

European Research Council



The global governance of AIDS 2000-2015: What has driven the global governance response?

Simon Rushton

Centre for Health and International Relations

Aberystwyth University, UK

sbr@aber.ac.uk

Draft: Not for citation

This research has been made possible through funding from the European Research Council under the European Community's Seventh Framework Programme - Ideas Grant 230489 GHG. All views expressed remain those of the author.

Introduction

HIV and AIDS have dominated the global health governance agenda for at least the last fifteen years. In that time the international response to AIDS has changed beyond all recognition. The bald figures tell some of the story. Back in 1999 global spending on the AIDS response was just under \$900 million (UNAIDS, 2005: 1). By 2009 this had risen to about \$16 billion (UNAIDS, 2010a: 145). The institutional landscape has undergone a similarly profound transformation. Fifteen years ago UNAIDS was created as a hub co-ordinating United Nations responses, taking on much of what had previously been the WHO's role in leading the global fight against AIDS. But since then some newer and (in financial terms at least) bigger kids have moved onto the block. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR) both have resources which dwarf those of UNAIDS. And they have not been the only new actors to emerge. Others – the Gates Foundation being a prominent example – have also come to play significant parts in the global governance of AIDS.

The inclusion of three specifically health-related targets amongst the Millennium Development Goals (MDGs) may initially have been a result rather than a cause of the political priority these issues had been accorded, but nevertheless the MDGs have had the effect of concretizing a particular global health agenda. AIDS, which along with "malaria and other diseases" is the subject of MDG6, has been one of – perhaps the primary – beneficiaries of this. In recent years child health (MDG4) and maternal health (MDG5) have begun to receive a greater share of attention yet they have received nothing like the resources which have been devoted to AIDS since 2000. MDG6 has three targets, the first two of which relate to HIV/AIDS.¹ These two targets are supported by five indicators for monitoring progress (UN Statistics Division, 2011):

6A. Halt and begin to reverse, by 2015, the spread of HIV/AIDS

6.1 HIV prevalence among population aged 15-24 years

6.2 Condom use at last high-risk sex

6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

6B. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

¹ The third target of MDG6 is "Halt and begin to reverse, by 2015, the incidence of malaria and other major diseases".

6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs

Not only, then, did the MDGs set a particular agenda for global health in the first 15 years of the 21st century - the time period which this paper examines - in the case of HIV and AIDS they also set out particular ways in which progress towards that goal would be measured. Some of the indicators concern prevention strategies (for example indicators 6.2 and 6.3) whilst target 6B focuses on the treatment side of the equation.

Over the last few years there has been an ongoing debate over whether current global responses to HIV and AIDS are striking the right balance between treatment and prevention. The argument that current approaches are too focussed on treatment at the expense of prevention has become commonplace. Whilst all agree that both are important, and some have argued that attempting to 'trade-off' treatment and prevention is unhelpful, the case that the global governance of AIDS has in practice tended to concentrate on the delivery of treatment is a strong one. Whilst important work in prevention is of course being done, scaling-up treatment has been at the centre of governance innovation, has dominated political attention, and has been allocated a large proportion of the global AIDS resource pool.

This paper does not seek to engage directly in the treatment vs. prevention debate but rather asks a slightly different question: why is it that the global governance of AIDS has been so treatment-centric over the last decade? The paper argues that a variety of factors underlie this trend. Some of these are scientific, some economic, but many – and it is on these that the paper largely focuses – are political. Finally, the paper looks ahead to the remaining years of the MDG period and beyond, looking at the challenges ahead and asking whether a shift towards a greater emphasis on prevention is likely to emerge.

The global governance of HIV/AIDS

The global health governance literature has made many attempts to describe the contemporary governance 'system'. Whilst the theoretical approaches adopted and the metaphors used have varied widely, all begin from a recognition that much has changed in recent years. In part the story is one of new health challenges, particularly those challenges posed by a globalized world, but the

architecture of global health governance has itself undergone a transformation, in part at least in response to these new challenges. Global health governance actors have increased in both number and variety. There have often been attempts in the literature to capture this through drawing a distinction between “international health” and “global health” (Brown et al. 2006; Kaplan et al. 2009), and consequently between “international health governance” and “global health governance” (Dodgson, Lee & Drager 2002), or – as Fidler (2004) would have it – between a “Westphalian” and a “post-Westphalian” system.

