

# HIV/AIDS Exceptionalism and Issues of Global Health: Critical view from Liberal Governmentalism

Joydeb Patra ,

Doctoral Research Scholar

Department of Sociology, Vidyasagar University

Kolkata:India

**Abstract:** HIV/AIDS , to consider as a biggest social issues for sciences and new knowledge domain of social intervention , that , has to be fuelled in current time with AIDS exceptionalism - that offer to new epistemology of knowledge and prevention model to extension right of health . In considering the prior issues from historical point of view that allow to reinvestigates its epidemiological status as well as embedding socio-political and socio-philosophical understanding also. By bringing felicitated state and non-state actors to engaged and make a decisions on the ground of public health, in realm of liberal governmentalism . Simultaneously, by demanding and achieving in scientific manner in name of Bio-Medical Model of Intervention, more equitable advocacy for pricing and treatment cost initiated by big pharmaceutical company. Globalised Economic transition, Liberalism, is not only present as an ideological hegemonic project but as a form of new governmentality: the in which the relation among the actors and non actors of State are re-imagined, re-interpretation and re-juvenile of social acknowledgment in regards of AIDS exceptionalism .

**Keywords:** Exceptionalism , Global Health , State and Non-State actors, Liberalism , Governmentalism .

**1.Introduction:** In the 40 years since it was first recognized, HIV has recognized as global disease with distinct clinical entity. An estimated 28 million people have died, and about 33 million people are currently living with HIV/AIDS all over world . The epidemic is not homogenous in nature; the global picture is characterized by diverse virological nature and wider cultural understanding . Developed nations as well as, most of Latin America, Asia, north Africa and the Middle East, infections are concentrated in particular geographical locations and among specific risk groups. Those are historically , socially and politically marginalized populations, including injecting drug users, men who have sex with men, and commercial sex workers. Generalized epidemics are found in developing countries, where about 30% of adults are infected. However, even here, specific groups, such as child and women, remain disproportionately at risk. The development of HIV “risk environments” has been shaped by social-structural, economic and political factors specific to each context and indicated by differing prevalence rates. In the history of public health, HIV/AIDS is unique in terms of how it is spread and attacks the body immunity system and because of its widespread and long-lasting demographic, social, economic and political impacts take into consideration. HIV/AIDS is a long-wave event: an epidemic that, where it is most prevalent, will have consequences that will be felt for generations(Smith et.al,2010). Just as the epidemic is distinctive, so has been the response, though for opposite reasons. Despite the progression and spread of the epidemic, thereafter, the HIV/AIDS response from the globally has been characterized by both lack of action and fevered aid at different points in time and spaces . This disease-specific response has achieve special status which known as AIDS exceptionalism. The word, “exceptionalism”, means “to treat or to give something the status of being exceptional, and can be positive or negative”(Smith and Whiteside,2010). AIDS exceptionalism began as a Western response to the originally terrifying and lethal nature of the virus, which disproportionately affected specific groups[Risk Groups]. The first activists argued that HIV/AIDS required an exceptional response or global level intervention in order to protect the rights of those infected people , to generate and distributed resources to assist them and to curb a then mysterious epidemic through . More recently, AIDS exceptionalism came to refer to the disease-specific global response. This international response was unprecedented, as the commitment of resources exceeded any other health cause. International organizations, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global address HIV/AIDS. In the past few years, there has been a backlash against this exceptionalism, with critics claiming that HIV/AIDS receives a disproportionate amount of international aid and health funding, and that this has implications for other health issues..

## 2. History of AIDS Exceptionalism

Officials within the public health realm have made the charge that AIDS exceptionalism overprotects people with HIV while threatening overall public health. In an article written in 1997 entitled; "Inventing AIDS Exceptionalism", the belief of some public health officials is that in order to deter numbers of HIV infections, mandatory testing and names reporting is necessary (Hanssens, 1997/1998).

The idea of AIDS exceptionalism is not a new idea; it has been around for many years. AIDS exceptionalism defines the preferential treatment that AIDS, AIDS research and AIDS education receives above other deadly global pandemic diseases. When it was realized that AIDS was not only a localized issue, but one of worldwide concern, the United Nations institutionalized UNAIDS (UNAIDS 2009). Currently, this organization helps to keep HIV/AIDS from spreading, and gives aid to those struggling with the disease. By 2010, they hope to have universal access to mitigate HIV/AIDS; and by 2015, UNAIDS hopes to eliminate the spread of AIDS (UNAIDS 2009).

According to Dr. Peter Piot (2008), former UNAIDS director, AIDS is a disease of inequality, not of poverty. This inequality is between men and women, and on the basis of sexual orientation. Piot (2006) argues that HIV/AIDS is an exceptional disease, and the developments that have been made over the years fighting this disease cannot be maintained if we continue to work in isolation from mainstream development.

Further he (2008) presents his stance on AIDS exceptionalism in his speech "AIDS: exceptionalism revisited." There has been much controversy over Piot's true stance on exceptionalism. Essentially, Piot's goal is to normalize AIDS as a disease, but he also says that we cannot do that until the problem of AIDS is dealt with now. Currently, AIDS needs to be exceptionalized in order to gain control over its' spreading (Piot 2008). After the AIDS pandemic is under control, AIDS, and the rights of people with HIV, can be normalized. In 1983 the CDC and state health departments came together to form a new AIDS reporting form. It was to be that all new cases of AIDS would be reported by physicians to state health departments instead of directly to the CDC (Payne 2006). There were concerns that patient names on the forms would result in a breach of privacy, although the CDC denied ever releasing names to health agencies other than state. The CDC did however admit to releasing AIDS patients' names to local health agencies three different times throughout 1983. Every state eventually adopted the confidential AIDS reporting form, which sent confidential name reports of AIDS cases directly from physicians to state health departments (Payne 2006).

The HIV antibody test was developed in 1984. This gave blood banks the ability to screen blood donors for the infection, so they did not have to rely on the evaluation of donor risk factors. The need for confidentiality of the identities of infected donors was a heated issue. The then director of the Federal Drug Administration's Division of Blood and Blood Products summarized the two sides of the confidentiality debate. He said that public health has a valid need to know the identities of those who are infected and at risk of transmitting the virus. By making names available, the risk is that people outside of the public health setting will gain access to these names (Payne 2006). The antibody test was greatly useful in one way; it protected the blood bank from blood that was infected with HIV. There were no medications available at this time to slow the progression of the disease. The test might have also been useful to health care workers who needed to handle the blood of patients infected with HIV. If they knew who was infected they could take the proper precautions to protect themselves from transmittance.

It was deemed that mandatory testing would be acceptable only if it could be shown that the effects of such testing would have results superior to interventions that did not require testing. During the mid- to late-1980s, several states within the United States passed laws that required physicians to report HIV cases by name to the state health departments, as was the case with AIDS. This caused angry protests from the homosexual community, who say their confidentiality was being compromised (Payne 2006). Dr. Roger England (2008), chairman of the Health Systems Workshop in Grenada, states his position on AIDS exceptionalism in his article "The Writing is on the Wall for UNAIDS."

UNAIDS was created after the assertion that AIDS deserves exceptional treatment. England does not support AIDS exceptionalism. He essentially states AIDS as one disease of many. Other diseases worldwide are killing greater numbers of people at a higher frequency (England 2008). England believes that it may be AIDS exceptionalism itself that drives the stigmas and discrimination associated with HIV/AIDS (England 2008). According to England (2008), the foundations of exceptionalism were created when demands of right to confidentiality, informed consent, the discouragement of routine testing, and tracing of contacts made it that way. This exceptionalism grew over the years to define HIV as a disease that requires special attention and intervention that extended beyond the leadership of the World Health Organization (England 2008). According to England (2007), those who make HIV out to be a global disaster are guilty of sensationalism. The exceptional status that has been given to HIV has caused excessive funding, and the gross misuse of funds to fight this disease.

The overfunding for HIV has caused the underfunding of other deadly diseases. Much of the excess funds are spent on programs and activities that mainstream HIV into various social activities. This money would be better spent in the public health sector, which provides prevention interventions (England 2007).

## 3. Problems with AIDS Exceptionalism

Of those who disagree with the exceptional view of AIDS, Roger England is one individual who has spoken out quite publicly. He has, as recently as of May of 2008, spoken against the claim that AIDS is exceptional in comparison to other diseases. He states that "we" need to put "HIV in its place" (England 2008). He also claims that stating that HIV/AIDS is a

threat to the survival of the people of this century is a melodramatic claim and that it is a possibility that exceptionalism drives stigma and discrimination. As an advocate against AIDS exceptionalism Roger England argues a number of different reasons as to why AIDS is no more important than any other epidemic (England 2008). England is outraged at the formation of UNAIDS or in other words a UN agency that specifically deals with this disease. He asks why there is not a UN agency for either pneumonia or diabetes which kills more people annually than HIV/AIDS. He dictates that UNAIDS should be shut down immediately believing that the technical functions of UNAIDS should be refitted into the World Health Organization (WHO). This would allow for HIV/AIDS to be balanced with other diseases (England 2008). England believes that government funding for UNAIDS is exorbitant, and has created a multitude of problems. England (2008) states that HIV/AIDS is now being treated as an economic segment rather than a disease. Excessive funding on HIV/AIDS relative to other needs and disease are damaging other health system services. He states that large amounts of money have been wasted through the funding of projects instead of putting that money toward public health care. England states that an out of control HIV industry has been created, in which there are too many vested interests as well as too many "single issue NGOs" (non-government organizations) (England 2008).

As recently as 2003, policy makers in Botswana have begun to work to break free from the AIDS exceptionalism position. Botswana would rather focus on voluntarism, confidentiality, and the rights of patients, than to focus on the politics involved in the argument that AIDS is exceptional (Heald 2005).

