

AIDS Treatment Policies and New Capital Imperatives

In Nigeria there are two major antiretroviral (ARV) treatment policies. One is the Nigerian government's, which uses only generic drugs produced in India by Ranbaxy and Cipla for the 20,000 enrolled patients (out of four million HIV-positive people, 400,000 of whom are estimated to be in immediate need of ARVs). The second uses both generic and proprietary drugs that are being supplied by PEPFAR, the largest international health initiative ever to target a single disease. In Nigeria, PEPFAR subsidizes and distributes U.S. proprietary drugs to over 100,000 patients.¹⁹ Over \$20 million for fiscal years 2004–6 were allocated to PEPFAR in Nigeria. There is no long-term plan of sustainability for either PEPFAR or the government's program. The initial PEPFAR plan was to allocate drugs and treatment for five years, which was extended to an additional ten years by the Bush administration. In the meantime, the Nigerian government plan is slowly yielding ground to PEPFAR, which is less expensive for patients.

Both programs involve different treatment regimens, are differently subsidized, and are highly politicized. As a Nigerian government supplier, Ranbaxy cornered the generic market in the early 2000s, and their drug prices actually exceeded the cost of similar generics. There have been other tensions: while at the 2004 Nigerian National AIDS conference, I witnessed a confrontation between Ranbaxy representatives and Nigerian AIDS activists over the fact that the company was selling ARVs at its booth without requiring prescriptions. There have also been numerous incidents that indicate that Ranbaxy does not want the more extreme problems of drug distribution in Nigeria to become public knowledge, particularly around the issue of counterfeits. The company must contend with a popular Nigerian opinion, held since SAP, that the majority of counterfeits are made and exported from India (generics and fakes can be often confused for each other, but fakes are

often referred to as "India" drugs). Moreover, the Nigerian government has been accused of poor distribution and operations, the worst of which was a two-month-long drug shortage in 2002, due to bureaucratic complications, and with the implementation of PEPFAR, the government is slowly surrendering ground to the new U.S. operations.²⁰

PEPFAR constitutes the largest roll out of public-health funding in history. It follows a particular policy logic initiated by Bill Clinton, who declared HIV/AIDS a national security threat in the mid-1990s. Since then, the rationales of health and security policies have increasingly merged in several different international arenas. For example, the emerging U.S. Africa Command (AFRICOM) intends to integrate staff structures from the U.S. Department of State, the U.S. Agency for International Development, and humanitarian organizations into existing military structures to conduct tasks ranging from managing AIDS to sharing intelligence. Indeed, the Office of the U.S. Global AIDS Coordinator, which heads PEPFAR, has been moved out of U.S. offices managing traditional development work and now answers to the U.S. Department of State under the secretary of state. Furthermore, the U.S. Department of Defense has a large role to play in the PEPFAR countries, including Nigeria, which rank high among U.S. security concerns. In Nigeria, not only does the Department of Defense have well-endowed AIDS projects, but so too does the Henry M. Jackson Foundation, a philanthropic organization dedicated to subsidizing what it calls "military medicine," which largely constructs infectious disease as part and parcel of security discourse.²¹

Stefan Elbe (2005) shows how these events reflect the ways a range of actors (international organizations, governments, and NGOs) are cast in the name of the survival of communities, economics, militaries, and governments. Key here is how such mobilization is enrolled by the language of security and emergency, which as Alan Ingram describes "takes HIV/AIDS out of the sphere of 'normal politics' and creates obligations to respond in ways that are adequate to the new salience of the problem" (2007, 516). As a result, policy becomes less directed toward civil society and more directed to security and intelligence (Elbe 2006; Ingram 2007). Vinh-Kim Nguyen sums up much of these new rationales and deployments through his term *experimentality*, which he describes as exercising "a new form of legitimate domination through highly mobile, disaggregated and mutable governmentalities. The latter are biological and political technologies for constituting populations and transforming subjectivities in a focused manner around a particular predicament of government. These predicaments are framed in

humanitarian terms and call for urgent measures designed to save lives and prevent suffering, which is understood as an immediate and embodied (or even biological) phenomenon" (2007, 1).