HIV/AIDS is often seen as the “signature project” of global health governance (Ingram, 2009) – perhaps even one of the key factors in bringing about the transition from international to global health. Kirton and Mannell (2007: 115) cite the spread of HIV as “the first sign of the failure of the old multilateral and regional health actors.” Similarly Ilona Kickbusch (2007: xi) has argued that HIV “transformed public health into a global endeavour”. Partly as a result, it is around HIV and AIDS that we have seen many of the most notable examples of governance innovation, many of which will be discussed below. Given that it is generally recognised that the governance of HIV/AIDS is a “fragmented process involving various actors” (Seckinelgin 2005; 2008: 33-4), it is interesting to note how unified the literature is on the question of who the key actors are in the global governance of AIDS. States, of course, remain central to this enterprise, with some bilateral programmes – not least the United States’ PEPFAR programme – being unprecedented in scale in the history of global health or international development. Aside from states, the governance system is comprised of a number of institutions and organizations including traditional multilateral organizations (such as the WHO, the World Bank, and UNAIDS), new forms of public-private partnership (the most notable in the AIDS case being the Global Fund to Fight AIDS, Tuberculosis and Malaria), philanthropic foundations (with the Gates, Kaiser Family, Ford and Clinton foundations being amongst the most high-profile in the AIDS field), and a huge number of civil society organizations some of which were specifically created to address AIDS, others of which address it as part of a broader remit, particularly well-represented being those organizations addressing AIDS in the context of international development and human rights.

Balancing treatment and prevention

Since Highly Active Anti-Retroviral Therapy (HAART) began to come on stream in 1996 there has been a debate over the appropriate balance between treatment and prevention in the global HIV

response. Over the first decade of the 21st century this debate intensified. Whilst the technical epidemiological aspects of the debate are largely beyond the scope of this paper, there are two important issues which need to be examined. The first is the appropriate balance between treatment and prevention. The second is the related issue of whether current global responses are properly achieving this balance.

The debate over the appropriate treatment-prevention balance has not reached a settled conclusion. There have, however, been a number of attempts to forward particular answer to the question based on a variety of methodologies. Interestingly, although perhaps not surprisingly, many of the interventions in the debate have sought to judge the relative economic cost-effectiveness of prevention and treatment activities. Marseille et al (2002), for example, argued that prevention was 28 times more cost-effective than HAART, and argued as a consequence that primacy should be given to prevention interventions in sub-Saharan Africa. In the same year a review of previous studies of cost-effectiveness similarly found “a strong economic case” for prioritising prevention activities, although it also noted that the cost-effectiveness of different types of prevention activities varied greatly (Creese et al, 2002). In 2005 Salomon et al returned to this issue, and did so in a context in which the economics of treatment had changed dramatically. As is discussed further below, both the cost of ART and the level financing available for the global AIDS effort had changed radically since 2002 and a significant political momentum had begun to develop behind large-scale treatment roll-out. Starting from the position that “widespread access to effective antiretroviral therapy for people living with HIV/AIDS is now conceivable even in countries with severely limited resources” (Salomon et al, 2005: 51) the authors went on to recommend a comprehensive approach which integrated treatment and care activities with prevention, whilst noting (p.55) that “Over the long term, it is effective prevention that will reduce the burden of illness due to AIDS and the number of people in need of ART.” This need for a comprehensive approach has been taken-up elsewhere. In a response to Marseille et al’s 2002 article, for example, Peter Piot (then-Executive Director of UNAIDS) and colleagues argued against simplistic cost-benefit analyses, arguing that “Prevention and care involve different sectors and constituencies, investment in both simultaneously can achieve more than would be accomplished by separate investment” and that humanitarian considerations, not merely economic ones, must remain central to the AIDS response (Piot, Zewdie and Türmen, 2002). Notwithstanding this widespread rhetorical commitment to doing both, efforts to determine the ideal split of funding between the two continued (e.g. Stover et al., 2006; Mugisha, 2005).

Those who have commented on the balance actually being struck in the global response to AIDS since 2000, and especially since 2002, have often argued that it is disproportionately oriented towards scaling-up treatment. Coovadia and Hadingham (2005: 5), for example, express concern that the focus of many of the most prominent global AIDS programmes is on treatment rather than prevention. Countless others have expressed the same concerns either about the general global response or the priorities of particular actors (e.g. Over, 2008). Certainly it is true that many of the most high-profile programmes in the global governance of AIDS have been predominantly concerned with scaling-up treatment. PEPFAR, for example, allocated 55% of its budget to treatment during its first period (2003-8) (with 20% going to prevention; 15% to palliative care; and 10% to supporting orphans and children). Following its recent reauthorisation (2009-13) these explicit percentages have been removed, although the Act still requires ‘more than half’ of funds to be spent on treatment-oriented interventions (US Congress, 2008: Sec.403(c)). The Global Fund, a body which by its own estimate is responsible for a quarter of international financing for AIDS, pursues “an integrated and balanced approach to prevention and treatment” and provides resources in response to requests from states. Yet much of the money goes to treatment programmes. The Fund claims that 2.8 million people receive ART through the programmes it supports (Global Fund, 2010a: 15). The WHO’s 3 x 5 programme – that organisation’s most high-profile intervention in AIDS terms in the last decade – was by its nature a treatment focussed endeavour, with the aim of getting 3 million people on ART by 2005. The World Bank’s Africa Multi-Country AIDS Program (MAP) appears to be a notable exception to this trend. The World Bank has divided its 2000-2006 expenditure between five ‘service delivery areas’ and reports the overall spending breakdown as being 34% for prevention and only 16% to care and treatment (World Bank, 2007: 35).²

