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RECONSTRUCTING TRIPS: A RIGHTS-BASED APPROACH TO PATENT LAW AND PUBLIC HEALTH IN THE GLOBAL SOUTH

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ABSTRACT

The relationship between the human right to health and international intellectual property law has become a source of ethical and legal conflict, especially after the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) was ratified. In an attempt to promote pharmaceutical innovation, TRIPS mandates minimal global standards for patent protection; nonetheless, its execution has severely limited the capacity of developing countries to preserve access to life-saving drugs. This paper explores the legal, normative, and political problems that arise when people's right to healthcare is denied due to stringent patent restrictions.

The paper begins by giving a summary of how patent law evolved prior to TRIPS, showing how nations like Brazil and India used legal flexibility to prohibit pharmaceutical companies from obtaining patents in order to safeguard public health. When assessing the doctrinal gap between TRIPS obligations and international human rights standards, special attention is paid to the right to health as guaranteed by Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the definitive interpretations found in General Comments 14 and 17. By highlighting how corporate lobbying and TRIPS-Plus trade agreements have expanded access to drugs, a political economy perspective deepens the analysis even more. The report suggests a rights-based reform paradigm that incorporates legislative safeguards, judicial activism, and increased South-South legal collaboration in order to solve these issues. Lastly, it promotes a framework for patent governance that balances public health obligations with incentives for innovation and upholds the right to health as a moral and legal priority over commercial exclusivity.

Keywords- TRIPS Agreement, Right to Health, Pharmaceutical Patents, Human Rights and Intellectual Property

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INTRODUCTION

International intellectual property standards underwent a radical shift as a result of the TRIPS Agreement's enforcement, which forced poorer countries to impose stringent patent protections, especially in the pharmaceutical sector.[2] Before TRIPS, developing countries had considerable freedom to modify patent laws to suit their economic and health needs. They often excluded pharmaceutical products from patent coverage in order to increase access to medications and foster the growth of regional enterprises.[3]

Prior to the TRIPS Agreement, several developing countries used their legal power to deny patent protection to pharmaceutical products, putting public health ahead of private interests. By passing the Patents Act of 1970, which only allowed process patents for pharmaceuticals, India, for instance, established a robust indigenous generics industry.[4] Large-scale manufacturing of reasonably priced drugs was made possible by these flexible regimes, especially for illnesses that disproportionately impacted the impoverished classes.

By bringing national legal systems into line with international patent norms, the TRIPS Agreement's harmonization of intellectual property laws severely restricted domestic policy autonomy. This change has disproportionately impacted nations with weaker economies and technological capabilities.[5]

These conflicts were recognized in the 2001 Doha Declaration on TRIPS and Public Health, which said that the TRIPS Agreement should not prevent members from taking measures to protect public health.[6] In reality, due to political and administrative barriers, flexibilities like parallel importation and compulsory licensing have not been fully employed in practice.[7]

Concurrently, the right to health has become a fundamental human right recognized by international law, especially through the interpretation of General Comment No. 14 and Article 12 of the ICESCR. This right commits states to provide access to necessary medicines and healthcare free from discrimination.[8] Moreover, courts in developing nations are being asked to decide the clash between the enforcement of patents and access to lifesaving drugs. These courts are becoming important spaces to invoke the pre-eminence of human rights over profit-driven entitlements.[9]

This study aims to investigate a key legal question, "How well can developing nations balance their constitutional and international commitments to protect the right to health with pharmaceutical patent systems that comply with TRIPS...?" The study examines this issue by assessing the suitability of TRIPS flexibilities as well as the function of domestic courts in reinterpreting IP standards to take public health vulnerability into account. The relationship between international patent law and the right to health is examined in this work using a doctrinal and analytical approach.

2. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, 1869 U.N.T.S. 299.
3. E. Schiff, *Industrialization without National Patents: The Netherlands, 1869–1912, Switzerland, 1850–1907* 115–122 (Princeton Univ. Press 1971).
4. Shamnad Basheer, *India's Tryst with TRIPS: The Patents (Amendment) Act 2005*, 1 Indian J.L. & Tech. 15, 17 (2005).
5. B. Lindstrom, *Scaling Back TRIPS-Plus: An Analysis of Intellectual Property Provisions in Trade Agreements and Implications for Asia and the Pacific*, 42 N.Y.U. J. Int'l L. & Pol. 917 (2010).
6. World Trade Organization (WTO), *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2 (2001) [Doha Declaration].
7. E.M. Anderson, *Unnecessary Deaths and Unnecessary Costs: Getting Patented Drugs to Patients Most in Need*, 29 B.C. Third World L.J. 85 (2009).
8. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (2000), ¶ 12.
9. Ochieng et al. v. Attorney General, High Court of Kenya, Petition No. 409 of 2009, ¶¶ 14, 76–78.

In order to evaluate how courts have handled conflicts between patent protection and access to medicines, it uses comparative judicial analysis through a selection of decisions from developing jurisdictions and examines the TRIPS Agreement in conjunction with pertinent international human rights instruments and interpretative materials. Secondary empirical research on public health outcomes and pharmaceutical innovation supports the study. Only when the legal framework and opposing intellectual viewpoints have been thoroughly examined can normative ideas put forth.

LITERATURE REVIEW

The academic debate around pharmaceutical patents and drug accessibility shows a distinct division between those who support innovation incentives and those who support public health requirements. Henry Grabowski and Joseph DiMasi, among other economists and academics with ties to the industry, have vehemently defended the patent system as necessary to counteract the high expense and unpredictability of drug development.[10] Their empirical studies support the claim that exclusive rights are necessary to recover investment and finance future innovation, estimating that the cost of bringing a single new medicine to market surpasses USD 800 million.[11]

On the other hand, trade-driven patent norms have been contested by critical legal scholars like Philippe Cullet and Emmanuel Kolawole Oke, who contend that TRIPS, despite its seeming neutrality, places an unfair burden on developing nations.[12] Cullet argues that TRIPS promotes a transition from health sovereignty to market dependency and diminishes regulatory autonomy.[13] Oke has furthered the claim that the right to health must function as a conceptual check on the enforcement of pharmaceutical patents in nations where it is established in the constitution.

ECONOMIC JUSTIFICATION FOR PATENTS IN THE PHARMACEUTICAL SECTOR

Scholarly literature consistently recognizes that the pharmaceutical industry is especially reliant on patent protection because of the unique scientific and economic aspects of medication development. Pharmaceutical innovation is distinguished by lengthy research timetables, intense regulatory scrutiny, and large sunk costs, in contrast to many other technology-intensive businesses where competitive advantage may derive from quick market entry or production efficiencies. Only a small percentage of candidate molecules are ever approved for sale, and drug discovery and clinical testing involve a great deal of uncertainty. The scope and risk of investment in pharmaceutical research and development are highlighted by empirical studies that are commonly cited in this context. These studies estimate that the cost of bringing a new medication to market may exceed several hundred million dollars when direct research expenditures and the time value of capital are taken into account.[14]

Pharmaceutical innovators are vulnerable to free-rider dangers when patent protection is absent. Without having to pay the high expenses of original research, clinical trials, and regulatory approval, generic producers can access the market by proving bioequivalency. After exclusivity ends, regulatory regimes in countries like the US provide for shortened approval procedures for generics, greatly reducing entry barriers. According to this viewpoint, the lack of enforced patent rights deters

10. Henry Grabowski, *Patents, Innovation and Access to New Pharmaceuticals*, 5 J. Int'l Econ. L. 849 (2002).
11. Joseph A. DiMasi, Ronald W. Hansen et al., *The Price of Innovation: New Estimates of Drug Development Costs* 11 (Tufts Ctr. for the Study of Drug Dev. 2002).
12. Philippe Cullet, *Patents and Medicines: The Relationship between TRIPS and the Human Right to Health*, 79 Int'l Aff. 139 (2003).
13. *Ibid.*, at 145–147.
14. Joseph A DiMasi, Henry G Grabowski & Ronald W Hansen, 'Innovation in the Pharmaceutical Industry: New Estimates of R&D Costs' (2016) *Journal of Health Economics*.

businesses from investing in capital-intensive, high-risk innovation pipelines, which could lower the total amount of new medicine research.[15]