Additionally, others feel that focusing attention on AIDS exceptionalism puts other factors at risk. Once again experts state that the position of support for AIDS exceptionalism increases the stigma already associated with AIDS and overshadows funding and treatment for other diseases. (Slater et al.2005).

#### **4.The Argument for AIDS Exceptionalism**

Dr. Peter Piot has argued that there is room for an exceptionalist position in the battle against HIV/AIDS. Piot contends that though the affect of HIV/AIDS is felt more by those in poverty, it is not necessarily a disease of poverty but of inequality as it disproportionately affects issues of gender inequality, age and populations of intravenous drug users (Piot 2008). Its effects are further complicated and magnified by social exclusionary factors, conflict and unequal distributions of power, affecting primarily those most with little or no power (Chatterjee 2001). In effect, the HIV/AIDS pandemic reaches across every aspect of society and as requires an integrated approach that addresses every level, from the economic to the many different social patterns (Chatterjee 2001). The measures taken against HIV/AIDS during the past decade have been effective in some areas of society and in different parts of the world. There are currently 3 million people on antiretroviral therapy; this number was only at 200 thousand in 2001. In the past two years access to services that prevent mother to child infection have doubled from one eighth to one quarter (Piot 2008). However, despite progress in fighting this disease, there were an estimated two and a half million new infections in 2007 with five new infections for every two people newly put on antiretroviral treatment (Piot 2008). Piot (2008) further argues that since HIV/AIDS is now by far the number one cause of death in Africa it is of key importance not to become lax on the issue and tasks at hand. The gap between those with access to treatment and those without continues to increase due to large-scale failures in prevention. Piot argues against a normalization of HIV/AIDS in relation to other diseases. Though medical treatment should in fact be normalized, the cultural issues surrounding HIV/AIDS needs be normalized as well before the global community can truly treat it like other diseases (Piot 2008).

#### **6.The Stigmas Surrounding HIV/AIDS**

When considering the issue of AIDS exceptionalism, it is important to be aware of the many social issues that surround HIV/AIDS. These issues come in different forms depending on the society and culture. There is a stigma that surrounds HIV/AIDS that is felt globally (UNAIDS 2009; WHO 2005). This stigma exists with different levels of discrimination, rejection, and prejudice depending on the country, culture, society and/or community to which the infected person belongs. Discrimination can exist on many levels, including gender, ethnicity, social status and sexual orientation (Herek 2002).

There are incalculable cases of violence, neglect, ostracism and discrimination related to HIV/AIDS. Stigma can be defined as, "an enduring condition, status, or attribute that is negatively valued by a society and whose possession consequently discredits and disadvantages an individual" (Herek 2002:595). According to Herek (2002 & 2005), there are three characteristics of HIV/AIDS that generate stigma. The first is that HIV/AIDS is often perceived as being contracted through avoidable and often socially disapproved behavior. Some of the behaviors that possess negative connotations with HIV/AIDS are homosexual intercourse, injection drug use and the use of sex for income. The second characteristic is that AIDS is incurable. There is often a greater stigma to illnesses that are lethal. In most cases, being diagnosed with AIDS is perceived as being sentenced to death. Lastly, those diagnosed with AIDS are often seen as a threat to others physically, socially or morally (Herek 2002 & 2005). In 1999 Gregory Herek conducted phone interviews that found that nearly one-third of participants believed that people with AIDS deserved to have the disease and that nearly one-half believed those with AIDS were responsible for their illness. Herek also found that one-fifth felt fear towards people with AIDS (Herek 2002). It is these prejudices that prevent people with HIV/AIDS from seeking medical help for themselves, and preventative measures of spreading the disease (Singer 2007; WHO 2005).

The discriminatory practices of the past twenty-five years have hindered the fight against the HIV/AIDS pandemic. The mistreatment of those affected by HIV/AIDS has driven individuals away from getting tested (UNAIDS 2009). By not getting tested a person does not know if he or she is infected and therefore has plausible deniability. The discrimination has also led known people living with HIV/AIDS (PLWH/A) away from treatment, for fear of their HIV status being revealed. Governments practice this prejudice as well. For example, in England the legal system has the right to prosecute an individual who passes on the virus, even if they did so without the knowledge that they were infected (Zaccagnini 2009). The current healthcare system is another example of discrimination towards those with HIV/AIDS. Availability of healthcare is currently an important issue within the United States. Discrimination occurs in multiple ways regarding health industries. "Hospital staffs refusing to treat patients, the withholding of treatments, HIV testing without consent, lack of confidentiality, and denial of hospital facilities and medicines are all ways that PLWHA can experience stigma and discrimination in healthcare settings. Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff" (Zaccagnini 2009). Prejudice and discrimination towards PLWH/A are felt in many countries around the world. One example of this is in India, where PLWH/A are seen as a new class of untouchables (Burns 1996). In a 1996 article in the *New York Times* John Burns reported on the conditions HIV/AIDS patients face from the public and medical community. "Indian AIDS specialists tell many stories of AIDS sufferers driven from their communities by fearful neighbors, pushed from one hospital to another by doctors and staff 12 members reluctant to treat them and, finally, approaching death in the AIDS ward, left virtually to fend for themselves" (Burns 1996:4). In 2004 the Indian government began to acknowledge the pandemic in their country and started offering free drug therapy. However, as of 2005, only two percent of the estimated half-million infected were receiving this treatment. The stigma still remains and many health care workers believe that the only way to minimize this problem is to offer access to treatments and testing (Sengupta 2005). Cultural standards of male dominance have been suggested to fuel HIV/AIDS stigma in many cases. One particular country that has been the subject of extensive research is South Africa. Case studies have shown that men will use violence as a way of demonstrating masculinity, which often results in disregard for their safety against HIV/AIDS. Sexual violence is woven into many societies in South Africa where women have little say in decisions for protection from sexually transmitted diseases (STDs) (Outwater et al. 2005). Despite the high numbers of HIV infected people in South Africa, it is still often seen as a taboo subject. In December of 1998 a South African AIDS activist publicly announced that she was HIV positive on the radio and television on World AIDS Day. According to nurses who knew her, after going public, she was threatened many times by people in her village, telling her that she was bringing shame and a bad reputation to their community. Less than a month after she announced her condition, she was stoned and beat to death by a mob at her home (McNeil 1998). The stigmas that surround HIV/AIDS make it particularly difficult to implement policies for universal treatment and testing of HIV. Those living with HIV/AIDS face discrimination and prejudice which must be considered when making these policies. There are two main schools of thought with regards to AIDS exceptionalism; those who believe that AIDS is an exceptional disease and should be treated as such, and those who believe that the first view is creating an imbalance in the aid and funding of other serious diseases. In all cases, those who have AIDS do not die directly from the disease, but from the weakening of their immune system which makes them much more susceptible to other illnesses. AIDS is connected with other illnesses, namely tuberculosis, malaria and malnutrition, which must also be examined to understand the pandemic.

## 7. AIDS exceptionalism In west:

The rise of exceptionalism in the West In the early 1980s, when previously healthy, mostly homosexual young men began dying, the unknown cause and rising numbers of deaths combined with homophobia to generate a response of blame and fear. Extreme religious right-wing advocates spoke of divine punishment for "sinful" lifestyles. The disease was initially termed the gay-related immunodeficiency disease (GRID), or "the gay plague". Homosexual men were openly discriminated against when they tried to access health services. As haemophiliacs, women and children in the West increasingly presented with the same symptoms, it became clear that the cause of illness was not related to sexual orientation. In 1983, the human immunodeficiency virus (HIV) was identified as the cause of AIDS. The realization that HIV could spread to the general public, and that it was linked to the life-giving and pleasurable acts of sexual intercourse, resulted in increased hysteria. Governments, the media and scientists sought a quick response:

*"A sense of urgency defined the problem, and the public information materials developed in this period often emphasized danger at the expense of clear information about prevention measures"*.

Even as information about modes of transmission (unprotected sexual intercourse, injecting drug use, and from mother to infant) became more accurate, the original fear and stigma prevailed. The gay rights movement, building on the momentum it had gained in the preceding decades, began campaigning for HIV/AIDS to be viewed as a human rights issue. Advocates argued that infection was not the only risk; if found positive, individuals also faced harmful discrimination. In this, they were supported by public health officials, who feared that stigma would prevent those at risk from getting tested, and those infected from accessing health services: Avoiding compulsory measures such as isolation

and quarantine, which were so much a part of the public health tradition, was all the more crucial, since the people with increased risk – gay and bisexual men, drug users, and their sexual partners – were already socially vulnerable ... Policies and practices that appeared to threaten such persons could only drive the epidemic underground and make it more difficult to work with the populations within which HIV was spreading . Recognizing the unique needs of populations at risk of HIV infection, an exceptionalist alliance, including the gay community, liberal and left-wing parties, and the healthcare and psychosocial professions, was formed to advocate for a unique response. Bayer writes, “The embrace of exceptionalism must be understood in broad political terms, as representing in large measure, a singular victory on the part of gay men, their community based organisations and their allies” . The alliance promoted the empowerment of those groups most at risk, and the assurance that their rights would be protected. During the 1980s, public health adopted a human rights framework that took societal-based vulnerability into consideration and increasingly became involved in societal transformation efforts . HIV/AIDS was positioned as not only a health condition, but also as a social issue that required a political, as well as a medical, response . The scientific establishment’s control on public health was challenged, and a new type of public health initiative was called for: one that provided counselling, protected privacy, and empowered the patient.

