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Global Governance, HIV/AIDS and the MDGs:
Where are we now and what lessons have been learnt for the future?

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GLOBAL GOVERNANCE, HIV/AIDS AND THE MDGS: WHERE ARE WE NOW AND WHAT LESSONS HAVE BEEN LEARNT FOR THE FUTURE?

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Executive summary

Since their adoption by the UN General Assembly in September 2000, the Millennium Development Goals (MDGs) have had an unprecedented impact on the global development arena. However, the MDGs will not be met in parts of Sub-Saharan Africa, largely due to the devastating impacts of the AIDS epidemic on the economic progress and social conditions of the region. In this paper we explore why this is happening. We highlight examples from three of the MDGs, selected with the understanding that their interconnection means that the failure to achieve one limits progress in the others. We go on to argue for an exceptional response to the AIDS epidemic in Sub-Saharan Africa. We then explore the limitations of the global HIV/AIDS response to date, which has focused heavily on technical and individual behavioural interventions without addressing the underlying drivers of the epidemic. We advocate for changes in two main aspects of the global response to AIDS: first, for a reorientation in the prevention response to empower communities and local governments to design and implement contextually appropriate and multi-sectoral interventions; second, for a transformation of global health governance so that at the macro level it can embody the principles of equity and self-determination.

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List of acronyms and abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Anti-Retroviral Therapy
HIV	Human immunodeficiency virus
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MDGRs	Millennium Development Goal Reports
MARPs	Most at risk populations
PHC	Primary Health Care
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
WHO	World Health Organisation

1. Introduction

Since their adoption by the UN General Assembly in September 2000, the Millennium Development Goals (MDGs) have had an unprecedented impact on the global development arena. They are a set of goals intended to "make the right to development a reality for everyone and to free the entire human race from want". In this paper we discuss the interaction between the MDGs and the HIV/AIDS epidemic in parts of Sub-Saharan Africa and outline why HIV/AIDS must be treated as exceptional here. We explore how HIV/AIDS will prevent the achievement of the MDGs in this region. We do this by focusing on three of the eight MDGs: gender equality and empowering women; reducing child mortality; and improving maternal health (MDG 3, 4, and 5). These goals have been selected as examples, with the understanding that all MDGs are affected to some extent by HIV/AIDS and by each other. Their interconnected nature means the failure to achieve just one limits progress in the others. It is clear that the targets for MDG 6 (combat HIV/AIDS, malaria and other diseases) will not be reached in parts of Sub-Saharan Africa, although in this paper we do not look at this MDG. We explore the limitations of the global HIV response to date.

Despite critiques and limitations, the MDGs are the global operating framework for development. They continue to shape funding and partnership priorities of global governance as they represent the "common ground" of the international community. Our recommendations for future action must, therefore, work within their framework. Conceptualising how to move forward as a global HIV/AIDS community, we must also continually reassess the operating environment.

Strategies to effectively address the AIDS epidemic in Sub-Saharan Africa need to take the effects of three critical contextual forces into account, namely: climate change, globalization, and the recent global financial crisis. Developments in each of these areas make the need to shift the global response all the more pressing. To effectively address the underlying structural factors of the epidemic, we need to re-evaluate both the focus

and the process of the response. We advocate for a reorientation of the prevention response that returns to the empowering principles of Alma Ata1, resulting in context-response and community-led interventions.

At the macro level, we suggest that sustainable and effective change requires a transformation of the global health architecture itself. Addressing the inequitable distribution of global resources and the institutions that maintain the status quo is critically important to making real progress regarding the drivers of the epidemic. When we can do this, as a global community we will be better able to support the development of resilient communities and effective responses to the epidemic.

2. The Millennium Development Goals

2.1 History and overview of the MDGs

In the 1990s a series of international conferences and world summits was held to understand and assess global poverty, health and development. The major outcome was that world leaders, representing 189 national governments, adopted the "Millennium Declaration" at the UN General Assembly. The MDGs are broadly supported, comprehensive and specific poverty-reduction targets. They are the current paradigm for economic and social development (UN Millennium Project 2005).