Thus there seems to be some truth to the claim that the global governance of AIDS has been weighted towards treatment over prevention for much of the last decade. As this paper will now go on to argue, developments in both the science and the economics of treatment have been major factors in producing this characteristic. Yet a variety of political factors have also been involved.

Science

The discoveries of the HIV virus and the modes of transmission precipitated major prevention campaigns from the early 1980s onwards and for obvious reasons prevention dominated early

² The remainder went to systems strengthening (40%); impact mitigation (5%); and monitoring and evaluation (4%).

responses until the development of HAART began a shift to a more treatment-focussed global response. Antiretrovirals, which have continued to be improved through new pharmaceutical discoveries and new combinations of drugs, have had a dramatic impact on the life expectancy of HIV infected individuals and a real effect in reducing rates of AIDS mortality (e.g. Jones, 2009). This alone has been sufficient to motivate major efforts to scale-up treatment. Through the provision of medication PLWHA can lead far longer and more productive lives than would otherwise be the case.

As science continues to develop, however, it is possible that scaling-up of new prevention methods may take on a higher priority. Vaginal microbicides are seen as one promising development, and in the longer-term concerted efforts are ongoing to discover an effective HIV vaccine. There is, therefore, a strong link between scientific developments and the overall character of the global response to AIDS although, as this paper will go on to argue, science does not determine the nature of the global governance of AIDS.

Economics

The economics of treatment scale-up have altered dramatically since 2000, a fact which Piot et al referred to in their response to Marseille et al in which they noted

Historically, at more than US\$10,000 per patient-year, treatment was unaffordable. As prices plummet and resources increase, implementation capacity will rapidly replace finances as the limiting constraint. (Piot et al, 2002)

Although financing remains a serious obstacle to achieving universal access, as the prices of ARVs have come down we have indeed seen huge increases in the number of people receiving treatment. The WHO's target of 3 million by 2005 was not met, but in subsequent years the increases have been dramatic. The precise numbers are difficult to track for a variety of reasons, but approximately 5.2 million people were receiving antiretroviral therapy in 2008, an increase of 30% in one year (UNAIDS 2010: 8). Nevertheless, this is still only just over half of the 10 million people who, according to the WHO, are currently eligible for treatment. The goal of universal access remains a distant one.

The real achievements which have been made, however, have been the result of both a massive increase in financing and a variety of efforts to reduce the price of therapies. There have been three

major processes going on here, each of which has been central to the development of the global governance of AIDS in the MDG period. The first has been the massive increase in the amount of Overseas Development Assistance (ODA) targeted at the AIDS pandemic. Around 50% of current global spending on AIDS is domestic (including governments' domestic health spending, and the spending by individuals and their families on treatment, care and other support (UNAIDS, 2010a). The other 50% of the money comes from donors, mostly (about 48%) from the aid budgets of the rich, developed nations of the West.³ Of these, the US is by far the biggest spender. PEPFAR's budget for FY 2010 was \$6.8 billion. So much more than half of all donor spending – and about 25% of total global spending – on AIDS comes from the US aid budget. As the US Global AIDS Coordinator Eric Goosby is fond of saying, PEPFAR is bigger than the Marshall Plan after World War II (Fisher-Thompson, 2009). The UK is the second biggest donor on \$779 million, followed by Germany, the Netherlands and France, although all of these spend much less. Although it has not been enough to comprehensively address HIV and AIDS worldwide, by any measure this has been a massive level of international spending.

The second process has been the search for innovative financing solutions, often attempting to harness new sources of finance, including from the private sector. The Global Fund has been the highest profile attempt to achieve this kind of public-private partnership in AIDS terms. In many ways it has been a roaring success, in eight years going from a standing start to now accounting for about a quarter of international financing for AIDS (and much more for TB and malaria). Indeed the talk recently has been of adopting the model to create a more broadly-focussed Global Fund for Health. But although the model has widely come to be seen as a good one, there are questions over whether the Global Fund has really been a success in attracting private resources. Whilst it is generally treated in the literature as a "global public-private partnership" (and indeed describes itself as such) Hein and Kohlmorgen (2008: 87) are perhaps more accurate in calling it "a multilateral funding mechanism that works like a partnership." 96% of the Fund's money actually comes from states with almost all of the remainder coming from the Gates Foundation (Bartsch 2007; 2011). The Global Fund is, then, an unusual kind of PPP: one in which private "partners" are represented, including on the Board, but provide only a minute proportion of the resources. Yet this inclusion of the private sector has had the effect of cementing its position as a "stakeholder" in global efforts to combat HIV (Seckinelgin 2008: 32), and has also raised concerns about conflicts of interest, especially relating to the pharmaceutical industry (e.g. Poku 2002: 122).