Lazzarini summarizes: Descriptively, exceptionalism posited that in the early years of the HIV epidemic, HIV was considered so different, so “exceptional” in comparison to other communicable diseases that advocates and public health officials agreed that HIV policy should cater to the uniqueness of the epidemic rather than treat it like all other communicable diseases. Supposedly, the argument goes, public fear was so great, the political power of gay men so substantial, and concern over stigmatization so real, that public health authorities abandoned “traditional” approaches to communicable disease control in favor of a civil liberties approach .

II

**8.Global Health :**The world has committed to ending the AIDS epidemic by 2030. How to reach this bold target within the Sustainable Development Goals is the central question facing the United Nations General Assembly High-Level Meeting on Ending AIDS, to be held from 8 to 10 June 2016. The extraordinary accomplishments of the last 15 years have inspired global confidence that this target can be achieved. UNAIDS recommends a Fast-Track approach: substantially increasing and frontloading investment over the next five years to accelerate scale-up and establish the momentum required to overcome within 15 years one of the greatest public health challenges in this generation. The latest UNAIDS data, covering 160 countries, demonstrate both the enormous gains already made and what can be achieved in the coming years through a Fast-Track approach. In just the last two years the number of people living with HIV on antiretroviral therapy has increased by about a third, reaching 17.0 million people—2 million more than the 15 million by 2015 target set by the United Nations General Assembly in 2011. Since the first global treatment target was set in 2003, annual AIDS-related deaths have decreased by 43%. In the world’s most affected region, eastern and southern Africa, the number of people on treatment has more than doubled since 2010, reaching nearly 10.3 million people. AIDS related deaths in the region have decreased by 36% since 2010. However, huge challenges lie ahead. In 2015 there were 2.1 million [1.8 million–2.4 million] new HIV infections worldwide, adding up to a total of 36.7 million [34.0 million–39.8 million] people living with HIV.

This public health approach helped contain the epidemic among those groups most at risk, and meet, to varying degrees, their specific needs. New infections in the United States fell from approximately 130,000 in 1984 to about 60,000 in 1991 . The feared general epidemic never occurred in the West. The hysteria surrounding HIV/AIDS faded; the media and public policy lost interest. The human rights Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the US President’s Emergency Plan for AIDS Relief (PEPFAR), were formed to specifically approach that had previously been revolutionary was integrated into existing public health traditions that included education, technical solutions and regular testing. In 1991, Bayer wrote, “As AIDS has become less threatening, the claims of those who argued that the exceptional threat would require exceptional policies have begun to lose their force” . Highly affected communities continued to advocate for the rights of people living with HIV and AIDS (PLHIV) and against stigma, but much of the sense of urgency among the

general public was lost. When antiretroviral treatment (ART) was unveiled at the 1996 International AIDS Conference in Vancouver, Canada, AIDS was transformed into a treatable disease.

The advent of treatment shifted Western priorities of response: “The availability of more advanced antiretroviral therapies has made it possible to treat effectively those with HIV infection, thereby increasing the importance of early identification and tracking. These developments establish a strong case for moving beyond HIV exceptionalism and treating HIV antibody tests like other blood tests” .

As technical solutions of testing and treatment gained priority, the social movement that had spurred the early HIV/AIDS response continued to fade from public awareness. This shift was assisted by a rapid fall in the price of the drugs. Had they remained expensive, AIDS exceptionalism would have been perpetuated. As Casaratt and Lantos noted, “Medical therapy has become more effective but also prohibitively expensive. A medical tragedy has been transformed into a financial crisis and society has responded by establishing special programs and sources of funding for AIDS. These manoeuvres parallel earlier approaches to HIV testing and reporting that have collectively come to be known as exceptionalism” . The mobilization of resources to make treatment available in the West altered HIV/AIDS from a lethal disease to a manageable chronic illness. By 2000, AIDS exceptionalism, as it had originally been conceived, was over. Throughout the rise and fall of Western AIDS exceptionalism, the growing global epidemic remained largely ignored by the international community . During the 1980s, reports from Africa of similar diseases and symptoms were ignored . There were few attempts, and even resistance, to linking HIV/AIDS to “slim disease”, as it was called in central Africa . When the African AIDS epidemic was finally recognized, in the late 1980s, little international attention or resources were forthcoming. In 1990 and 1991, only 6% of the total global spending for HIV prevention went to the developing world . For international organizations, after the first fears of a Western rampant unstoppable epidemic were allayed, HIV/AIDS was not a priority. The Global Programme on AIDS in the World Health Organization (WHO) lacked both the funding and capacity to respond to the epidemic. Outside of WHO, HIV/ AIDS was not on the agenda of other United Nations (UN) agencies. International responses between 1986 and 1996 were characterized by denial, underestimation and over-simplification . AIDS exceptionalism was originally a Western-focused phenomenon that advocated for the rights of those most affected and became a decreasing public force as effective treatment was rolled out in North America and Europe. International exceptionalism In 1996, UNAIDS was formed as a joint programme of UN agencies engaged in the AIDS response . In 1998, it published its first set of comprehensive data on HIV/AIDS, demonstrating the global scale of the epidemic, and increasing awareness about the generalized epidemic in parts of sub-Saharan Africa. Such data provided an information arsenal for those advocating for increased resources for HIV/AIDS in mid- and high-prevalence developing countries . UNAIDS, adopting public health rhetoric from the early AIDS response in the West, stressed the need for comprehensive responses that reached beyond a medical approach, and began advocating for increased funding for AIDS programmes . During the same period, donor countries began to scale up international aid contributions. General overseas development assistance increased from US \$53.6 billion in 2000 to US\$61.1 billion in 2003 . This aid was targeted towards issues perceived as “global”, such as poverty, debt relief and communicable diseases. HIV/AIDS gained prominence among these issues through the language of securitization and globalization. In 2000, US Vice President Al Gore said, “It [HIV] threatens not just individual citizens, but the very institutions that define and defend the character of a society ... It strikes at the military, and subverts the forces of order and peacekeeping” . The US National Intelligence Council then produced *The Global Infectious Disease Threat and Its Implications for the United States* . Six months later, the UN Security Council passed Resolution 1308, stating, “The HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security” . In 2001, UN Secretary General Kofi Annan called for a “war chest” of \$7-10 billion to address the global HIV/AIDS crisis [23]. The Pretoria-based Institute for Security Studies wrote, “The severe social and economic impact of HIV/ AIDS, and the infiltration of the epidemic into the ruling political and military elites and middle classes of developing countries may intensify the struggle for political power to control scarce state resources. Such dynamics, even singularly, have the potential to lead to political instability]. It was argued that HIV/AIDS could hinder processes of democratization by undermining social development and intensifying the struggle for resources. It was further suggested that AIDS orphans could contribute to social unrest as they made likely recruits for terror and rebel groups: “Bluntly put, those who are orphaned may be indifferent to prevailing norms and values, may look for salvation to millenarian and fundamentalist beliefs of one kind or another, and may ultimately do this with assistance from a Kalashnikov or a bomb” [2]. While there was little evidence to actually link HIV/ AIDS prevalence and security issues , the discourse of global threats drew international attention to the epidemic. Barnett and Prins write, “The combination of AIDS, orphans and terror begins to take on an independent life, perhaps regardless of either the strength of the evidence or the precise value of the parallel” . HIV was seen as a virus that could have widespread repercussions for the most affluent and powerful, even though risk of infection and disease spread in these populations had abated. The epidemic was positioned as a homogenous issue with impacts for both the developed and developing world. However, as policy and activists spoke of a global HIV/AIDS epidemic, it became apparent that, like many diseases that are expensive to treat, how this epidemic was experienced differed drastically by region. ART,

available from 1996, proved effective in curbing AIDS deaths in those regions that could afford the high costs of medications (originally more than \$25,000 per patient per year). In those countries with mid to high HIV/ AIDS prevalence, ART remained unaffordable, even while costs dropped to about \$10,000 per patient per year by 2000 and to less than \$100 by 2010. A mid to high disease burden combined with lack of health resources in much of the developing world, making the benefits of ART beyond the reach of most domestic health budgets. While AIDS had become a chronic disease in the West, in most of the developing world. It was still a death sentence. What made this discrepancy unique was the international mobilization that occurred around it, positioning the inequity of treatment access for people living with HIV and AIDS (PLHIV) as an international human rights cause. The International AIDS Conference in Durban in 2000 called for treatment to be rolled out in the developing world and for prices of ART be cut. Activists in South Africa demanded that their government provide universal access to ART, despite political resistance and denial. The governments of India and Brazil took on the World Trade Organization, arguing for compulsory licensing that would enable them to manufacture cheaper generic medications. Activists in the United States, largely led by the PLHIV organization, ActUp, began a sustained campaign against the US government's support for pharmaceutical companies' patent legislation. Arguments that ART could not be provided in the developing world due to limited capacity and poverty were challenged by the successful implementation of such programmes by health organizations like Médecins Sans Frontières. Researchers found that people living in poverty adhered to medication regimes just as consistently, if not more so, as those living in the developed world. Economists argued that the benefits of ART (keeping populations healthy for longer) outweighed the costs of treatment [28], adding further fuel to the human rights argument. In 2002, Botswana implemented the first universal access programmes in sub-Saharan Africa. In 2003, the South African Government gave in to local and international pressure and announced its public treatment programme. The World Health Organization launched the "3 x 5" campaign, aiming to place 3 million people on treatment by 2005. In 2006, 111 countries committed to achieving universal access to prevention, treatment, care and support by 2010. The development of international AIDS programmes with a favourable political environment to create a new discourse of AIDS exceptionalism. At the 2001 UN General Assembly Special Session on AIDS, 189 nations agreed that HIV/AIDS was a national and international development issue of the highest priority [30]. This translated into increased international funding for HIV/AIDS programmes. In 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established. In 2003, US President George W Bush pledged \$15 billion toward PEPFAR. In 2004, Kofi Annan prioritized HIV/ AIDS, stating, "AIDS is a new type of global emergency— an unprecedented threat to human development". In 2004, at the Copenhagen Consensus, a policy think tank in Denmark, a panel of eight prominent economists ranked controlling HIV/AIDS as the number one economic priority in terms of a cost-benefit analysis in health and nutrition. UNAIDS Executive Director Peter Piot encapsulated the exceptionalist point of view, saying, "This pandemic is exceptional because there is no plateau in sight, exceptional because of the severity and longevity of its impact, and exceptional because of the special challenges it poses to effective public action". The world had realized the size and impact of the AIDS epidemic, and was treating it as an emergency. The end of AIDS exceptionalism? Arguments against exceptionalism began to gain attention in 2007.