Aside from the general merging of health, development, and security organization and rationales, Nigeria occupies a particular place in these new activities as it is a country that is viewed by the United States both as strategic to peacekeeping operations in Africa and, perhaps more important, as key to security efforts related to oil supplies throughout the Bight of Benin. Oil is crucial because it constitutes a significant chunk of the country's income, and several authors have demonstrated how security and oil are abstracted, where private forms of health development erase the politics and violence of extraction.²² In order for the rationales and linkages of partnership development and security to actually take hold and play out, HIV prevention and treatment policies must be rationalized as normative in precisely the same way as oil extraction and security paradigms (Zalik 2004). Translating these paradigms into policy requires a particular form of management: indeed, PEPFAR under the Bush and Obama administrations mirrors the ways in which the Iraq and Afghanistan wars are managed—largely contracted and outsourced to private partners. The indirect result is that as West African security concerns and expansion appear to be continually facilitated not only by anti-terrorist efforts and the search for steady oil supplies, but also off the back of subsidized pharmaceutical products that rely on AIDS treatment policies for their mobility and consumption.

One of the early predecessors to the Bush administration's PEPFAR initiative was a lesser-known program that may mark the beginning of multi-lateral AIDS policy networks: the United Nations (UN) Accelerated Access Initiative (AAI) of 2000, a joint initiative among the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), and the proprietary pharmaceutical industry that utilized public-relations firms to bilaterally negotiate the reduction of high and out-of-reach drug prices in Africa.²³ In exchange, stringent intellectual-property laws were conceptualized, proposed, and often implemented for African states in a manner that favored and protected multinational pharmaceutical companies' business practices in Africa. After a coalition of drug companies withdrew a well-known suit against South Africa, in 2001, claiming that its 1997 Medicines Act violated World Trade Organization (WTO) regulations on compulsory licensing and parallel importation—legislation that South Africa never acted on—companies taking part in the AAI began to heavily recruit many African countries to negotiate bilateral confidential agreements with the

apparent aim of wiping out the generic drug industry. Two years into the program, ACT UP Paris reported that UNAIDS and the WHO, which orchestrated the negotiations, never provided technical assistance to participatory countries in protecting intellectual-property law or creating guidelines on relations between countries and companies. The WHO and UNAIDS forfeited power and follow up, which empowered the companies to take advantage of the lack of UN oversight (ACT UP Paris 2002). The Health Gap Coalition declared, "UNAIDS drug access policies are currently being structured, by and large, in response to big pharma's displeasure" (2000).

While these negotiations were hailed as some of the best and only options to access treatment, even though only 0.1 percent more people were put on treatment, other issues were crucially erased (ACT UP Paris 2002). At the end of this program, drug prices were not heavily slashed, but the AAI served as one of many now existing gateways for the proprietary pharmaceutical industry to outcompete generics by making policy that eradicated the generic industry. Such policies and actions have shaped the compilation of future drug markets, not simply in Africa, but throughout the world.

In addition to bilateral intellectual-property negotiations, the Trade Related Intellectual Property (TRIPS) Agreement of the WTO, to which Nigeria is a signatory, gives proprietary pharmaceutical companies exclusive twenty-year manufacturing, pricing, and distribution rights on their drug patents. The U.S. government's Agency for International Development (USAID) funds the Commercial Law Development Program (CLDP), an initiative of the U.S. Department of Commerce to "assist" Nigeria in complying with TRIPS. The CLDP sponsored several meetings jointly with the Nigerian Intellectual Property Law Association between 2000 and 2004. At these meetings, there were many panels and instructions on how to comply with the TRIPS/WTO geared around how Nigeria can "be on the right side of globalization." Consistently, the discourse, without any explanation, was that the stronger a country's intellectual-property law was, the more economically viable and powerful it would become in the global economy. Compared to the vast numbers of intellectual-property lawyers in the United States and European patent offices who have access to worldwide databases that can easily determine if an invention is new or discern an intellectual-property violation, the Nigerian patent office awards a patent if the two-page application form is filled out correctly. Given such technological and expertise disparities, Nigeria can hardly be expected to compete internationally or instantly instantiate power in the global economy.

The United States submitted its own drafts of a new Nigerian intellectual-

property law to the Nigerian government, in 2002. I acquired these drafts, which clearly showed that the United States desires a law that favors U.S. businesses while it wipes out all legal provisions to import less expensive generic drugs. At the "final" drafting meeting, AIDS activists (with technical support from international actors like Médecins Sans Frontières [MSF] and Ralph Nader's Consumer Project on Technology) muscled their way into the meeting to demand the inclusion of "healthcare safeguards," which were incorporated into the draft. This was perceived as a great victory.

However, less than a year later, the CLDP returned to Nigeria, apparently (at least according to rumor) under the instructions of the U.S. Patent and Trademark Office, which had determined that Nigeria's new intellectual-property-law draft did not satisfy U.S. preferences. A secret meeting took place, without activists' or government health officials' knowledge. But the meeting became known when its "successful conclusion" was announced on national television.