³ The other 2% comes from various other sources including philanthropists such as the Bill and Melinda Gates Foundation, charities, NGOs and the private sector.

The third process impacting on the economics of treatment has focussed on the other side of the equation: reducing the cost of treatments rather than increasing the available resources to pay for them. A detailed examination of these strategies lies beyond the scope of this paper, but they have been well-examined elsewhere in the literature (e.g. Waning et al, 2009). Three of the most successful strategies to date have been pooled procurement (pooling orders in order to benefit from economies of scale); tiered pricing (in which manufacturers agree to sell drugs at a lower price in certain markets) and third-party price negotiations (a strategy which has been pursued with considerable success by the Clinton Foundation HIV/AIDS Initiative (Youde, 2011)). There are also some early signs that some pharmaceutical firms may be willing to look a patent pooling for some HIV medicines (Boseley, 2011).⁴

Politics

Whilst the scientific development of treatments and the changing economics of scale-up have clearly been major factors in producing a treatment-centred global response, there have also been political factors which have underpinned this trend. In this section I examine four political issues which have either helped create or reinforce the primacy of treatment-based responses.

Human rights and the access debate

The clear political and moral contradictions arising from the inability of the poor to afford ARVs made this issue a target of concerted civil society activism in the late 1990s and early 2000s. Groups such as the South Africa-based Treatment Action Campaign (TAC) and Médecins sans Frontières argued forcefully for measures to be put in place to improve access to these treatments. On one side of this debate were those who argued that pharmaceutical industry profits from these drugs are vital for stimulating further research and development. On the opposing side were those who argued for universal access, often on the grounds of morality and human rights.

The TAC in particular pursued a campaign based heavily on the framing of access as a human rights issue (Friedman and Mottiar, 2005; Heywood, 2005; Mbali, 2005). The TAC's campaign has made use of a variety of approaches ranging from demonstrations to legal challenges, but undoubtedly its

⁴ Details of the current state of negotiations with manufacturers can be found at <http://www.medicinespatentpool.org/LICENSING/Company-Engagement>

most high-profile success was its involvement in the case brought against the South African government by the Pharmaceutical Manufacturers Association (PMA) in 1998. The TAC played a significant part in the case as an *amicus curiae* ('friend of the court'), challenging the PMA's assertions on rights-based and constitutional grounds. The PMA eventually withdrew from the case.⁵

In framing access as a human rights issue the TAC drew upon a long history of rights-based discourses in global health which first became formalized in the WHO Constitution, was reaffirmed at Alma Ata, and had previously been forwarded in relation to HIV/AIDS, perhaps most prominently by Jonathan Mann (Fee and Parry, 2008). Despite this, as Friedman and Mottiar (2005: 531) have pointed out, within the South African context there was nothing 'natural' about the fact that access to ARVs came to be seen as a rights issue: this state of affairs was actively constructed by the TAC and others in the face of a government initially reluctant to prioritise AIDS. The same framing has characterised much of the global-level civil society engagement with the access issue. Yet attempts to cast access as a human rights issue have not been unchallenged. The pharmaceutical industry framed the access/patents issue in its own terms (Sell and Prakash, 2004), arguing that the pricing of ARV medications reflected the significant financial risks involved in pharmaceutical R&D and that profits are a necessary part of stimulating future R&D. Indeed in some cases the industry also relied on rights arguments, albeit in their case the 'right to property' (Sell, 2001).

This debate has largely been won by access campaigners, leading Jeremy Youde (2008: 436) to argue that universal access is emerging as an international norm "despite the very high costs and the potentially negative consequences for Western pharmaceutical companies." Indeed, in the 2001 Declaration of Commitment on HIV/AIDS UN member states explicitly recognised access to medications as a human rights issue, stating that

access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (UN General Assembly, 2001: para 15).

The principle of universal access has thereafter been the focus of many of the most significant global commitments in the global governance of AIDS, not least the promise made by the G8 to get "as close as possible to universal access to treatment to all who need it by 2010" (G8, 2005).

⁵ For detailed examinations of this case see, inter alia: Bond, 2009; Dolmo, 2001; Friedman and Mottiar, 2005; Joni, 2001-2.