III

**9. Governmentality** :Foucault's lectures at the Collège de France on government rationality (governmentality) have traditionally conceptualised the topic within the frame of security studies, but have lately been applied to global health and securitisation (cf. Elbe 2009; Ingram 2011; Nguyen 2007; Joseph 2010a; Lemke 2002). During the 1970s, when Foucault first introduced the term governmentality, he was concerned with understanding the birth of liberalism as a political rationale in the course of investigating political power. Foucault's work suggests that governments were beginning to formulate an alternative rationality of government that was concerned less with maximizing sovereign and territorial power, but rather on managing a 'complex global assemblage' (Collier, 2006). Foucault understood governmentality as the shaping and regulating of the social, political, and economic realm of society from a distance and the study of techniques and practices of governing. Already in the 1970s there were classical accounts written on transnational relations in world politics.<sup>1</sup> In the 1980s there were, for example, work published on international governance regimes. However, it took until the end of the Cold War when the perspective of global governance was properly getting foothold in international relations. More attention than before was started to be paid to a global change that was seen as reorganizing political authority. Few years after the end of the Cold War James N. Rosenau influentially declared that:

the constitutions of national governments and their treaties have been undermined by the demands and greater coherence of ethnic and other subgroups, the globalization of economies, the advent of broad social movements, the shrinking of political distances by microelectronic technologies, and the mushrooming of global interdependencies fostered by currency crises, environmental pollution, terrorism, drug trade, AIDS, and the host of transnational issues that are crowding the global agenda. These centralizing and decentralizing dynamics have undermined constitutions and treaties in the sense that they have contributed to the shifts in the loci of authority. Governments still operate and they are still sovereign in a number of ways; but, as noted above, some of their authority has been relocated towards sub-national collectives. Some of the functions of governance, in other words, are now being performed by activities that do not originate with governments.<sup>3</sup>

In addition, as the state's capacity for governance was seen as changed and weakened, it was believed that authority has been in some extent transferred to somewhere else. In this transformation states were seen as losers and different non-state actors were perceived as winners. Non-state actors were many times seen as more effective actors in relation to global issues than states. Non-state actors were, for example, perceived to master the network character of contemporary global order and thus they were seen able to influence certain global issues, such as respect of human rights, better than states. Thus, due to the complexity of global issues that were now seen to haunt political authority and due to the existence of non-state actors that knew how to manage this complexity sometimes more efficiently than states, state led geopolitical management of global issues was seen as becoming all the time less plausible. Many were demanding a greater involvement of other actors than states to the management of global issues. They were advocating for genuine global governance, in which different types of actors would cooperate, as in a interconnected world of diverse nation-states, in which non-state actors also wield enormous influence, hierarchical forms of managing global affairs are losing their efficacy and legitimacy.”

More specifically, the type of non-state actors that have since been particularly celebrated from the global governance perspective have been representatives of the so-called civil society. There is no specific agreed definition on what civil society is, but at present the term is usually used when referring to different people's consortiums that are in the one end highly organized non-governmental organizations (NGOs) and in the other end much more loose gatherings of volunteers. Even though there is no specific agreed definition on what civil society is, it is widely agreed to be the main engine of global change. As put by Ann M. Florini, “[t]he state system that has governed the world for centuries is [...] changing, and one of the most dramatic changes concerns the growing role of transnational civil society.” As a consequence of activities of this civil society, it is

perceived that “[t]he site of politics has shifted from formal national institutions to new local and cross-border spaces”. Thus what is seen as new in the contemporary global governance in relation to older form of management of global issues is the role of the civil society in it.

An empirical enquiry to contemporary management of global issues confirms the significance of civil society in contemporary world politics. For example, in relation to HIV/AIDS, the role of civil society is constantly emphasized and a greater involvement of it is frequently demanded. It is seen that without the civil society HIV/AIDS simply cannot be efficiently managed:



The role played by civil society is often underestimated, largely because it is not systematically measured. Yet it is clear that without the nongovernmental sector's participation—including the work of vast numbers of volunteers at community level—many of the strategies and targets set by countries and the international community for responding to HIV would be unattainable. The experience and knowledge of these front-line providers is of utmost importance to national policy-making and to the development of stronger public health sectors.

Furthermore, it is important to stress that today also states, and not only non-state actors or different scholars, have begun largely to celebrate the contribution of civil society. States actively fund different civil societies and pursue for the capacity building of different civil societies, especially in the developing countries. It is at present everything but rare to see expression from states that emphasize the role of the civil society, such as this:

Progress towards democracy and the rule of law and the consolidation of human rights and *a functioning civil society* is a precondition for economically, ecologically and socially sustainable development. The simultaneous strengthening of development and security demands dialogue, coordination and cooperation between *all the stakeholders involved*.

Hence, if the transformation of authority from states to non-state actors has taken place, it seems that today states have largely submitted to this transformation and are not confronting non-state actors. In fact, it seems that states are inviting non-state actors to participate into the governance of global issues. Non-state actors are celebrated in statements given by state representatives and non-state actors are invited to participate in the activities of international organizations. Non-state actors, especially those that represent civil society, have clearly become legitimate parts of global governance.

## 10. POLITICS OF GLOBAL GOVERNANCE

Despite the fact that the involvement of civil society to global governance is widely celebrated, it would be a bit too hesitant and uncritical to declare the contemporary form of global governance simply better or more just than the state led management of global affairs. As Michael Barnett and Raymond Duvall have emphasized, the scholars of international relations need to be attentive to ways which power matters in global governance. Fortunately, some scholars have replied to this call and there now exists some work on the analytics power within global governance.

From the perspective of analytics power within global governance, the enlarged role of the non-state actors in shaping and carrying out of governance functions should not be seen simply as a transfer of power to these actors from states. Rather, this transformation should be seen as an expression of a changing logic or rationality of government. This is so, even though there does not exist clear hierarchy or chain of

command in the contemporary global governance, but multiple actors that seem to be engaged in a complex competition against each other. However, what links the complexity of contemporary global governance together is liberalism or, as it is frequently called at present, neoliberalism. The practices and institutions that are prevalent in the contemporary global governance are liberal in their character and thus the rationality that guides global governance is liberalism.

In this context liberalism should not be understood as a normative political doctrine or an ideology, but as a particular way of governance. Barry Hindess has written that it is unsophisticated to see liberalism as pursuing for the maintenance of individual liberty as an end in itself or to view liberty as setting the limits to objectives and manners of government. Liberal governments have frequently violated liberty by using different illiberal means against the poor and other minority groups or against whomever in the states of emergency. Liberty is only respected when it is effective to govern through this liberty. Thus liberalism is about constant calculation on what is required by the government in order to achieve its aims efficiently and cost-effectively as possible. Liberalism is about ‘calculation for this cost of manufacturing freedom’.

Civil society fits to this picture of liberalism very well. As liberalism, civil society is ambiguous notion that has been used in relation to many things. For example, civil society has been used to refer to particular value, space, anti-hegemony, etc. However, from the perspective of liberalism as way of governance, civil society is simply ‘the correlate of a technology of government’. From the perspective of liberalism as way of governance, civil society is seen as natural social bond which is a result of spontaneous synthesis between its members. Civil society is a reality arising from the interests of each individual part of it. Thus civil society is something that has to be respected by liberal government, but not in way of leaving it completely alone. On the contrary, civil society is a target of permanent governmental management, not in a way of direct intervention, but in a way of ensuring that the workings of individual rational interests guarantee the natural functioning of civil society. Liberal government has to ensure that the environmental conditions for civil society are such that the rational economic interests of individuals can work naturally and lead to consequences that are desirable for government.<sup>21</sup>

Regarding global governance, then, the rise of civil society should not be seen simply as a step towards a better future or even decline of state power. The self-association and political will-formation characteristic of civil society does ‘not stand in opposition to the political power of the state, but is a most central feature of how power operates in late modern society.’ Civil society has been granted its role because it can perform certain governance tasks most efficiently and cost-effectively. For example, at present underdevelopment of societies has become dangerous as it is perceived to correlate with terrorism and other hazards. Direct interference and societal reconstruction is, however, beyond the capabilities of legitimacy of individual governments. In this

case, then, there is also a need for civil society actors, such as different development and humanitarian NGOs, which can legitimately act within these underdeveloped societies.