I acquired the latest intellectual-property draft, which may or may not be the official document, as, historically speaking, multiple drafts have circulated among Nigerian and U.S. officials, who have generated confusion over the "real" document. However, lawyers at MSF in Europe analyzed the draft in my possession and found that it included "data exclusivity" measures that, in short, effectively reduce the generic drug industry's capacity to quickly manufacture generics coming off patent. Such provisions already carried out in other free-trade agreements allow proprietary drug companies to keep data confidential. Such an act actually undermines the original intent of a patent that exchanged inventive data for short-term exclusive marketing. Moreover, it may be a strategy that slowly whittles away the public domain. That is, without the data in hand, a generic company is prevented from developing the technological design to engineer a generic product, a delay that can essentially extend the life of a patent.

USAID simultaneously funds a great number of local AIDS NGOs to carry out prevention and education programs. To some AIDS activists, there is the appearance of a USAID policy contradiction, which supports AIDS activism yet also works to severely curtail drug access. But there may not in fact be a contradiction, as prevention and education campaigns are located in the realm of individual empowerment and responsibility, drawing attention away from the legal structures that generate obstacles to pharmaceutical flows. AIDS activists and NGOs have objected to the relationship between the Nigerian and U.S. governments. But this relationship demonstrates a conflict that the state itself has with multilateral organizations. That is, the state

opposes U.S. and European stances on treatment access at global trading negotiations, but at the same time attempts to meet the pressure to comply quietly behind the doors of federal ministries. This represents an increasingly common strategy utilized by the United States, whereby it capitalizes on the lack of communication between ministries, and between ministries and Nigeria's Geneva representatives; and bilateral and regional (trade or otherwise) agreements become the alternative avenue and means for compliance when global negotiations continually fail. Yet what exactly does it mean for Nigeria to buy generic drugs for its own national antiretroviral program while at the same time it cooperates with the U.S. government to legally wipe out generic drug access? Such an action will effectively make its own antiretroviral program illegal. Nigeria still has not complied with TRIPS, and it is not clear when or if it will happen.

Conclusion

The "implicit agreements" made among multilateral institutions fundamentally drive a political economy that relies on dispossession as its primary organizational strategy. Unlike the massive state and economic adjustments made under the IMF that literally teeter economies on the edge of collapse, a sustained dispossession is very particular and targeted; it takes place amid already chaotic economic and social environments and therefore must operate in more delicate ways that do not threaten the existing thresholds of disintegration. The most particular example is found in struggles over intellectual-property designs, which do not necessarily destroy entire economies, but target specific industries that are viewed as especially competitive; and the massive introduction of free ARV drugs that will not be sustained over time will also have a similar impact on this industry.

While dispossession on a large scale produces sustained clearings for new transnational capital to take root, there is something far more productive in the margins, as Janet Roitman would put it. But at the same time, dispossessed capital and its new formations and mobilities have to rely on other orchestrations of individual and institutional struggles and consent that should suggest just how we might rethink political economy. Rationales for public health and imperatives of capital, and humanitarianism efforts and security cultures, combine and conflict, but ultimately show that the AIDS crisis itself is the greatest thorn in any country's national neoliberal agenda, or perhaps its greatest opportunity.

Notes

1. Some of the literature on the global and globalization that informs my thinking follows. On the global city, see Sassen 2001. On cosmopolitanism, see Cheah and Robbins 1998; Derrida 2001. On globalization, transnationalism, and global networks, see Grewal and Kaplan 1997; Appadurai 1991; Appadurai 2001; Jameson and Miyoshi 1998. On neoliberalism, see Comaroff and Comaroff 2000. On finance markets, see Lee and LiPuma 2002.

2. Notable recent exceptions include Ferguson 2006; Mbembe 2001; Cooper 2002; Moore 2005. James Ferguson (2006) in particular has referred to Africa as the "inconvenient case" that runs against contemporary works of globalization, which describe unencumbered transnational flows; particularly provocative is the analysis by Ferguson (2005) of the way that capital does not flow but "hops" through privatized spaces, especially of oil extraction.

3. I acknowledge Kaushik Sunder Rajan for helping me think through this argument.

4. I acknowledge Don Moore who spoke to me about how "emptying-out" as a form of dispossession is generated by political technologies that contribute to creative destruction accompanied by consequential material realities.

5. Few of the globalization paradigms in circulation today entirely apprehend the complicated ways that African states are positioned in these scenarios. That is, global cities, finance markets, and widespread manufacturing bases do not exist on the continent in congruent ways found elsewhere in the world; and local-global relationships do not adequately capture the nature of the state where kinship and private and public forms of power commingle (Ake 1996).