Commitments breed commitment

As noted above, one of the consequences of the creation of the MDGs has been the effective concretization of a particular set of global development priorities. It is of course the case in international politics that commitments are made and broken all the time, and indeed there is little chance that all of the MDGs will be met. Nevertheless, in the AIDS case at least the commitments made at the Millennium Summit do indeed seem to have galvanized global effort to tackling AIDS. This is not least the case because AIDS has been widely presented as one of the key inhibitors of development, and as an obstacle to dealing with the other MDGs (both health- and non-health-related).

Other global commitments on AIDS have followed the MDGs, with the 2001 Declaration of Commitment (UN General Assembly, 2001) being a prime example. That Declaration both committed states to addressing AIDS in their own societies and globally, and also paved the way for the creation of the Global Fund, one of the most significant innovations in the global governance of AIDS in recent years. Having established the Fund the pressure was on to resource it. Perhaps even more significant in terms of the treatment-oriented nature of the contemporary global governance of AIDS was the universal access by 2010 commitment, made by the G8 at the 2005 summit in Gleneagles. As has already been discussed, that target was not even close to being met. However, the very existence of the commitment has contributed to a gearing of the global health governance system towards treatment roll-out, and has heightened the costs of failure for G8 states in particular. Governments, such as the UK, have continued to track progress against the Gleneagles commitments on an ongoing basis (DFID, 2010). It has also provided ammunition for their critics. Indeed a significant part of post-2005 civil society engagement with the treatment issue has focussed on precisely this commitment, arguing that more needs to be done in order for it to be met. One example of this is the International AIDS Society which, in 2009, called for a 'recommitment' to universal access, arguing that "major donors and domestic governments appear to be pulling back on this commitment" and making the case that

the G8 members must act quickly to follow through on their commitment to universal access. The end of the HIV pandemic cannot be achieved if the G8 nations fail to meet the

commitments they made at the 2005 Gleneagles Summit. Like all of us, they must be held accountable for keeping their promises on AIDS. (IAS, 2009)

The desire to measure outcomes, attribute credit, and establish legitimacy

The MDGs have also provided a clear set of targets and indicators for global development efforts against which progress can be measured and governments and international institutions held to account. This has similarly allowed for attempts by various actors to hold governments and international institutions to account, but it is also symptomatic of a broader shift in global governance (and indeed in many states in domestic policy processes) towards an emphasis on measurability of policy outcomes. The MDGs themselves are both product and evidence of this trend.

As the global health governance system has changed this trend has become further entrenched, for two reasons. Firstly, different actors within the ‘system’ are in some respects ‘competing’ with one another, notwithstanding the fact that they also co-operate. Partly as a result for this, there has been a noticeable growth in the tendency for global health institutions to ‘advertise’ the scale of their impact, publishing on their websites the number of people receiving treatment through their programmes, the number of condoms distributed, the value for money their interventions represent and so on. Secondly, there is a legitimacy angle to this tendency. As Bartsch has noted (e.g. 2011), many of the new actors in global health – not least partnerships such as the Global Fund and philanthropic foundations such as the Gates Foundation – tend to focus on output legitimacy (i.e. legitimacy derived from the results they produce) to compensate for their questionable input legitimacy (i.e. the legitimacy of their mechanisms and procedures, an area in which it has been argued they have a democratic deficit). It has been argued, indeed, that PPPs such as the Global Fund have brought about a shift in the way in which the entire “system” of Global Health Governance is legitimized. As Bull & McNeill (2007: 90) put it:

The legitimacy of the system is now more dependent on its “ability to deliver” than on its relation to democratically elected governments or its legal status; in other words, it is judged on the extent to which it really provides health for all.

Crucially for the argument here, treatment lends itself to such quantification of results much more readily than prevention. Whilst prevention measures such as the number of people tested for HIV, the number of condoms distributed and so on can relatively easily be measured, quantifying the actual prevention impact (i.e. number of infections prevented) of these activities is difficult, if not impossible. The number of people receiving ART, however, is far more readily measurable, in theory at least.⁶

Political sensitivities

Another factor in the bias towards treatment which should not be discounted is the political sensitivity which surrounds some aspects of prevention. In stark contrast to the principle of universal access to treatment, a principle which has gained widespread acceptance, prevention activities intrude on a number of well-known areas of sensitivity including working with often-marginalized high-risk groups (including sex workers, injecting drug users and gay men) and also deeply-embedded beliefs around the appropriateness and effectiveness of strategies such as the promotion of abstinence, faithfulness, and condom use (so-called ABC strategies).