The implementation of robust and consistent patent protection across jurisdictions is defended by proponents of the TRIPS system. They argue that in order to maintain long-term investment in pharmaceutical research and development and to guarantee that innovation stays commercially feasible, uniform and predictable patent requirements are crucial. By integrating developing nations into international networks for research and manufacturing, uniform patent protection is also offered as a means of promoting knowledge transfer and capacity building. This perspective holds that lowering patent standards, especially in developing nations, runs the danger of deterring investment in research-intensive treatments and could eventually jeopardize public health by decreasing the rate of pharmaceutical innovation.[16]

Although these arguments are highly persuasive in environments with robust public research infrastructure, significant purchasing power, and efficient regulatory bodies, their basic presumptions are not easily applied to low- and middle-income nations. According to empirical research, pharmaceutical innovation is still largely focused in high-income economies, and commercial profitability rather than the burden of sickness worldwide dominates research objectives.[17] Despite the global growth of patent protection, diseases that disproportionately afflict underdeveloped nations continue to receive relatively little research attention. Furthermore, many developing nations lack the industrial, technological, and institutional capacity necessary to convert patent protection into domestic manufacturing capability or better access to reasonably priced medicines, so the expected benefits of technology transfer under TRIPS have frequently failed to materialize in practice.[18]

Therefore, even while patents can serve as a tool for policymakers to strike a balance between post-exclusivity price competition and innovation incentives, this balance becomes more precarious when applied consistently across states with significantly different economic capacity. Instead of reducing structural disparities in access to necessary medications, the TRIPS regime runs the risk of reinforcing them by requiring uniform patent requirements without adequate consideration for developmental asymmetries.

TRIPS AGREEMENT AND THE RIGHT TO HEALTH: LEGAL AND POLITICAL ANALYSIS

An important turning point in the globalization of intellectual property law was the World Trade Organization approval of the TRIPS Agreement in the year 1994. It established legally obligatory minimum criteria of protection for trademarks, copyrights, and patents, including pharmaceutical items. The requirement that all WTO member states offer inventions at least 20 years of patent protection, irrespective of their economic standing or degree of development, severely limited the domestic policy options available to developing nations that had previously excluded pharmaceuticals from patentability. Although Articles 7 and 8 of TRIPS make reference to social welfare and the public interest, their practical applicability is limited by the general requirement that all such actions be "consistent with the provisions of this Agreement".[19]

15. Frederick M Scherer, *Innovation and Growth: Schumpeterian Perspectives* (MIT Press).
16. World Trade Organization, *TRIPS Agreement*; see also Carlos M Correa, *Intellectual Property Rights, the WTO and Developing Countries* (Oxford University Press).
17. World Health Organization, *Global Health R&D Observatory* reports; see also Dean Baker, *The Pharmaceutical Industry and Access to Medicines*.
18. Carlos M Correa, 'TRIPS and Development: Flexibilities and Public Health' (South Centre); UNDP, *Intellectual Property and Access to Medicines*.
19. Agreement on Trade-Related Aspects of Intellectual Property Rights arts. 7–8, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299 [hereinafter TRIPS Agreement].

In 2001, the Doha Declaration on the TRIPS Agreement and Public Health was released in response to international concern over access to necessary medications. Reiterating that TRIPS "should not prevent members from taking measures to protect public health", the Declaration acknowledged nations' rights to employ mechanisms like parallel importation and forced licensing.[20] Nevertheless, complicated procedural constraints, a lack of industrial capability in many developing nations, and political pressure from wealthier nations have hindered the practical implementation of these flexibilities.

Beyond the language of the law, strong economic interests influenced the TRIPS regime's basic creation. Throughout the Uruguay Round negotiations, the Intellectual Property Committee (IPC), a group of multinational companies including Pfizer, IBM, Merck, and DuPont, was instrumental in influencing the US government.[21] Global norms were successfully shifted from public-interest-oriented models to proprietary, industry-driven standards as a result of their concerted efforts, which led to the inclusion of IP enforcement in the trade agenda. Therefore, rather from being a neutral compromise among WTO members, the TRIPS framework constitutes a highly asymmetrical arrangement that prioritizes corporate innovation incentives over the objectives of public health and development.