6. Contrary to widespread popular dissent, the IMF negotiated a SAP with then head of state General Ibrahim Babangida shortly after he took over by coup d'état. This event marks the beginning stages of a protracted prodemocracy movement that coexisted with a heightened culture of militarism characterized by the quest for wealth and violence. With rising poverty and lack of security, a culture of militarism lingers now into the current civilian era and importantly informs retrospective debates and discourses about IMF fallouts such as governance, and the politics of healthcare, pharmacy, and drug manufacturing.

7. Julia Elyachar (2005), Janet Roitman (2005), and Donald Moore (2005) examine the micropolitics of dispossession and the various forms of reinvestment and political stakes in Egypt, the Chad Basin, and Zimbabwe, respectively.

8. George Caffentzis (1995) made an almost identical argument about structural adjustment and dispossession in Africa, where he traces its dramatic impact on social transformation.

9. According to official statistics, oil wealth makes up over 46 percent of Nigeria's gross domestic product and accounts for 85 percent of the country's foreign exchange (World Bank Report 2004). The rumor on the street in Lagos is that 40 percent of Nigeria's crude oil goes missing each year (Apter 2005).

10. Brotherton, however, refers to the Cuban state.

11. For more recent excellent analyses on oil in Nigeria, see Watts 2001; Watts 2004; Apter 2005; Naanen 2004; Okonta 2004.

12. I first found an analysis of this quote in Avery Gordon's introduction to Cedric Robinson's *The Anthropology of Marxism* (2001), which is reprinted in Avery Gordon's *Keeping Good Time* (2004).

13. James Ferguson (2005), however, points to how these scenarios become possible when capital hops, rather than flows, into privatized sectors, like oil extraction.

14. A. P. Robertson estimates that "capital flight from Nigeria alone vary from \$50 billion, to 135–150 billion, to 3,000 billion British pounds" (n.d. 5).

15. The Nigeria debt-cancellation deal of 2006 included forgiving all but the U.S. \$12 billion owed to Paris Club members. This deal included adhering to the controversial IMF Support Policy Instrument, which is extended to countries that do not need IMF loans but that nonetheless seek IMF endorsement signaling an easier release of funds from multilateral donors and banks. This mechanism extends older forms of legitimacy-making in the context of debt-worthiness (not necessarily credit-worthiness). In return, countries must adhere to the usual privatization schemes geared toward foreign direct investment. Nigeria agreed to completely privatize the national energy sector and reorganize its banking sector, among others, in exchange for the deal.

16. In fact, one pharmacist who has worked in the national inspectorate estimated to me that 95 percent of all registered pharmacies would not actually pass inspection; they manage to get their licenses in exchange for money to "look the other way," as he put it.

17. A survey by A. O. Bright and O. Taylor (1999) showed that irrespective of socioeconomic stratum, self-medication is very high, recording 75 percent as the lowest figure. It concluded that if pharmacists refuse to assist the self-medicating population, then morbidity, mortality, iatrogenicity, and other adverse effects will be on the increase. Their statistics on reasons for self-medication are worth reporting here: cheapness, 32.9 percent; effectiveness, 71.35 percent; sure relief or cure, 85.23 percent; time saving, 66.19 percent; respondents with clear knowledge of pharmacists, 88.79 percent; respondents who would ask for pharmacist intervention, 52.49 percent; respondents who would see doctors first if ill, 9 percent; respondents who feel they do not need a pharmacist, 36.11 percent.

18. Julia Elyachar (2005) shows how in the aftermath of structural adjustment the poor—their networks and social practices—have been incorporated into the rhetoric and logics of free market expansion by the World Bank and other institutions that use an explicit neoliberal vision (and not other alternatives) to implement such policies and practices.

19. There are several other international bilateral treatment programs that are also part of this mix.

20. It should be noted that at least one indigenous Nigerian drug-manufacturing firm was poised to begin producing anti-HIV medication. The subsidization of both

U.S. and Indian products has essentially eliminated the prospects of Nigerian manufacturing at this time.

21. The other top two PEPFAR countries that get Department of Defense funding are Tanzania and Kenya, perhaps matching antiterrorist efforts since the 1998 U.S. embassy bombings in those countries.

22. Apter 2005; Okonta and Douglass 2003; Watts 2001; Zalik 2004; Ingram 2007.

23. The pharmaceutical industry was represented by five companies: Boehringer Ingelheim, Bristol-Myers Squibb, GlaxoWellcome, Merck, and Hoffmann-La Roche.