Much of the most high-profile controversy around these issues has surrounded the US PEPFAR programme, particularly in its early years. The religious right was one of PEPFAR's most important constituencies, and indeed the increasing interest of conservative Christian groups in the global AIDS issue was one of the primary motivations for George W. Bush's creation of PEPFAR (Burkhalter, 2004). Some of these groups, however, were keen to prioritise the A and B over the C, and were reluctant to see US funding spent on working with sex workers and other high risk groups. The result was a series of legislative conditions which restricted the ways in which PEPFAR funding could be used. Whilst many of these restrictions have subsequently been relaxed, they show clearly how these kinds of sensitivities can impact upon the ways in which money is spent. And the US was not the only case in which those sensitivities were very real. Many recipient country governments have been similarly reluctant to engage in certain types of prevention activities.

⁶ In practice there are a number of grey areas, not least a certain amount of 'double counting' of impact by different institutions. For example, as Youde (2011) points out, adding together the numbers of ART recipients 'claimed' by the Global Fund, PEPFAR and the Clinton HIV/AIDS Initiative gives a far higher total than the number of people currently receiving treatment worldwide. Clearly, then, there is a certain amount of double-counting going on.

Whilst these controversies have not directly affected all institutions playing roles in the global governance of AIDS, the impact has nonetheless been more widespread than it would first appear. A number of interviewees have reported that they feel on politically safer ground when their work focuses on treatment efforts, and that they are highly aware that prevention work risks embroiling them in difficult political disputes. It would be no surprise if such institutions as a result decided to fight shy of controversy and focus their efforts on treatment.

The path to 2015 – and beyond...

Although much progress has been made in tackling AIDS over the last decade, there is good reason to be gloomy about the future. One of the most worrying phrases increasingly being spoken by people working in the AIDS field is 'donor fatigue'. AIDS has been at the very top of the global development agenda for the last decade, and many feel that its time in the spotlight may be coming to an end. Part of this might be just the natural turnover of political priorities: things rise and fall. Many who were involved in the summit in New York last autumn examining progress on meeting the MDGs came away with a sense that the priority was palpably shifting away from AIDS and towards other things, especially maternal and child health; malaria; and broader efforts to strengthen health systems rather than single-disease approaches. In response, those working in the AIDS field have been keen to stress the broader health gains that investments in AIDS can bring. UNAIDS, for example, has promoted the idea of 'AIDS plus MDGs', an approach that "recognizes and maximizes the AIDS response as essential to achieving the MDGs, and conversely, supports the role of the MDGs in achieving universal access to HIV prevention, treatment, care and support" (UNAIDS, 2010b: 1). The Global Fund has also been vocal in highlighting the links between MDGs 4, 5 and 6, and at its April 2010 Board meeting the Board committed itself to "work with partners in exploring ways to further enhance and integrate the Global Fund's contributions in this area" (Global Fund, 2010b: 28). As well as worries about donor fatigue there are also some concerns about the effect which the progress which has been made on AIDS may have on political will. The number of new HIV infections has been falling over the last decade and access to treatment has improved massively. There is a real danger of the wrong message getting out: that AIDS is being dealt with and that we can afford to shift attention to other things.

New HIV infections continue to outstrip the increase in people receiving treatment. It is estimated that there were approximately 2.6 million new HIV infections in 2009, and in the same year 1.2

people were put on medication. Yet there are few signs so far of a significant shift towards prevention in the global response. There are exceptions – there is significant global interest, for example, in the prevention of mother-to-child transmission, an area in which virtual elimination of new infections seems potentially possible – but in general terms the focus of attention and resources remains on treatment. For all of the political and economic reasons highlighted above, this seems unlikely to change dramatically between now and 2015. The likelihood of major new prevention technologies coming on stream at scale within that time-frame is also low.

It is also clear that we are in a very difficult time financially. The past 10 years have seen a huge increase in AIDS funding, especially from states and from philanthropists such as Gates. But those were largely years of economic growth. It would be dangerous to assume that the next ten years will bring the same, and indeed indications from events such as the 2010 Global Fund replenishment process are not positive. Overseas aid budgets are under pressure and the emphasis on demonstrating value for money is increasing. As discussed above, this emphasis brings an in-built privileging of treatment over prevention.

All of this should focus attention on what follows the MDGs. Will a new set of targets be agreed for a period from 2015 onwards? Will HIV/AIDS be amongst those targets? And how will those targets be set, what will the indicators be? The answers to all of these questions will have profound implications for the future global governance of AIDS.

Bibliography

Bartsch, Sonja. 2007. The Global Fund to Fight AIDS, Tuberculosis and Malaria. In Wolfgang Hein, Sonja Bartsch and Lars Kohlmorgen (eds.), *Global Health Governance and the Fight Against HIV/AIDS*. Basingstoke: Palgrave Macmillan

Bartsch, Sonja. 2011. A critical appraisal of global health partnerships. In Simon Rushton and Owain D. Williams (eds.), *Partnerships and Foundations in Global Health Governance*. Basingstoke: Palgrave Macmillan.