This discrepancy is further reinforced by the inclusion of TRIPS-Plus provisions in bilateral and regional trade agreements, such as those the US and EU have signed with various developing countries. These clauses sometimes limit the flexibility of state policy by imposing restrictions on forced licensing, extended patent terms, and data exclusivity commitments that go beyond TRIPS rules.[22] The use of TRIPS flexibilities is politically costly and legally complex since countries that prioritize access to medicine have been threatened with economic consequences or the loss of trade advantage.[23]

When combined, TRIPS's legal strictness and political economics provide a significant barrier for developing countries trying to strike a balance between their international obligations and their moral or constitutional obligations to public health. This dual structure, which consists of political pressure and legal restraint, must be considered in any attempt to reinterpret or modify international intellectual property law through a rights-based perspective.

JUDICIAL RESPONSES AND THE ROLE OF COURTS IN DEVELOPING COUNTRIES

The struggle in developing states to effectively manage demands on public health care on one side while living up to TRIPS commitments on the other has made the judicial system in these states vital in the fight to ensure the rights to health protected from general patenting. In states where healthcare is considered a justiciable right based on either legislation and/or constitutional provisions, there is evidence that there is an increased willingness on the part of the judicial systems in these states to decode patenting legislation in relation to healthcare needs.

One of the notable examples that can be found within the case laws of the courts of Kenya is that of: In *Ochieng et al. v. Attorney General*, the High Court of Kenya recognized the right to health under Article 43 of the 2010 Constitution and established the government's obligation to make key medicines

20. World Trade Organization, *Declaration on the TRIPS Agreement and Public Health*, WTO Doc. WT/MIN(01)/DEC/2 (Nov. 14, 2001).

21. Susan K. Sell, *Private Power, Public Law: The Globalization of Intellectual Property Rights* 96–102 (2003).

22. Carlos M. Correa, *Integrating Public Health Concerns into Patent Legislation in Developing Countries* 12–14 (South Centre 2000).

23. Frederick M. Abbott, *The TRIPS Agreement and Its Implications for Access to Medicines in Developing Countries*, 5 Widener L. Symp. J. 11, 24 (2000).

available to all in spite of patent limitations.[24] The court held that intellectual property rights, as statutory rights, have to be weighed against core human rights especially when they interfere with the enjoyment of constitutionally guaranteed health services.[25]

In a previous case, *Pfizer Inc. v. Cosmos Ltd.*, a multinational drug corporation alleged patent infringement of azithromycin dihydrate.[26] The respondent, who was a domestic generic manufacturer, had recourse to Kenya's statutory provision for parallel importation. The Industrial Property Tribunal ruled in favour of Pfize, not bothering to consider the implications of enforcing public health.[27] These rulings demonstrate how judges have evolved to interpret the law in a way that is purposeful and health-sensitive. Indian courts have also been pioneer forces in safeguarding access to medicines by interpreting the patent law. In *Novartis AG v. Union of India*, the Supreme Court upheld Section 3(d) of the Patents Act, 1970, refusing patent protection to altered cancer drug on the basis that it did not lead to greater therapeutic efficacy.[28] The Court noted that patent monopolies cannot be used to increase control over insignificant inventions, especially when doing so prevents millions of people from obtaining life-saving medications.

These examples demonstrate that Global South courts can create constitutional and statutory concepts that harmonize intellectual property regulation with the right to health, rather than being only passive agents of international IP compliance. Courts can effectively prevent proprietary claims from going too far and jeopardizing public health objectives by considering health rights while making patent decisions.

PUBLIC HEALTH EMERGENCIES AND GLOBAL REFORM

The COVID-19 crisis revealed inherent flaws in the global intellectual property system, specifically its failure to address public health crises in an equitable manner. While vaccines were produced at record rates, upper-income nations pre-ordered a majority of the doses available, leaving low- and middle-income countries with minimal or no access. This trend, commonly known as "vaccine nationalism", exposed an underlying imbalance in the international health system, where purchasing power and market influence determined the course of events instead of public demand.[29] Even with colossal investments by public funding in vaccine development, pharmaceuticals held exclusive rights over manufacturing and dispensation.