Within the international political system they have shaped development policy and continue to be the framework through which foreign aid and development assistance priorities are defined and measured (Fourie and Schoeman 2010). In the case

[1] The declaration of Alma-Ata in 1978 positioned primary health care as a core policy of the WHO and the strategy to achieve 'Global Strategy for Health for All by the Year 2000'. The philosophy of primary health care as put forth by Alma-Ata is is based on the following pillars: universality, quality, equity, efficiency and sustainability. The declaration also identified five key components and values of primary health care: 1) active community participation, 2) social relevance, 3) multi-sectoral involvement, 4) health service provision andhealth promotion, 5) use of appropriate and effective technologies. (For more detail please see: http://www.emro.who.int/mei/PHCalma.htm)

of the resource poor countries, the goals provide a yardstick for measuring progress. The development of a set of clearly defined goals with targets and a fixed deadline (2015) denoted a shift away from the preceding rather vague international promises usually made on an ad hoc basis.

In the arena of health and development, the most influential international agreement prior to the MDGs was the Alma Ata Declaration of 1978. This focused on health as a "state of physical, mental and social wellbeing, not only the absence of disease or infirmity" and as a fundamental human right. The Alma Ata Declaration highlighted the links between social and economic development and health. It promoted comprehensive primary health care (PHC) as a means to attain health (Global Health Watch 2008). The definition of PHC and the necessary approach to development was political: it emphasized community participation in the spirit of "self-reliance and self-determination" and promoted inter-sectoral action to attain what are now referred to as the social determinants of health.

Although the MDGs address some of these determinants (poverty, gender and education), the politicized language of empowerment and participation, necessary for the health and development outcomes that featured so prominently in the Alma Ata Declaration, are absent. The MDGs shifted towards a narrower conceptualization of health, with a focus on measuring medical indicators such as morbidity and mortality, as opposed to indicators of success in attaining PHC and social change. The objectives of the MDGs are simpler to assess.

The MDG goals and targets have shaped global policy by providing a development framework for governments, multilateral agencies, civil society and non-governmental organisations. They represent a consensus by signatory nations on the notion of a collective global responsibility for the right to development of all peoples.

The second paragraph of the declaration states:

> We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs (UN 2000).

The declaration emphasises the right of all people to social progress and improved standards of living stating that:

> We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.
>
> We resolve therefore to create an environment—at the national and global levels alike—which is conducive to development and to the elimination of poverty (UN 2000).

The Millennium Declaration outlines eight goals and twenty-one targets (see Table 1). Each target in turn has a set of indicators, which can be found at: http://mdgs.un.org/unsd/mdg.

Table 1: The Millennium Development Goals and their targets

Goals		Targets	
Goal 1	Eradicate extreme poverty and hunger	**Target 1**	Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day
		Target 2	Achieve full and productive employment and decent work for all, including women and young people
		Target 3	Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2	Achieve universal primary education	**Target 4**	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Goal 3	Promote gender equality and empower women	**Target 5**	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
Goal 4	Reduce child mortality	**Target 6**	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
Goal 5	Improve maternal health	**Target 7**	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
		Target 8	Achieve universal access to reproductive health
Goal 6	Combat HIV/AIDS, malaria, and other diseases	**Target 9**	Have halted by 2015 and begun to reverse the spread of HIV/AIDS
		Target 10	Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
		Target 11	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
Goal 7	Ensure environmental sustainability	**Target 12**	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources
		Target 13	Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss
		Target 14	Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
		Target 15	Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers
Goal 8	Develop a global partnership for development	**Target 16**	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system
		Target 17	Address the special needs of least developed countries
		Target 18	Address the special needs of landlocked developing countries and small island developing states
		Target 19	Deal comprehensively with the debt problems of developing countries
		Target 20	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
		Target 21	In cooperation with the private sector, make available benefits of new technologies, especially information and communications

Source: Adapted from: (Fourie and Schoeman 2010).

In this paper, we focus on Goals 3, 4, and 5 (one gender and two health MDGs) in areas of Africa where there is moderate to high HIV prevalence rather than on Goal 6 relating to HIV/AIDS, TB and Malaria. These three goals aim to promote gender equity and empower women; reduce child mortality; and cut maternal mortality. We will argue that because AIDS is a unique epidemic these goals may be unattainable in some African countries. We suggest this has not and is not being considered properly. We assess why the epidemic has been so ignored and what the implications are for global health governance.

Our contention is that HIV and AIDS generally only have a minimal impact on all the goals in most of the world. We need to focus on specific regions and countries. We further note that the remaining five MDGs build a foundation for the social determinants of health and are, indirectly, but demonstrably, affected by HIV/AIDS in some regions (Fourie and Schoeman 2010; Hecht et al. 2006; Alban and Andersen 2007; Kim et al, 2011).