Bond, Patrick. 2009. Globalization, Pharmaceutical Pricing, and South African Health Policy: Managing Confrontation with U.S. Firms and Politicians. *International Journal of Health Services* 29(4): 765-792.

Boseley, Sarah. 2011. Big Pharma shows willingness to pool HIV and Aids drug patents. 10 February. <http://www.guardian.co.uk/society/sarah-boseley-global-health/2011/feb/10/drugs-pharmaceuticals-industry>

Brown, Theodore M., Marcos Cueto & Elizabeth Fee. 2006. The World Health Organization and the Transition from “International” to “Global Health”. *American Journal of Public Health* 96: 62-72.

Bull, Benedicte, and Desmond McNeill. 2007. *Development Issues in Global Governance: Public-Private Partnerships and Market Multilateralism*. Abingdon: Routledge.

Burkhalter, Holly. 2004. The Politics of AIDS: Engaging Conservative Activists. *Foreign Affairs* 83(1): 8-14.

Coovadia, Hoosen M. and Jacqui Hadingham. 2005. HIV/AIDS: global trends, global funds and delivery bottlenecks. *Globalization and Health* 1(13).

Creese, Andrew, Katherine Floyd, Anita Alban and Lorna Guinness. 2002. Cost effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. *The Lancet* 359: 1635-42.

DFID. 2010. Meeting our Gleneagles commitments. <http://webarchive.nationalarchives.gov.uk/+http://www.dfid.gov.uk/Media-Room/News-Stories/2010/Meeting-our-Gleneagles-commitments/>

Dodgson, Richard, Kelley Lee & Nick Drager. 2002. *Global Health Governance: A Conceptual Review*. LSHTM/WHO Discussion Paper No. 1. Available at http://whqlibdoc.who.int/publications/2002/a85727_eng.pdf

Dolmo, Bess-Carolina. 2001. Examining Global Access to Essential Pharmaceuticals in the Face of Patent Protection Rights: The South African Example. *Buffalo Human Rights Review* 7: 137-163.

Fee, Elizabeth and Manon Parry. 2008. Jonathan Mann, HIV/AIDS and Human Rights. *Journal of Public Health Policy* 29: 54-71.

Fidler, David. 2004. *SARS, Governance and the Globalization of Disease*. Basingstoke: Palgrave Macmillan.

Fisher-Thompson, Jim. 2009. U.S. PEPFAR Program Helps Millions with AIDS in Africa. 19 November. <http://www.america.gov/st/scitech-english/2009/November/200911191603341ejrehsiF0.2920191.html>

Friedman, Steven and Shauna Mottiar. 2005. A Rewarding Engagement? The Treatment Action Campaign and the politics of HIV/AIDS. *Politics and Society* 33(4): 511-565.

G8. 2005. 'The Gleneagles Communiqué'. Available at http://www.unglobalcompact.org/docs/about_the_gc/government_support/PostG8_Gleneagles_Communique.pdf

Global Fund. 2010. *The Global Fund 2010: Innovation and Impact*. Geneva: Global Fund. http://www.theglobalfund.org/documents/replenishment/2010/Global_Fund_2010_Innovation_and_Impact_en.pdf

Global Fund. 2010b. Twenty-First Board Meeting, Geneva, Switzerland 28-30 April 2010. http://www.theglobalfund.org/documents/board/21/GF-BM21-DecisionPoints_en.pdf.

Hein, Wolfgang & Lars Kohlmorgen. 2008. Global Health Governance: Conflicts on Global Social Rights. *Global Social Policy* 8(1): 80-108.

Heywood, Mark. 2005. Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan. In Peris Jones and Kristian Stokke (eds.), *Democratising Development: The Politics of Socio-economic Rights in South Africa*. Leiden: Martinus Nijhoff.

IAS, 2009. Reaffirming the G8 Commitment to Universal Access: Gleneagles + Five. http://www.iasociety.org/Web/WebContent/File/IAS_GC%20Backgrounder_%2019%20Nov%202009.pdf

Ingram, Alan. 2009. The international political economy of global responses to HIV/AIDS. In Adrian Kay & Owain Williams (eds.), *The Crisis of Global Health Governance: Challenges, Institutions and Political Economy*. Basingstoke: Palgrave Macmillan.

Jones, Sabde Gracia. 2009. Looking Inside the Pill Bottle: The Evolution of Antiretroviral Combination Drug Therapy. In Cynthia Pope, Reneée T. White and Robert Malow (eds), *HIV/AIDS: Global frontiers in prevention and intervention*. New York and London: Routledge.

Joni, Jennifer. 2001-2. Access to treatment for HIV/AIDS: A Human Rights Issue in the Developing World. *Conneticut Journal of International Law* 17: 273-280.

Kaplan, Jeffrey P. et al. 2009. Towards a common definition of global health. *Lancet* 373: 1993-5.