It should be understood that civil society and state are not opposite forces within contemporary global governance, but both are subjects created by liberal rationality. At present civil society and state are both under constant pressure, which norms of liberal rationality lay on them, as acting against these norms is likely to cause outrage in other actors of global governance. If civil society actors do not act according to these norms states and other donors of civil society will take their money away. If a state does not act according to these norms liberal states and civil society actors will try to force it to change its course; for example, by labelling the state as a rogue state or by imposing different sanctions. On the other hand, behaviour perceived as good will be celebrated. When civil society actors operate along the norms civil society is proclaimed to be an essential part in the efforts to manage contemporary global issues. When a state operates along the norms it is also cherished. For example, if a developing country has adopted policies that are guided by liberal norms this country is usually said to be one of the success stories of development. This way contemporary global governance should be grasped as a form of productive power that moulds and establishes actors – both civil society actors and states, or what sort of actors ever that are needed – along its own needs.

The power that functions through liberalism is mostly a type of power that cannot be owned, but this type of power functions only through practices and in relation to something. Thus the target and operator of power are both constituted by power relation, which is formed between these entities when the operator successfully claims the position of authority and succeeds to portray the target as being in a subordinate position. Both of these positions already exist in the rationality of power before these two entities are attached to these positions. Thus the power already exists before it is used. From this perspective, then, it is not a reasonable thing to say that power and authority have been transferred from states to civil society or somewhere else in the contemporary global governance. In the contemporary global governance states, civil society or any other subject can practice power in a non-zero-sum game if one just acts according to liberal rationality.

The demands of a greater involvement of other actors than states to the management of global issues and the celebration of multilateral global governance cannot be clearly separated from liberal objectives. These demands and celebrations support the liberal rationality that guides contemporary global governance. As these demands and celebrations support this particular way of governance, these statements should be seen as politically charged statements. Thus, regarding these statements, what should be disputed is the naïve conception of liberal form of power. In order that these statements could be seen as politically charged more explicitly there is a need to understand the workings of contemporary global governance better than done at present. There is a need to understand the way in which action of different actors, whether they are states, civil society actors or international organizations, is guided by power and transmit power.

However, as Martyn Sama and Vinh-Kim Nguyen state, "health is above all a political matter, of which biology and epidemiology are the expression. Epidemics of cholera, tuberculosis or HIV are the embodiment of politics". Thus it seems that the way HIV/AIDS intertwines with the issues that normally preoccupy political scientists such as the state, institutional reform and development, democratization, civil society, globalization and global governance is not evident to many people."

When talking about resistance within liberal governance it is, however, essential to specify what kind of character this opposition has. In relation to liberal governance it is important to separate the question of resistance from the question of what kind of order would guarantee liberty to individuals. This is because one of the main tasks of liberal governing is to create specific kind of freedom and attract civil society to function within the limits of this particular freedom. Within liberalism

[f]reedom is never anything other [...] than an actual relation between governors and governed [...] [G]overnmental reason needs freedom [...] it consumes freedom, which means it must produce it. It must produce it, it must organize it. [...] Liberalism must produce freedom, but this very act entails the establishment of limitations, controls, forms of coercion, and obligations relying on threats, etcetera.

Thus if resistance is understood as pursuing some given liberal freedom we are not resisting liberal governance as such, but actually only acting within the limits set by it. In this way we would already on beforehand define certain limits for resistance as resistance could only be practiced within the limits of this particular freedom. Within liberalism, then, in the end resistance cannot be about anything ready-made. On the contrary, resistance has to be about refusal of liberal governance in concrete complex situations faced by individual people when these people themselves decide to perform an act of resistance. As written by Sergei Prozorov, "[p]ower relations become unacceptable not by virtue of any normative criterion but simply when(ever) they are not accepted."

### **GOVERNANCE From LOCALITIES :**

HIV/AIDS, as it has been stated, "is the first global epidemic of which we have been commonly conscious". There seems to have emerged a consensus around the world that HIV/AIDS should be highlighted as a serious global problem. It is seen as a humanitarian catastrophe as the HI-virus is now so prevalent especially at some poorer regions of the world that the consequences of the virus are seen as devastating for these areas. These areas are perceived to be in a need of immediate relief, which can be only achieved through global cooperation. Global cooperation is also perceived to be central in the long-term attempt to sweep the burden of HIV/AIDS completely from these poorer regions. In this case tackling HIV/AIDS is understood as being intertwined with the development of these regions. Either way, the taming of the devastating effects of HIV/AIDS is seen as a common responsibility of us all. Yet, this common responsibility is made even greater through different prognoses where the future is seen potentially even gloomier than the present

as the growth of global networks and the weakening of state borders could spread the devastating effects of the virus to areas outside the poorer regions of the world. Thus, in addition to being perceived as a humanitarian and development issue, HIV/AIDS is also grasped as a global security issue. In this way HIV/AIDS is a good example of the merging of humanitarianism, development and security so prevalent in our times.

As it can be already seen from the previous, regardless of perceiving HIV/AIDS as a humanitarian, development or global security issue, our common consciousness of HIV/AIDS is related to two different aspects. According to Hakan Seckinelgin, “the globality of the disease is related to both to

its occurrence in multiple country contexts across the world and to the international policy context”<sup>9</sup>. Thus what is global about HIV/AIDS is not only the magnitude of the problem but also the approved response to the problem. As Seckinelgin continues, “the *globality* locates policy formulations into a certain *global* context whereby *global* intervention policies are to be supported by *global* funding with *other resources* formulated accordingly.”

Also, regardless of perceiving HIV/AIDS as a humanitarian, development or global security issue, the approved global response to HIV/AIDS is organized through the very same global governance regime. This regime consists of many multilateral and bilateral organizations, which constitute complex system where the coordination is, however, mostly centralized to the Joint United Nations Program on HIV/AIDS (UNAIDS).<sup>51</sup> In addition to these organizations, there also exist influential programs and funds that are important parts of the governance regime. Most of these programs and funds were launched by the time and after the Special Session of United Nations General Assembly (UNGASS) in June 2001 to discuss HIV/AIDS. UNGASS produced a final Declaration of Commitment, according to which HIV/AIDS should be treated as a matter of highest priority especially in sub-Saharan Africa. In this way HIV/AIDS, and especially sub-Saharan epidemic, was firmly set on the global policy agenda.

Even though UNGASS was a highly important moment in the evolution of the global governance of HIV/AIDS, it wasn't the beginning of it. The beginning of the global governance of HIV/AIDS can be better situated in the mid-1980s. From the beginning, at the centre of global governance there were different UN agencies with the World Health Organization (WHO) taking the lead role by founding the Global Program on AIDS (GPA). Bilateral donors also activated themselves with the United States being the most salient donor through the United States Agency for International Development (USAID), but other bilateral donors started to contribute as well mainly, though, through funding of GPA. GPA took the professional and technical lead and established AIDS programs in its member countries. In this way general consensus among the major powers started to emerge that the problem should be managed multilaterally. In 1996 this multilateral governance was clarified and strengthened when the GPA and other subordinate HIV/AIDS related programs of different UN agencies were merged under UNAIDS. Since then HIV/AIDS has all time moved higher in the priority list of global policy agenda, as exemplified by already mentioned UNGASS.

The common acceptance of the fact that HIV/AIDS should be treated as a matter of highest priority and through cooperation has not lead to consensus in the views about how the HIV/AIDS should be fought, especially in the resource poor settings. For the resource poor settings there have been mainly two paradigms of tackling HIV/AIDS. Namely, these paradigms have been prevention and treatment; although, community-based care, education, protection from violence and promotion of human rights have all been frequently emphasized as well. For a long time prevention was considered as a best way to tackle HIV/AIDS, but lately the situation has been more confusing. For

example, although the UNGASS Declaration of Commitment still acknowledged “that prevention of HIV infection must be the mainstay of the national, regional and international response to the epidemic”, the programs and funds launched by the time and after UNGASS have mostly concentrated on treatment. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Health Organization’s 3 by 5, the HIV/AIDS Initiative of William Jefferson Clinton Presidential Foundation, the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Bank’s Multi-Country HIV/AIDS Program (MAP) all made access to treatment their main priority.

The parallel promotion of treatment has been an outcome of two processes. Firstly, from about mid-1990s there emerged a constantly growing dissatisfaction in international atmosphere to the fact that HIV positive people in Africa, and other resource poor settings, rarely held access to multiple drug therapy that kept HIV positive people alive in the industrial world. Secondly, there was a gradual appearance of treatment successes in resource poor settings in the beginning of Millennium. Before the early Millennium the use of multiple drug therapy was simply seen as too complicated and costly to be implemented in the resource poor settings by the aid providers. However, in the beginning of the Millennium the dissatisfaction in international atmosphere on the access to multiple drug therapy had grown so large that the pharmaceutical companies were, for example, made to face certain limitations in relation to intellectual property rights and in the year 2002 Barcelona AIDS conference several groups presented examples of treatment successes in resource poor settings. It was in this atmosphere that treatment got into the focus of international efforts. Yet, the enthusiasm behind the promotion of treatment has been lately turned down a bit because it has been noted that the channeling of resources from the prevention to treatment has created problems

as treatment cannot influence the increasing infection rates. Thus prevention is now being tried to bring back as a central focus, for example, by UNAIDS.

Even though individual actors can voice differing policy priorities within the global governance regime, as exemplified by the shifts from prevention to treatment and back, there still exists a common framework that guides the regime. The existence of this common framework is a result of the fact that the whole regime is bound up

with comprehensive development ideas as exemplified by the inclusion of the fight against HIV/AIDS to the Millennium Development Goals (MDGs). In this way the global governance of HIV/AIDS is firmly anchored to general development framework and, further, to neoliberal development principles. Of course, there should not be anything surprising in this intertwining of HIV/AIDS governance and neoliberal development principles as I have just listed a bunch of international funds, programs and organizations that constitute the backbone of HIV/AIDS governance. Because what is neoliberal development, if it is not delegation of traditional state functions to other stakeholders? As written by David Craig and Doug Porter, the neoliberal development orthodoxy that emerged in 1980s saw the answer to underdevelopment in dismantling of state power. The idea was that by dismantling state power the instruments used by elites to accumulate political and material wealth would be undermined and the peasantry would be free to take advantage of new market opportunities. Thus the view emerged that states should be displaced as the engines of development and the state functions should be externally delegated to international regulatory bodies, like International Monetary Fund (IMF), and internally delegated to non-state organizations, like different NGOs.