In October 2020, India and South Africa submitted at the World Trade Organization a temporary waiver of some TRIPS provisions to enable wider access to COVID-19-related health products.[30] The waiver would enable member nations to suspend patent covers on vaccines, tests, and treatments without risking international trade law penalties. The initiative was backed by a broad group of developing nations and non-governmental organizations. But it was strongly resisted by a number of developed nations, including European Union members, the United Kingdom, and formerly the United States. The subsequent talks were long and eventually yielded a narrow waiver that did include diagnostics and treatments, short of the wider global need.[31] It underscored not just the legal inflexibility of the TRIPS regime but also the political reluctance to place global equity first during a crisis.

24. Ochieng et al. v. Attorney General, Petition No. 409 of 2009, High Court of Kenya, ¶¶ 14, 76–78.
25. *Ibid.*, ¶ 77.
26. Pfizer Inc. v. Cosmos Ltd., Indus. Prop. Tribunal, Nairobi (2008), at 3, 13.
27. *Ibid.*, at 14–16.
28. Novartis AG v. Union of India, (2013) 6 SCC 1, ¶¶ 90–95.
29. Matthew Kavanagh, *Vaccine Nationalism*, 397 Lancet 10268, 10268–69 (2021).
30. WTO General Council, *Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of COVID-19*, IP/C/W/669 (Oct. 2, 2020).
31. World Trade Organization, *Ministerial Decision on the TRIPS Agreement*, WTO Doc. WT/MIN(22)/30 (June 17, 2022).

The pandemic also highlighted the ineffectiveness of voluntary approaches like COVAX and public-private collaborations that did not manage to provide timely and equitable access to vaccines. The experience confirmed that market-based solutions alone prove inadequate during emergencies and that a new intellectual property regime must include enforceable obligations in favor of public health goals. It also uncovered the demand for increased legal independence among developing nations to react to crises without threats of retaliations or external pressure.

In this regard, a feasible route to structural adjustment is offered by South-South legal cooperation. The African Medicines Agency (AMA) and the ASEAN Working Group on Intellectual Property Cooperation are examples of regional initiatives that aim to improve pharmaceutical capacity in the region, standardize legal standards, and promote coordinated efforts to counter health risks.[32] These forums can be used as vehicles for sharing legal strategies and jurisprudence that ensure access to medicines. For instance, India's Section 3(d), limiting patentability over small changes to drugs, and Kenya's constitutional provision on the right to health provide models for other Global South developing countries to emulate.

Through the exchange of legal information, shared procurement capacities, and common policy stands in international negotiations, Global South nations are able to push back against external TRIPS-Plus pressures and negotiate together to further public health interests. Instead of being limited to higher-level diplomatic platforms, these cross-cutting coalitions can build a stronger and health-focused intellectual property system. In this process, they cultivate a vision of patent law that places equity, sustainability, and human dignity at the forefront of combating global crises.

REIMAGINING PATENT LAW THROUGH A HEALTH EQUITY LENS

Building on the foregoing legal and judicial analysis, this section addresses the policy considerations that emerge in relation to patent law and public health. While the TRIPS Agreement formally recognizes the importance of innovation and incorporates certain regulatory flexibilities, its structure has not adequately responded to persistent inequalities in access to essential medicines across differing economic realities.[33]

The realization that intellectual property rights, particularly patents, are tools of policy that serve to advance the public interest rather than objectives in and of themselves is at the heart of this change.[34] The CESCR has stressed that as patents are social products with a social purpose, they shouldn't be interpreted in a way that compromises the enjoyment of fundamental rights.[35] General Comment No. 17 makes a clear distinction between ownership claims under patent regimes and moral and material interests under human rights law, concluding that the latter are tools that can be restricted to safeguard more general public values.[36]

However, in the absence of fundamental legal reform, procedural flexibilities are inadequate. National legislatures must make sure that clear public health protections are incorporated into domestic patent laws in order to operationalize a rights-based approach. For instance, Section 3(d) of the Patents Act of India, which prohibits "evergreening" and protects the supply of generics, prohibits new forms of well-known substances

32. African Union, *Treaty for the Establishment of the African Medicines Agency (AMA)*, https://au.int/ama (last visited June 22, 2025).

33. Agreement on Trade-Related Aspects of Intellectual Property Rights, arts. 7–8; *Declaration on the TRIPS Agreement and Public Health*, WTO Doc. WT/MIN(01)/DEC/2 (2001), ¶¶ 4–5.