Kickbusch, Ilona. 2007. Foreword: Governing Interdependence. In Wolfgang Hein, Sonja Bartsch and Lars Kohlmorgen (eds.), *Global Health Governance and the Fight Against HIV/AIDS*. Basingstoke: Palgrave Macmillan.

Kirton, John J. & Jenevieve Mannell. 2007. The G8 and Global Health Governance. In Andrew F. Cooper, John J. Kirton & Ted Schrecker (eds.), *Governing Global Health: Challenge, Response, Innovation*. Aldershot: Ashgate.

Marseille, Elliot, Paul B. Hoffmann & James G. Khan. 2002. HIV prevention before HAART in sub-Saharan Africa. *The Lancet* 359: 1851-56.

Mbali, Mandisa. 2005. The Treatment Action Campaign and the History of Rights-Based, Patent-Driven HIV/AIDS Activism in South Africa. In Peris Jones and Kristian Stokke (eds.), *Democratising Development: The Politics of Socio-economic Rights in South Africa*. Leiden: Martinus Nijhoff.

Mugisha, Joseph Y. T. 2005. Balancing Treatment and Preventions: The Case of HIV/AIDS. *American journal of Applied Sciences* 2(10): 1380-88.

Over, Mead. 2008. Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What to Do About It. *Center for Global Development Working Paper no.144* (Washington, DC: Center for Global Development).

Piot, Peter, Debrework Zewdie and Tomris Türmen. 2002. Letter: HIV/AIDS prevention and treatment. *The Lancet* 360: 86.

Poku, Nana K. 2002. Global Pandemics: HIV/AIDS. In David Held & Anthony McGrew (eds.), *Governing Globalization: Power, Authority and Global Governance*. Cambridge: Polity Press.

Salomon, Joshua A., Daniel R. Hogan, John Stover, Karen A. Stanecki, Neff Walker, Peter D. Ghys and Bernhard Swartländer. 2005. Integrating HIV Prevention and Treatment: From Slogans to impact. *PLoS Medicine* 2(1): 50-56.

Seckinelgin, Hakan. 2005. A Global Disease and Its Governance: HIV/AIDS in Sub-Saharan Africa and the Agency of NGOs. *Global Governance* 11: 351-368.

Seckinelgin, Hakan. 2008. *International Politics of HIV/AIDS: Global Disease – Local Pain*. Abingdon: Routledge.

Sell, Susan K. 2001. TRIPS and the Access to Medicines Campaign. *Wisconsin International Law Journal* 20: 481-522.

Sell, Susan K. and Aseem Prakash. 2004. Using Ideas Strategically: The Contest Between Business and NGO Networks in Intellectual Property Rights. *International Studies Quarterly* 48(1): 143–175.

Stover, John, Stefano Bertozzi, Juan-Pablo Gutierrez, Neff Walker, Karen A. Stanecki, Robert Greener, Eleanor Gouws, Catherine Hankins, Geoff P. Garnett, Joshua A. Salomon, J. Ties Boerma, Paul De Lay and Peter D. Ghys. 2006. The Global Impact of Scaling Up HIV/AIDS Prevention Programs in Low- and Middle-Income Countries. *Science* 311(5766): 1474-1476.

UNAIDS. 2005. Global Resource Availability For Aids 2005.

http://data.unaids.org/pub/Report/2006/2005-globalresourceavailability_en.pdf

UNAIDS. 2010a. *Global Report: UNAIDS Report On The Global Aids Epidemic 2010*. Geneva: UNAIDS.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf

UNAIDS. 2010b. AIDS plus MDGs: synergies that serve people.
http://data.unaids.org/pub/Report/2010/jc1998_aidsplusmdgs_en.pdf.

UN General Assembly. 2001. Declaration of Commitment on HIV/AIDS. A/RES/S-26/2, 2 August.

UN Statistics Division. 2011. Official list of MDG Indicators.
<http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>

US Congress. 2008. Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. H.R.5501, 3 January.

Youde, Jeremy. 2008. Is Universal ARV Access an Emerging International Norm? *Journal of International Relations and Development* 11: 415-440.

Youde, Jeremy. 2011. The Clinton Foundation and Global Health Governance. In Simon Rushton and Owain D. Williams (eds.), *Partnerships and Foundations in Global Health Governance*. Basingstoke: Palgrave Macmillan.

Waning, Brenda, Warren Kaplan, Alexis C. King, Danielle A. Lawrence, Hubert G. Leufkens and Matthew P. Fox. 2009. Global strategies to reduce the price of antiretroviral medicines: evidence from transactional databases. *Bulletin of the World Health Organization* 87: 520-528.

World Bank. 2007. *The Africa Multi-Country AIDS Program, 2000-2006*. Washington, DC: World Bank.