However, during the decades following the 1980s the state's role has been gradually reinvented and the state has been brought back to development. Nevertheless, this has not meant that the state has gotten back its old role as an engine of development. On the contrary, the state has been only brought back when the state has been able to fundamentally transform in the terms of neoliberal principles. The state that has been brought back has as its primary function to 'facilitate the movement of capital across space, while at the same time ensuring that the logics of the market [...] are both articulated into and bolstered by social services, protection and security measures.' Thus the state has been included to the neoliberal development in neoliberal terms.

All the above-mentioned about neoliberal development is highly evident within the global governance of sub-Saharan HIV/AIDS as most of the African states have adopted a multisectoral approach to their epidemics as promoted by different international organizations. Within the multisectoral approach there are many different actors working against HIV/AIDS in cooperation. Usual actors that participate in the multisectoral cooperation are government, international non-governmental organizations, civil society, private sector and community of international donors. Consequence of the multisectoral approach is that in most of the African countries it is impossible to speak about national approach against the epidemic, in a strict meaning of the word national. Usually national measures aimed against the HIV/AIDS cannot be voiced without mentioning different international organizations, international donors or NGOs. Although governments of African countries are partners in the multisectoral approach, usually the approach marginalizes their position. Within the multisectoral approach international organizations, international donors and international NGOs operate directly with the local people without a proper contact to the local governments.

Despite the integration of local people into the global governance of sub-Saharan HIV/AIDS through the direct contact of global and local levels, local people in Africa can very seldom get their voices heard within the global level. The result of this is that the practices of global governance of sub-Saharan HIV/AIDS and the experiences of Africans do not always correspond. This has made many projects that have tried to address the problems caused by

HIV/AIDS in sub-Saharan Africa ineffective. However, despite these failures, international policy circles are still insisting that they know what works. They denote that they know which are the best practices and tools for dealing with HIV/AIDS. They measure the success of interventions by wider implication of these practices and tools, not by the long term outcomes of these interventions. If local people do not seem to be responding to these practices and tools the problem is usually perceived to be with the knowledge of local people, not in the neglect of local people's own experiences of their lives in their multiple social contexts. In this way, within the global governance of sub-Saharan HIV/AIDS, local people's lives usually make sense only according to knowledge that international policy makers have, even though this knowledge may not have any resemblance how local people experience their circumstances.

What international policy circles seem to be doing, by dismissing the failures of projects and insisting on their knowledge, is apoliticization of the global governance of sub-Saharan HIV/AIDS. This apoliticization of governance in relation sub-Saharan HIV/AIDS is hardly surprising as similar apoliticization has been present in the general development framework for a long time.

As written by James Ferguson, the development industry forms an anti-politics machine that dispels politics from development by insisting that it consists only of neutral-technical policies and not politics of any sort

However, in reality the anti-politics machine is highly political as it renders the politics of those who are to be developed as neutral-technical problems to which the anti-politics machine has neutral-technical 'solutions'. In this way under the cover of a neutral, technical mission to which no one can object the anti-politics machine performs extremely sensitive political operations.

Furthermore, the anti-politics effect' regarding the global governance of HIV/AIDS is made even stronger, than is usual in development, by the fact that it is a global health issue. According to Mika Aaltola, pandemics are refined into governance exercises that are thought to be beyond politics. Modern health propaganda highlights the general human interest and because of this the political agenda of health policies often go unrecognized. However, alternative visions, different agendas, co-optive purposes and clashing interest are present in the global health governance. The global health governance differentiates among actors and defines the way in which they collaborate. In this way even expert-driven neutral-technical health governance recognizes some legitimate forms for politics. Thus the apoliticization of governance action in pandemic emergencies is among the most important places to look for the ways in which politics and power hierarchies matter.

From this 'anti-politics' perspective, then, the question whether prevention or treatment is the right way to fight HIV/AIDS in sub-Saharan Africa loses some of its meaningfulness. Instead, what becomes the most meaningful thing to know is: what kind of politics the global governance of sub-Saharan HIV/AIDS dispels, regardless if this governance recognizes prevention, treatment or whatever else as its main priority? Acknowledging the politics inherent in the global governance of sub-Saharan HIV/AIDS is extremely important as the authoritarian attempts to improve human condition have a gloomy history in modern times. James C. Scott has investigated a bunch of these authoritarian attempts and concluded that these attempts usually not only fail to improve the human condition but actually make it worse. These attempts have many times diminished the skills, agility, initiative, and morale of



their intended beneficiaries. Pretty much the only thing these attempts have usually succeeded in has been the abolition of local autonomy and extension of institutional authority of the improvers. Hence, I will now start to concentrate on the politics inherent in the global governance of sub-Saharan HIV/AIDS. In order to do this, I have chosen a starting point that is obvious. As the global governance of sub-Saharan HIV/AIDS is organized along the neoliberal development principles and the aim of the governance is a direct intervention in aspects concerning human sexuality, the obvious starting point is the thoughts of a man, who investigated both the interventions in human sexuality and liberal governing: Michel Foucault. Previous works have highlighted the contestation of discourses within the HIV/AIDS domain associated with securitisation, human rights, economic or international development (cf. Elbe 2010). Some scholars have assumed the hegemony of neoliberalism which has in many instances set the agenda and the parameters of the debate in HIV/AIDS governance (cf. Ingram 2013; Williams & Rushton 2009). However, and in order to draw out the entanglement between the HIV/AIDS relief and normalisation in terms of governmentality, the following section will highlight the contestation within global health governance surrounding HIV/AIDS relief to establish the drivers of the emerging agenda of normalisation. As emphasised earlier by citing Susan Sell, the power lies with the governor – but who is the governor and who is the governed in this case? In order to address this issue the following three chapters will highlight the tools of knowledge and technology operating within governmentality. Looking at how knowledge and technologies of global governance operate within the HIV/AIDS domain will point at the direction normalisation is taking. The role of knowledge in normalising the HIV/AIDS agenda Ample literature examines the rise and fall of funds directed towards HIV/AIDS R&D, innovation, prevention, and vertical programmes (cf. Fidler, 2010; Sridhar & Batniji, 2007) as well as the proliferation of private authority and non-state actors in the domain. GHG is on the one hand described as a domain characterised by fierce competition between actors for the limited amount of funding and resources and on the other hand as one between funders. Despite previous successes, there is a widespread perception that current attempts to turn back the tide of HIV/AIDS are failing (cf. Lee 2009) due to an absence of coordination in the global governance of HIV/AIDS. This does not merely result from a lack of coordination between the various agencies but also from their contesting worldviews and material interests (Williams & Rushton 2009). For the purposes of developing this research framework, how then do we describe the process of contestation: how does it manifest itself? Williams and Rushton (2009) distinguish two forms contestation: the obvious and the tacit. The more ‘obvious’ forms revolve around relational power processes, which have both material and ideological dimensions. The less obvious, or tacit, forms of contestation are the result of structural power and, in some instances, resistance to it. The authors conclude that ‘what matters here in terms of health and health policy outcomes is not so much who holds the power, but which particular worldview informs those actors’ perceived interests’ (Williams & Rushton 2009, p.15). One example is the U.S.’s position to TRIPS, which in turn was developed by U.S. Big Pharma and their interests (Sell 2007). The multi-sectoral character of the HIV/AIDS intervention is generally put forward as one of the key reasons for the creation of the UNAIDS programme in 1996 which took over the role of co-ordinating the UN-wide response to HIV and AIDS from the WHO, a body which had previously been widely criticised for its narrow, biomedically focussed response to the epidemic (Woodling et al. 2012). The proliferation of public-private partnerships (PPPs) at the beginning of the century suggested a structural