34. Peter Drahos & John Braithwaite, *Information Feudalism: Who Owns the Knowledge Economy?* 168 (Earthscan 2002).

35. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 17: The Right of Everyone to Benefit from the Protection of the Moral and Material Interests Resulting from Scientific, Literary or Artistic Production*, U.N. Doc. E/C.12/GC/17 (2006), ¶ 35.

36. *Ibid.*, ¶¶ 1–3.

from being protected unless they demonstrate improved efficacy[37]. Similarly, in order to achieve public health objectives, national legislation must include rules on parallel importation, mandatory licensing, research exemptions, and regulatory review exceptions.[38]

The role of adjudication is equally significant. Courts must adopt thoughtful readings of IP statutes that are in line with both international human rights standards and constitutional rights. The judicial system can be extremely important in resolving conflicts between the demands of individual rights and public health, as the legal systems of Kenya and India indicate.[39] The fundamental premise that the right to life or health must take precedence over patent enforcement in the event of a disagreement must serve as the foundation for judicial discretion.

Therefore, the future of patent law, especially in the case of life-saving medicines is not one of uniformity but of just adaptation where access and innovation need not be exclusive, and the right to health is not dealt with as a collateral matter, but as a constitutional and ethical imperative.

RECOMMENDATIONS: BUILDING A RIGHTS-BASED PATENT FRAMEWORK

To implement a rights-based approach to pharmaceutical patent regulation, particularly in developing countries, the following legal and institutional reforms are suggested:

1. Explicit Enshrinement of the Right to Health in Patent Law

National intellectual property laws must include explicit references to the right to health. Courts and administrative agencies must have the authority to reduce, override, or invalidate patents where enforcement is incompatible with access to vital medicines. Statutory modifications that give patent offices and courts the authority to reject or restrict patent enforcement where it clearly impedes access to necessary medications might operationalize this.[40]

2. Optimal Use of TRIPS Flexibilities

Governments must actively utilize and streamline the use of TRIPS flexibilities like:

- Compulsory licensing in the event of public health crises or unaffordability of prices;
- Parallel importation of low-cost versions of patented medicines;
- Exemptions for research and regulatory scrutiny (Bolar provisions).[41]

Efficient implementation also calls for administrative streamlining and political commitment, such as streamlined procedures and open mechanisms for invocation. Governments should set up explicit administrative processes and public health thresholds that immediately initiate mandatory licensing during proclaimed health emergencies in order to guarantee efficient utilization.

3. Curbing Evergreening through Patentability Standards

The developing world can maintain or enact provisions such as Section 3(d) of the Indian Patents Act, which prohibits patenting of marginal changes of established substances that do not have

37. The Patents Act, 1970, § 3(d), No. 39, Acts of Parliament, 1970 (India).
38. Frederick M. Abbott, *The TRIPS Agreement and Its Implications for Access to Medicines in Developing Countries*, in Carlos Correa & Abdulqawi A. Yusuf (eds.), *Intellectual Property and International Trade: The TRIPS Agreement* 425–440 (2d ed. Kluwer Law Int'l 2008).
39. Novartis AG v. Union of India, (2013) 6 SCC 1; Ochieng et al. v. Attorney General, Petition No. 409 of 2009, High Court of Kenya.
40. U.N. Dev. Programme, *Human Rights and Intellectual Property: Mapping the Global Interface* 82 (2011).
41. World Trade Organization, *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, WTO Doc. WT/L/540 & Corr.1 (2003).

improved therapeutic efficacy.[42] This restricts generic entry and limits monopolistic extension. Patent offices can put this into practice by releasing examination criteria that mandate independent clinical data and demonstrated therapeutic efficacy for secondary pharmaceutical patents.