2.2 Measuring progress

A major and frequently understated issue with the goals is the source of data, its collection, and it's reporting. Each country provides its own statistics. Progress is monitored nationally, with the United Nations Development Program (UNDP) coordinating and synthesizing country reports that link MDGs indicators from the national to global level. The UN Statistics Division collects information from a variety of agencies and organisations within and outside the UN system and maintains the official MDG Indicators database, accessible at http://mdgs.un.org.

One limitation to the system is the variability of reporting across national statistics departments. In a number of countries, the quality of data is dubious; information is suspect and often out of date. When countries lack the capacity and resources to collect the required data to assess progress on the MDG indicators,

international agencies construct estimates based on what little data are available and other related variables, and assumptions. Only under exceptional circumstances is the space for recording the data left blank. For more information on the reporting process see: http://www.mdgmonitor.org/aboutMDG.cfm. There is very rarely any analysis of the quality of data provided, and, while it may be unbelievable or inadequate, the UN system does not see its role as critiquing data.

Whiteside has written in frustration about the issue of reliability of the data collected to assess the HIV epidemic. There are problems with the data sources themselves, the methods of collection and representation, and with the unfortunate ways in which they are subject to misinterpretation and political spin (Whiteside et al. 2003). Although methods for measuring prevalence have improved over the last decade, collecting incidence data remains an ongoing challenge.

In many African countries there is no method of collecting and recording even the most basic vital statistics: the births and deaths of individuals within their governments' jurisdictions, for example. These data are used by public health programs to evaluate program effectiveness and are essential for assessing progress (or lack of progress) for a number of the MDGs. They are the cornerstones of public health systems today. Not only are these data lacking and/or have dubious quality, but the long-wave and multi-faceted nature of the AIDS challenges effective measurement. Additionally, the full impacts on health and development will take decades to become apparent (Whiteside et al. 2003).

Writing in 2002, Vandemoortle stated:

> The purpose of Millennium Development Goal Reports (MDGRs) is [sic] to raise public awareness; promote study, scholarship, and debate around the great development challenges; forge stronger alliances; renew political commitment; and help poor countries and donors create the deep, better financed and trusted partnerships … show progress at a glance … [and] focus the national debate on specific development priorities … [T] heir main audience is the media and the general public. MDGRs are meant to be short and easy-to-read reviews that convey messages quickly in a non-technical way. They should also provoke deeper analysis at the country level (Vandemoortele 2002).

Our comment is that while this would be the ideal, the lack of data in the MDGRs may allow the real issues to be obfuscated.

2.3 Critiquing the MDGs

Global goal setting for development is not new. It began in 1945 with the Charter of the UN outlining international targets for development and security. The MDGs, with their numerical and time-bound objectives, moved the practice in a new direction.

A common critique is that the MDGs are conceptually not cohesive, addressing different layers of development in a disjointed manner (Bradbury and Clark 2009). They are seen as the result of a top-down, technocratic, UN-led process that failed to account for local realities and constraints (Kumar and Burman 2009). Concerns about the ownership of and commitment to the MDGs stem from the fact that they were developed in the UN arena, but implementation responsibility rests in the hands of national governments. In addition, many governments of resource-poor nations are constrained by the lack of economic and social resources needed to progress towards the MDG indicators (Kumar and Burman 2009).

Although MDG 8, 'Develop a Global Partnership for Development', should theoretically increase resources for achievement of all MDGs, progress in Africa has been slow. The recent global economic crisis has shown that development assistance may be an early casualty of more limited government finances. This has been most clearly demonstrated by some countries reneging on pledges to the Global Fund for AIDS, TB, and Malaria.

It has also been argued that by overlooking the global systemic factors underlying poverty and inequality, the MDGs perpetuate neo-liberal approaches to development (Bradbury and Clark 2009). The MDGs fail to name the global economic systems and related inequitable distribution of wealth between (and within) nations as part of the problem. Instead they assume poverty is part of a linear development process and assert that through their application "developing" nations can move towards the ideal of 'developed nations' (Bradbury and Clark 2009).

Despite these critiques, the MDGs are the primary operating framework for global development. They "have been accepted by the widest constituency of any set of health and development goals in history" (Walley et al. 2008) and serve as a starting point from which to engage in global dialogue for development. Fourier states that "the practice of global goal setting creates a sense of common purpose in the development community" (Fourie and Schoeman 2010) and as such can be called upon to mobilize resources and political action worldwide.