tool of reform and a trend toward decentralisation in the provision of health care. This has occurred both in the expansion of PPPs in the arena of research, health promotion, and education, as well as in the institutional structures of health governance (Glasgow 2005). Health reform has come to exhibit a very strong feature of liberal rationality – namely the application of market principles to the activities of the state. Through the alliances of industry and the UN or intergovernmental groupings, industry interests were incorporated into global governance structures. One of the most prominent examples is PEPFAR; First, whilst PEPFAR was clearly in part a recognition of US foreign policy it was also inaugurated to ‘protect the commercial interests of Big Pharma, and enshrine these corporations’ place in the global supply chain for the rolling-out of HIV/AIDS treatment’ (Williams & Rushton 2009, p.24). PEPFAR was a major political response to the unparalleled social and governmental mobilisation and the growing international pressure but from the state’s perspective it was also based on a ‘perception that US commercial and patent interests were under threat’ (Williams & Rushton 2009). As highlighted in previous chapters, it is generally acknowledged that funds for the HIV/AIDS relief are stagnant if not decreasing. Furthermore, a recently published report by the HIV Vaccines & Microbicides Resource Tracking Working Group (hereafter ‘the 19 Working Group’) observes a decrease<sup>7</sup> in the pool of donors for biomedical HIV prevention R&D resulting in increasing sums being attributed to fewer major donors (2015). As in past years, the public sector made up the majority of total funding with 79% (US\$ 990 million), out of which 69% came from the US. Combined, the US public sector and the BMGF account for 83% of all funding in HIV prevention R&D. Philanthropic support for HIV prevention R&D increased by US\$ 9 million, up to US\$ 200 million in 2014, reversing the trend of steady decline seen in the past few years. While the total amount of philanthropic funding increased in 2014, the number of philanthropic funders engaged in HIV prevention research has been steadily declining since 2010. In 2014, 16 philanthropic funders invested in HIV prevention research, down from 30 in 2010, increasing the risk that resource allocations by one or two primary donors would have a disproportionate impact on the whole field. A similar picture prevails for R&D in HIV treatment: Again, the largest donation came from the public sector supplying 70% of total HIV treatment R&D funding with 63% being provided by the US. However, a closer look at reported funders in 2011 reveals that the second largest investor after the US National Institutes of Health was the pharmaceutical Gilead Sciences. Investigations into pharmaceutical-sector investment in HIV treatment R&D commissioned by UNAIDS consider these to be of high significance. Furthermore, the report concluded that private-sector companies are extensively involved in research and production of diagnostic tools as well as with ART development (PhARMA 2014; TAG 2013). With the main donors in R&D for ART residing in the US and with more than 90% of revenues from the sale of antiretrovirals (ARVs) HIER FEHLT EIN VERB in high-income countries, there are limited incentives to focus research on developing countries’ needs. Drahos and Braithwaite conclude: The Working Group has also ascertained a decrease in funds at the disposal of HIV Prevention R&D since 2012, which underlines the previously mentioned trend of the flat-lining of investments to the HIV/AIDS response. 20 ‘patent-based R&D is not responsive to demand, but to ability to pay ... Much of what happens in the...health sectors of developed and developing countries will end up depending on the bidding or charity of biogopolists as they make strategic commercial decisions on how to use their intellectual property rights’ (Drahos & Braithwaite 2002, pp.167–168). This highlights the vulnerabilities associated with relying mainly on the decisions and actions of private

companies. However, and despite high intellectual property (IP) protection in the US, the non-generic pharmaceutical industry's research and innovation has steadily declined. A report by Pharmaceutical Research and Manufacturers of America (PhRMA) revealed that America's pharmaceutical research and biotechnology companies were testing medicines to address HIV/AIDS and related conditions in 2014 opposed to 97 five years earlier. In order to fill this gap, President Obama has initiated the billion-dollar drug development centre, the National Institutes of Health (NIH) (PhARMA 2014). Sell analyses the provision of medication in light of TRIPS agreement concluding that 'ongoing contestation is the central process of the politics of intellectual property' (Sell 2011, p.29). Despite the 2001 WTO Declaration on the TRIPS Agreement and Public Health (the Doha Declaration), the implementation has been slow and TRIPS was just the start to subsequent IP rights negotiations. In her work on IP rights she examined the case of HIV/AIDS in the background of global power relations. She observes a 'strong trend toward transforming life-saving drugs into private commodities for sale at premium prices through higher levels of intellectual property protection has made them less available to those who need them most (Sell 2007, p.41). In recent years, critical voices have proliferated and states like Brazil, India, and South Africa have taken a leading example of addressing their public health emergencies. TRIPs have offered countries much flexibility to adapt their IP policies to allow public health policy goals. Albeit, 'public international law such as TRIPS is embedded in a broader context of asymmetrical power relationships between developed and developing 21 countries, and between producers and consumers of the fruits of intellectual property' (Sell, 2007, 58). Sell observes a vertical trend in IP norm-setting where powerful actors, like the US or even private actors, try to persuade governments to 'adopt and implement wildly inappropriate and potentially damaging policies that only benefit the rights holders, and to discourage behavior that seeks to exercise flexibilities in IP policy that help both the poor and consumers in general' (Sell 2011, p.20). In order to enforce stronger IP regulations, advocates negotiate while avoiding the multilateral arena in the hope of locking in changes that opposing countries (such as the BRICS) might over time feel compelled to adopt. 'This behavior clearly poses dangers to public health. Expanded intellectual property rights, economic concentration and strong-arm tactics against vulnerable populations add up to a dangerous situation' (Sell 2011, p.24). The suppression of low- and middle-income countries through TRIPS(-Plus) by powerful actors such as pharmaceutical companies and governmental organisations indicates a shift in the structure. As a number of ART patents will expire in the coming years and enable further generic production, competition in R&D between wealthy and middle-income countries will increase. All the above are indicators for a shifting environment: rising resistance to TRIPS(-Plus), advocacy for emerging new models for innovation in medicine (e.g. UNITAID's8 ), a proliferation of stronger south industries with high-level skills in innovation, manufacturing, and marketing, and expiring patents. Additionally, this agglomeration of changing factors will lead to peer-trade-competition between middle-income countries and Western countries. UNITAID established a patent pool for HIV/AIDS medicines in 2008 as an innovative model to help overcome the three main reasons for a limited access to ARVs in developing countries: 'increasing treatment needs, rising drug costs linked to the broader reach of ARV patents, and decreasing financial resources' (UNITAID 2009). While multinational drug companies seek out Chinese and Indian researchers to capitalize on the Eastern laboratories' efficiency in testing for drug candidates and new drug development, Eastern researchers enjoy the immediate benefits of profit shares and IP rights

with new medical breakthroughs and the development of a local industry waiting in the long run (Dionisio 2010). Yet, recent events have shed light on the delicate nature of this competition: In China, the scandal surrounding British GlaxoSmithKline (GSK) and the corruption crackdowns that seem to disproportionately emphasize the wrongdoings of global pharmaceutical companies should not just be interpreted as part of the growing governmental reform of the Chinese public health system but as part of the ‘one in a lifetime expansion’ of its healthcare system and its becoming less hospitable to multinationals. China is protecting its domestic pharmaceutical market - estimated to develop into one of the largest markets for generics worldwide in the coming years – and its state-owned enterprises (SOE), giving preferential treatment to SOE over multinational pharmaceutical companies. In addition, the incentives set by the Chinese government to encourage technology transfer within the public health sector will shift the competitive landscape both within the country and in many of the emerging economies worldwide once Chinese competitors demand their bit of the market share (Shobert 2014). Another indicator of a growing competitiveness and marketisation of global HIV/AIDS governance is a proliferation of market mergers to spur competition. Additionally, as non-generic companies are worried about losing weight, deals between originator companies have already been struck or are in progress as far as joint manufacturing of ARVs is concerned. Examples of such mergers are GSK and Pfizer merging their HIV/AIDS business into the new company ViiV Healthcare and the Bristol-Myers Squibb & Gilead Sciences’ venture for a non-generic ARV combination drug. This is no to say that the public context of health and health care is devolving irrevocably into the private. Several broad studies of welfare reform generally, and health reform more specifically, suggest that the welfare state in Western societies is not in the process of being dismantled. Rather, this process expresses an attempt of altering institutional configurations in accordance with a particular logic emphasizing competitiveness and efficiency. Glasgow points out that, ‘In none of these countries have policymakers sought to abandon planning and regulation. Rather, the aim has been to combine some market incentives with a framework of rules to guide competition and the capacity to intervene to tackle market failure. The reforms that are taking place are in this way leading to the development of regulated or managed markets’ (Glasgow 2005, p.191). After having highlighted the power disparities between private and state actors as well as between hitherto more powerful nations and less developed nations, the notion of competition seems to outweigh the idea of the HIV/AIDS agenda as an arena of collaboration. The great influence of pharmaceutical companies on R&D and the increasing neglect of the US market for less lucrative diseases, highlight the need of a diverse donor base. Conversely, the pharmaceutical market is trending towards hegemony; Powerful actors attempt to economically coerce countries whose growing (generic) pharmaceutical R&D markets pose potential threats in the coming decade through IP rights negotiations to retain their authority – a phenomenon that Sell (2011) termed ‘going granular’. The merging of markets and innovation models to incentivise competition are forerunners of an increasing commercialisation of medication and market dynamics. Additionally, patents still hinder third-party follow-on innovation, creating high barriers to market participation. This configuration translates into a greater influence of economic power over policy-making ‘that has hitherto been seen as the realm of the public sphere’ (Buse et al. 2002). The increasing commercialisation of medicine leads to a contortion of the global research agenda in favour of rich countries’ markets (e.g. in favour of lifestyle drugs) neglecting the diseases of the poor. So far, the HIV/AIDS agenda is driven towards a higher degree of

contestation, albeit outlooks on new alliances with opening markets (e.g. Chinese market) exist. In the following section, the impact of the introduction of indicators and standards in ‘governmentality’ to normalise the agenda away from the hitherto vertical approach will be demonstrated. Examples, like the ones shown above, rely heavily on market dynamics as the predominant attempt to reengineer the organising logic. In the case of the ‘old’ powerful actors (e.g. U.S. Big Pharma), this translates into a capitalist organising logic in order to retain authority. However, in both cases, the driving forces display a capitalist tendency, supported by the notion of competition rather than collaboration. With new (generic) markets growing stronger and pushing their boundaries, competition is likely to increase. Indicators as technology in global health governance