4. Judicial Capacity Building and Rights-Based Interpretation

Courts must have adequate instruction and scholarly exposure to international human rights commitments and public health jurisprudence. Judicial reasoning must adopt a purposeful mindset that prioritizes constitutional rights over intricate interpretations of intellectual property rules.[43] Strong doctrinal underpinnings can be constructed with the help of comparative jurisprudence from other jurisdictions. This may be achieved through judicial training programmes, specialized IP benches, and the incorporation of international human rights jurisprudence into continuing judicial education

5. Global Advocacy for TRIPS Reform

Long-term campaigning is needed on the multilateral front to amend the TRIPS Agreement to include non-derogable safeguards for access to medications, particularly during pandemics and other cross-border health emergencies.[44] Reforms must shift focus from optional flexibilities to obligatory duties based on human rights. This can be pursued by developing nations through coordinated recommendations at the WTO Ministerial Conferences, bolstered by joint submissions citing international human rights law's obligations for public health.

6. Strengthen South-South Legal Cooperation

Through institutions like the African Medicines Agency (AMA), ASEAN intellectual property frameworks, and larger South-South alliances, developing nations should formally establish regional legal and policy cooperation. These collaborations can encourage the sharing of effective legal tactics, such as Kenya's constitutional right to health and India's Section 3(d) standard for patentability, as well as the harmonization of public health protections, pooled procurement, and mandatory licensing mechanisms.[45] In international intellectual property negotiations, regional collaboration strengthens bargaining leverage and produces a coordinated legal response to TRIPS-Plus provisions.[46] Such programs would support fair access to medications throughout the Global South and increase long-term resilience. Regional agreements that allow for coordinated use of mandatory licensing procedures, shared resources for patent examination, and pooled procurement can institutionalize such collaboration.

CONCLUSION

While the TRIPS Agreement purports to encourage pharmaceutical innovation and harmonize intellectual property rights globally, it has disproportionately hurt developing countries by restricting their ability to ensure access to essential pharmaceuticals. Particularly in fields where monopolistic power and public health regulations collide, its enforced patent rules have made the structural gap between cost and innovation worse. Although Articles 7 and 8 offer flexibilities like required licensing, political pressure, a lack of

42. The Patents Act, 1970, § 3(d), No. 39, Acts of Parliament, 1970 (India).

43. Lorie Graham & Stephen McJohn, *Thirty-Two Short Stories About Intellectual Property*, 3 Minn. Intell. Prop. Rev. 1, 52–54 (2002).

44. U.N. Human Rights Council, *Access to Medicines in the Context of the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/HRC/RES/23/14 (2013), ¶ 5.

45. Shamnad Basheer, *India's Tryst with TRIPS: The Patents (Amendment) Act 2005*, 1 Indian J.L. & Tech. 15, 17 (2005); Ochieng et al. v. Attorney General, (2012) eKLR (Kenya) (recognizing the constitutional right to health under Article 43).

46. African Union, *Treaty for the Establishment of the African Medicines Agency (AMA)*, https://au.int/ama (last visited June 22, 2025); ASEAN Working Group on Intellectual Property Cooperation, *ASEAN IP Portal*, https://aseanip.org (last visited June 22, 2025).

domestic capacity, and convoluted procedures have significantly reduced their effectiveness.[47]

The UN Committee on Economic, Social, and Cultural Rights has made it clear that when commercial patent rights and the right to health, as stated in Article 12 of the ICESCR, clash, the right to health should take precedence.[48] Patent law has been brought into line with constitutional health provisions thanks in large part to the efforts of domestic courts, especially those in Kenya and India. However, legal texts are not enough on their own. The impact of multinational pharmaceutical corporations and TRIPS-Plus trade agreements are just two examples of how political and economic power affect TRIPS, which is more than just a legal framework.[49] Low- and middle-income nations' access to even the minimal flexibilities in TRIPS has been restricted by these procedures.

Geopolitical hierarchies and corporate interests won out over change, which reaffirmed the need for an IP regime that is egalitarian, legally binding, and focused on health.In this regard, South-South legal collaboration becomes an essential but underutilized tactic. Developing nations can coordinate policy responses, share expertise, and pool resources through platforms like the African Medicines Agency and ASEAN's IP efforts.[50] These collaborations allow for coordinated policy, pooled expertise, and resistance to outside influences, such as those imposed under TRIPS-Plus requirements.

This paper concludes by advocating for a rights-based approach to patent governance, which treats the right to health as a constitutional and international legal priority rather than as a secondary issue. TRIPS compliance should be viewed as a starting point rather than a cap, allowing nations to put life and human dignity ahead of profit.

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