3. The exceptional case of HIV/AIDS in Sub-Saharan Africa

3.1 HIV/AIDS in Sub-Saharan Africa

HIV was first identified thirty years ago. Since then at least 30 million people have died of AIDS and over 33.3 million are now living with HIV. However, an important feature of the epidemic is that HIV has not spread uniformly around the world or across populations, nor will it. The concerns in the 1980s that HIV would be the major health

challenge everywhere have proven to be unfounded (Kallings 2008). The reasons for this have been and will be debated, but are not the focus of this paper.

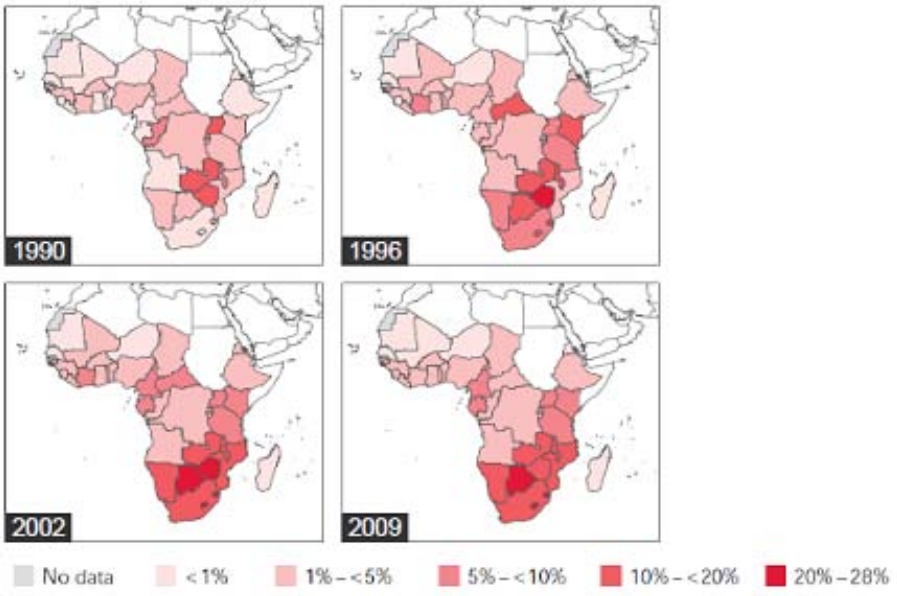
The reality is that the bulk of infections are in Africa. Sub-Saharan Africa is home to 12.6 per cent of the world's population, but carries the burden of two-thirds of global HIV infections, or 22.5 million people. UNAIDS estimated that globally, 69 per cent of the world's HIV infections and 72 per cent of AIDS deaths were in Sub-Saharan African countries (UNAIDS 2010). However, even in Africa there is huge variation in the epidemic. In West Africa, the levels of HIV prevalence are low in the general population (Nigeria may be the exception and issues of data quality are important here). In most of eastern and central Africa, the prevalence levels are stable and in many cases declining. The countries we focus on are the hyper-endemic countries: those with adult prevalence (15–49 years) of over 10 per cent. This is shown in Table 2 and Figure 1 (UNAIDS 2010). UNAIDS estimated in 2009 that 34 per cent of people living with HIV globally reside in 10 countries in southern Africa; with 31 per cent of new HIV infections and 34 per cent of all AIDS-related deaths occurring in this region (UNAIDS 2010).

Table 2: Estimated adult prevalence (%) of HIV for selected countries in 2009

Country	**Prevalence**
Swaziland	25.9
Botswana	24.8
Lesotho	23.6
South Africa	17.8
Zimbabwe	14.3
Zambia	13.5
Namibia	13.1
Mozambique	11.5
Malawi	11.0

Source: (UNAIDS 2010, pp180)