The normative power of standards and indicators has become a key tool in the transition of global governance attributed to its disciplinary power, making economies and producers commensurable (cf. Collier & Ong 2007). According to the Foucaudian framework, indicators are a technology of global governance affecting the ‘topology of global governance (who are the governors and the governed, and in what ways), the processes of standard setting and decision-making, and affecting ways in which contestation of governance occurs, with a potential effect also on the demand for and the supply of regulation in particular modalities’ (Davis et al. 2012, 100). The development of indicators will ultimately result in the definition of specific goals, the setting of targets, and the embedment of obligations to achieve these goals. Thus, indicators create standards against which societies, populations or governments can be measured. They are an expression of a rationalist functional and are widely institutionalised in the development domain (e.g. Human Development Index). However, this section will show that this also applies to global health governance when framed from a functionalist perspective. Discussing the role of indicators in global governance, Fisher (2012, p.2) notes that ‘Those evaluations can in turn form a basis for various actors’ decisions on how to create or distribute resources, and how to try to alter the behavior of others or their own behavior. Where a single actor (or set of actors) outside the state have governing power in relation to the state, the governing actors may use indicators in the exercise of this power, for example in taking decisions on whether the state merits particular resources and on whether measures aimed at inducing or achieving compliance with the relevant standard are warranted.’ This rational is expressed in the UNAIDS Introduction to Indicators guidelines (n.d.) claiming that ‘at the global level, harmonized indicator sets ... provide international agencies and organizations with much-needed strategic information, which influences their planning and allocation of resources. Indicators provide critical information on performance, achievement and accountability, which is the cornerstone of effective monitoring and evaluation. In addition, the data from indicators provide the strategic insights that are essential for the effective management of the AIDS epidemic and response’. Hence, indicators emerge as a powerful tool to shift the logic of the HIV/AIDS agenda as they have the potential to set targets and therefore evaluate states’ performance. The financial, political, and social attention surrounding the HIV/AIDS pandemic and especially the vertical approach with its result-based financing mechanisms spurred demand for more substantial statistics and evaluation processes. The monitoring of the pandemic was codified in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS with the operationalization of the UNGASS indicators (now Global AIDS Response Progress Reporting Indicators). Despite these recognised efforts, HIV/AIDS indicators fall short of producing crucial data due to the developing countries’ limited capacity in producing data and tracking progress. This shortcoming

relates back to one of the main contradictory tendencies in shifting from a conventional to a horizontal approach, 26 namely the broad spectrum of data required to evaluate and monitor HIV/AIDS. Further, the landscape of HIV/AIDS-related indicators mirrors the landscape of its response: there is a multitude of indicators from various actors. They are contested in so far as there is no consent on which indicators are actually key to evaluating and monitoring HIV/AIDS and to respective policy decisions. An architecture ensuring standardised data collection is missing which in turn hampers the efficient and effective generation and use of information. The Global AIDS Response Progress Reporting Indicators is one of the most widely used sets of indicators and forms the basis of UNAIDS' annual progress report. However, their influence remains limited: thus far, encouragement for funding has been based on a commodity approach that granted the coexistence of numerous strategies irrespective of their relative effects rather than enhancing indicator-based decision-making (Schwartländer et al. 2011). Nonetheless, donors are increasingly calling for quantifiable indicators. As Padian et al. (2011, p.199) argue on the USAID's Implementation Science Investment Framework: 'In the second phase of PEPFAR, characterized by an increased emphasis on sustainability, programs must demonstrate value and impact to be prioritized within complex and resource-constrained environments. In this context, there is a greater demand to causally attribute outcomes to programs. Better attribution can be used to inform midcourse corrections in the scale-up of new interventions (e.g. male circumcision) or to re-evaluate investments in programs for which impact is less clear.' This demonstrates the need for greater visibility, calculability and attributability of all aspects of the response. In general, global public health policy is driven towards a focus on technical expertise so that 'problem, cause and effect can be quantified and compared with others' (Ingram 2013, p.448). Another indication for increasing demand is the growing According to a study into HIV/AIDS indicator frameworks this holds especially true for the social factors shaping HIV/AIDS risk and vulnerability despite the acclaimed recognition of a need to integrate social drivers into HIV/AIDS relief (Mannell et al. 2014). Governments, private actors, and specialized agencies have been co-opted into the language of 'economism'. Hence, in the Foucauldian sense, global HIV/AIDS governance has largely become a technical exercise in monitoring, statistics, and the efficient delivery of biomedical solutions (Elbe 2005). Besides governments and governmental actors being calculating subjects under governmentality, they also become quantifiable objects by being turned into 'flexible and manipulable market subjects' (Isleyen 2014). Exposed to the market instrument of indexing, they are ranked in order of their performance. This trend finds expression in the BMGF's heavy investment in the IHME. Additionally, these examples show that an economic rationale has started to pervade the HIV/AIDS response, revitalising market forces. It established that indicators operate as a technology of global health governance. They are an expression of a shifting HIV/AIDS approach towards an outcome oriented, effectiveness-based rationale. To conclude this analysis, the last empirical section will concern itself with the question of global governmentality as raised earlier. The demonstrated interest to entrench the HIV/AIDS response within local systems yields a last piece of evidence indicating a shifting rationale and leading to the final operator of governmentality: the 'self-entrepreneur'. Governmentality emphasises the establishment of 'governance from a distance' through the responsabilisation of the individual. However, is this shift also apparent on a global level in an arena of uneven and combined character? In 2013, PEPFAR rendered 'moving from an emergency response toward a more sustainable and country-owned response to the HIV epidemic' a priority,

launching a ‘Roadmap of shared responsibility’ as part of its (2012) launched blueprint. UNAIDS (2015a) highlighted the ‘critical role of communities in reaching global targets to end the epidemic’ in a recently published report and has pronounced its view on country ownership as being ‘means to an end for achieving effectiveness, efficiency and sustainability of national AIDS responses’ (2011, p.5). Hence, the outstanding question is, whether international actors (e.g. IOs) can actually impose country ownership through governmentality given the nature of the economy, the state, civil society, and prevailing social conditions of the development partner and encourage countries to take on ownership and develop their own HIV/AIDS eradication strategies. Fostering country ownership, it is argued, contributes to improving local health systems and decreases dependencies of developing nations from (mostly) Western donors. The positive spill-over effects from integrating the HIV/AIDS intervention on the local level are also expected to strengthen a sustainable response (cf. Bärnighausen et al. 2011). By doing so, IOs are shifting the focus to local project ownership and an equal partnership. This implies a change in the role of IOs towards the provision of technical assistance, strengthening capacity building and fostering greater participation in the development process. From a classical understanding of governmentality, these programmes can be interpreted as tools to cultivate the ‘self-entrepreneur’, which is embedding an outsourced responsibility. They feed into the discourse of the cultivation of a responsible, self-governing subject via techniques of empowerment, self-surveillance, and towards the goal of a healthy and productive life (Glasgow 2005). Calling on countries to ‘to plan, manage, and monitor the implementation of the AIDS strategy effectively’ speaks to the calculable and instrumental terms of the relationships between donor countries and recipients. Further, the UNAIDS (2011, p.19) country-ownership report elaborates: ‘To achieve the goals of improved effectiveness, efficiency and sustainability of development aid, the agreements call for: country ownership; better alignment of donor support with country-developed strategies; donor harmonization; increased emphasis on results-based management’ The partners at play will have to shift their focus towards more result-oriented agendas in the future. The country ownership framework addresses mutual accountability between development partners and recipients suggesting a reciprocal approach. While this output-oriented strategy appears to prioritize the wealth, health and well-being of the population at heart, critics claim it to be about monitoring state compliance at its core (Joseph 2010a). In Joseph’s analysis of global governmentality exemplified by the World Bank’s ‘Poverty Reduction Strategy’, he concludes ‘that the targeting of populations is really only a small part of a bigger strategy’ (Joseph 2010a, p.47). Going beyond the rhetoric, one will have to anticipate the idea that these strategies imposed by powerful actors are attempting to institutionally embed the discipline of capitalist competitiveness exposing societies to the mechanisms of competition. The country ownership framework may well be a rhetoric used to cater to donor demands. Nevertheless, it is through this partnering process that governmentality is deployed most powerfully. Country-ownership strategies claim to have the well-being of populations at heart and whether or not this is the case is irrelevant when the aim is to regulate state behaviour. The rhetoric of country ownership takes shape in an apprehension for populations but with the real targets being states. In the end, the implications of country ownership strategies for global governmentality can be explained reformulating Foucault’s own claim ‘that global governmentality, in this context, becomes a complex ensemble of institutions, procedures, analyses, and tactics that has the state as its target, and a political economy of poor populations as its main form of knowledge’ (Joseph 2010a,

p.48). From this perspective, powerful actors are using asymmetrical power relations to their advantage with the effect of reinforcing market dynamics as the predominant organising principle.

#### IV

#### Conclusions:

The concept of AIDS exceptionalism developed as a Western response to an epidemic that threatened the lives and rights of specific populations in the developed world. As that epidemic was contained and effective treatment became available, the case for exceptionalism shifted to the international stage, where resources and organizations were mobilized to respond to the extreme need in developing countries. As a result, the numbers of PLHIV on treatment has increased each year. Infection rates in much of the world have stabilized. These gains have been accompanied by criticisms of the type and size of response. It is argued that the HIV/ AIDS response has done harm, as well as good, particularly by creating vertical programmes for a single disease, which may have diverted resources. As donor countries shift priorities, and in the context of the economic recession, the urgency around the HIV/AIDS response is once again declining. This shift in policy and international priorities does not change the reality of an epidemic that, after three decades, is still unfolding]. Both the human rights approach, originally adopted by the HIV/AIDS response, and the more recent demands for universal access to treatment, remain relevant to the 33 million people living with HIV/AIDS and to their communities; these issues should also remain pertinent within global health policy. Meanwhile new challenges are developing, not the least of which is the need to successfully integrate the HIV/AIDS response within broader public health responses to the benefit of all. As Sachs notes in a commentary in *The Lancet*, “We are not overspending on AIDS but underspending on the rest ... The choice is not between AIDS, health systems, and other Millennium Development Goals. We can and must support them all” [42]. As how to best approach such challenges is debated, we must not lose sight of the approximate 2 million AIDS-related deaths that occur each year. Defining these deaths as either exceptional or unexceptional seems both callous and arbitrary.

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#### V

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