Figure 1: HIV prevalence in Sub-Saharan Africa (adults aged 15–49), 1990–2009



Source: UNAIDS 2010 pp 26

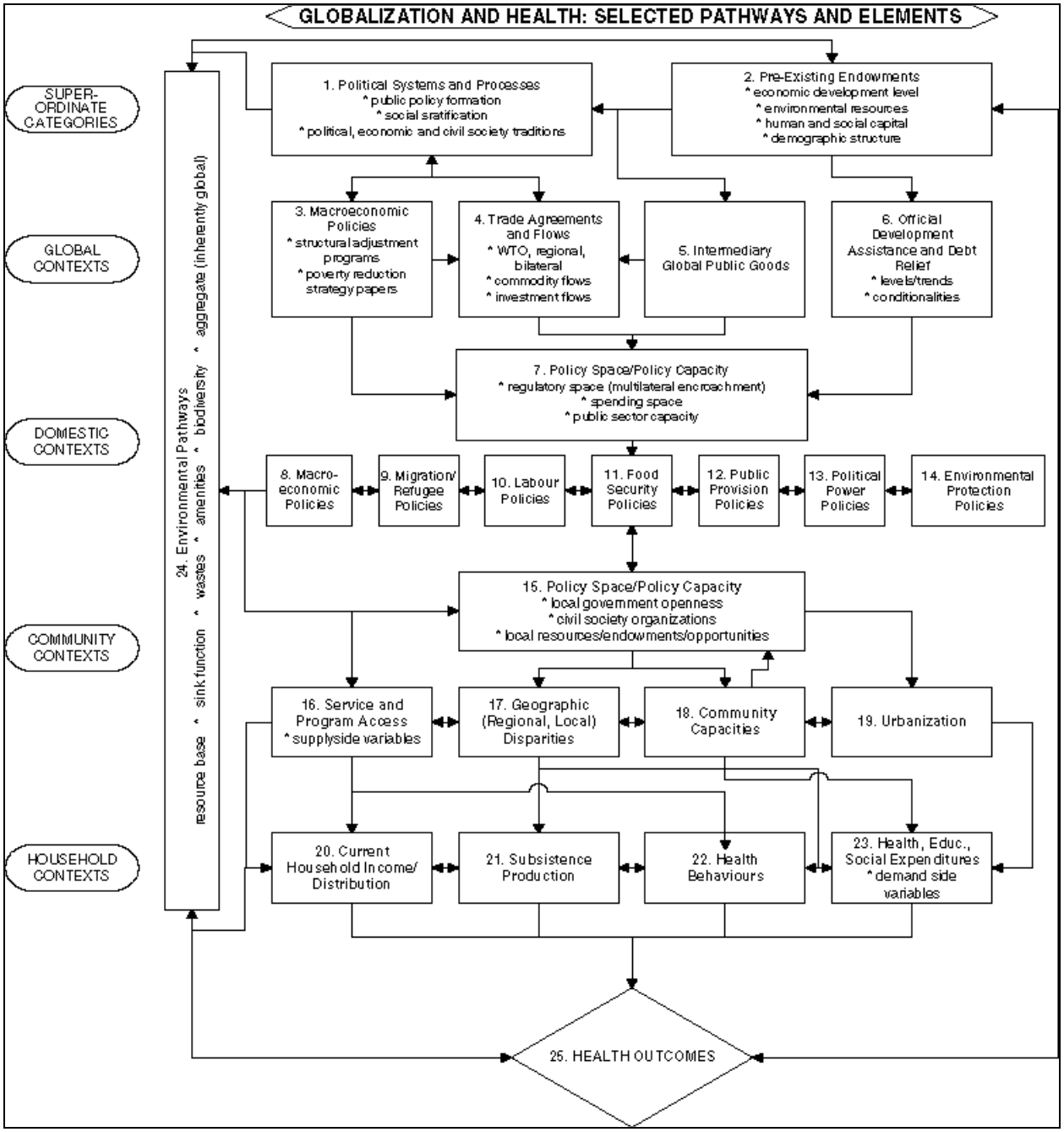
People infected with HIV will, in time, require treatment as they begin to experience periods of illness that increase in severity, duration and frequency. In the absence of such treatment, they will die. Given the sexual nature of the HIV transmission, most of those infected are young to middle-aged adults, resulting in an increase in morbidity and mortality among the working age and caring populations. The social and economic impacts of this are profound and will be felt for decades to come (Barnett and Whiteside 2006). These demographic impacts exacerbate existing challenges to society's capacity to respond to the epidemic. The loss of trained workers, combined with the increased social and health-related burdens of high morbidity, place additional stress on already fragile economic systems in many Sub-Saharan African countries. Women bear a disproportionate burden of the disease: their traditional roles as caregivers are increasingly called upon and at the same time the death or illness of a spouse may increase their need to earn incomes outside of the home.

A range of structural, contributing and key drivers determines risk and vulnerability to HIV and AIDS (Fourie and Schoeman 2010). Although individual

behaviour facilitates transmission of the virus itself, we know that behaviour is determined by a number of factors (Nutbeam and Harris 2005). These include, but are not limited to: enabling environments, psychosocial resources and socio-economic conditions such as livelihoods, migrancy, inequality and access to infrastructure (Barnett and Whiteside 2006; Campbell, Nair and Maimane 2007; Allen 2004). Drivers of the epidemic are complex and require multi-level and multi-sectoral responses.

A useful framework for understanding the complexity of factors affecting global health was developed by Labonte and Torgerson (2005). It outlines multi-level contextual factors, moving from household through community, domestic, global and super-ordinate categories (Figure 2). The dominant global response to HIV/AIDS in Sub-Saharan Africa has failed to control the epidemic in large part because it has focused on changing individual behaviour and biomedical interventions without accounting for the broader structural determinants of health, and the lived realities of vulnerable groups (Barnett and Whiteside 2006; Campbell, Nair and Maimane 2007).

Figure 2: Globalization and health framework



Source: Labonte and Torgerson 2005.

3.2 AIDS exceptionalism

A key issue for policy-makers and practitioners involved in the global HIV response has been the idea of AIDS exceptionalism (Whiteside 2010; Smith and Whiteside 2010). When the virus was first discovered, a number of factors contributed to

its "exceptional" status. It was a new disease from an unknown retrovirus, spread mainly through sexual intercourse, and first documented in the gay populations of the West. The exceptional status of AIDS was possible due to an alignment of interests, particularly from the health practitioners and gay advocates. The push for exceptionalism was initiated in the West, driven in part by the fear that standard public health interventions would force people underground, exacerbating stigma, high-risk behaviours and transmission. The gay rights movement played an important role in framing the international debate and response: its leaders were experienced activists, educated, and well connected politically and financially. These factors enabled AIDS advocates to succeed in their lobbying for exceptional attention to be given to the disease.

By 1996, there was a call for an end to this exceptionalism because AIDS had become less threatening than initially anticipated. In the West, the feared scenarios of widespread HIV prevalence did not materialize, treatment was widely available and the epidemic moved to the margins of society and into groups known as the "most at risk populations" (MARPs). In this paper, we argue that in terms of the MDGs, AIDS must still be seen as exceptional in the hyper-endemic countries. The numbers infected by AIDS, the consequent levels of mortality and morbidity, and the resulting demographic and social impacts warrant this status. AIDS is changing societies, preventing development gains and undermining efforts to meet the MDGs (Whiteside 2010).

AIDS and opportunistic infections linked to the virus are changing the structure of societies in hyper-endemic countries. By 2015, 6 million South Africans may have succumbed to AIDS—representing 13 per cent of the current population (UNAIDS and UNEP 2008). The Population Council (UN 2009) presents special tabulations using data from a 2009 UN Population Division report. It shows that by 2030 the percentage of AIDS-related deaths in the 15–59 age group in Botswana and South Africa will be 70–90 percent and for Uganda and Nigeria, between 20–30 per cent. Furthermore, by 2030, 14 per cent of deaths will be attributable to AIDS in the Sub-Saharan African region. The

UN Population Division (2005) has estimated that in the seven worst affected countries, AIDS will reduce life expectancy by 43 per cent between 2010 and 2015. And high rates of mortality amongst adults of reproductive age increasingly leave older people without caregivers, increasing dependency ratios (Kautz et al. 2010).

4. HIV and the MDGs

The focus of this paper is on three MDGs: gender equality, child mortality, and maternal health. In large part due to the HIV/AIDS epidemic, these goals might not be achieved. Through both direct and indirect mechanisms, progress on each MDG impacts positively on the others. As such, MDG-specific interventions should be constructed with awareness of their interconnection. Where the epidemic is exceptional, socio-economic systems are already fragile and AIDS is undermining progress towards the MDGs with startling force, and yet this is often not remarked upon.

It has been noted that while progress had been made in the human development indicators, Sub-Saharan Africa lags far behind on them and appears unlikely to reach, or even come close to reaching, its MDGs for 2015 (Hecht et al. 2006). The underlying threat to development and to the achievement of the MDGs in Sub-Saharan Africa is HIV/AIDS. By impacting upon performance in health, economic and social development, the epidemic limits progress in all of the MDGs. HIV/AIDS needs to be dealt with as part of every MDG (Alban and Andersen 2007). As noted in our literature review, this has generally not been recognised.

4.1 MDG 3: Gender equality and empowering women

The reality is that 60 per cent of infections in Sub-Saharan Africa occur in women, especially in younger women and girls (UNAIDS 2010). Women bear the brunt of the AIDS epidemic, impacting upon their economic and social opportunities and hindering their role as caretakers. This in turn has a detrimental impact on the well being of the family as a whole. Additionally, gender inequality and gender-based violence

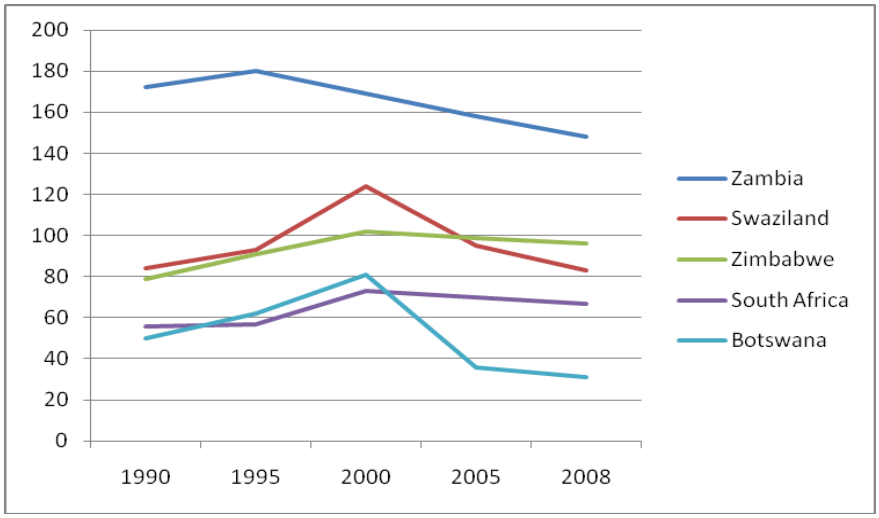
exacerbate those conditions in which the spread of HIV proliferates and increases individuals' risk of contracting the epidemic. Levels of illiteracy and limited financial independence aggravate the situation of women, particularly those living in poor rural areas of Sub-Saharan Africa. HIV/AIDS also places a high burden on grandmothers. Many have to care for and take in their grandchildren, shouldering a financial and social burden (Chazan 2008; Fourie and Schoeman 2010).

4.2 MDG 4: Reduce child mortality

Several high-prevalence countries in Sub-Saharan Africa are off-track in meeting MDG4. The negative impact of HIV/AIDS on child mortality is particularly relevant and acute in high-prevalence areas. According to one study, by 2015 up to 90 per cent of under-5 deaths in Botswana will be directly or indirectly caused by HIV/AIDS (Hecht et al. 2006). A number of studies have shown that children born to mothers with HIV are approximately three times more likely to die than children born to mothers not infected by HIV. The majority of HIV positive children acquired it perinatally and in 2004 it was estimated that about 60 per cent would die before their fifth birthday (Newell et al. 2004). This was in part because paediatric ARV formulations are few and their availability is poor. In five countries with adult HIV prevalence rates above 10 per cent (Zambia, South Africa, Zimbabwe, Botswana and Swaziland), under-5 mortality not only failed to decline between 1990 and 2003 but also actually increased (UNDP 2011). Figure 3 below represents trends for these countries, showing a changing landscape over the last two decades. With the spread of the epidemic, child mortality rates initially rose, peaking in the year 2000 in most countries. The explanation is that child mortality rates have begun to fall in Southern Africa in the last decade because of the rollout of PMTCT and ART.

Although this has resulted in a significant drop in child mortality, rates would be much lower overall without the epidemic's impact.

Figure 3: Child mortality in high HIV–prevalence countries of Sub-Saharan Africa



Source: UNDP HDI Indicators Database: http://hdr.undp.org/en/data/explorer/ (Accessed June 27 2011)

The epidemic worsens the nutritional status of children through macro and micro level links between child nutrition, food security, and HIV/AIDS (Hecht et al. 2006; Stillwaggon 2002). The epidemic impacts upon child health more broadly, as it erodes social safety nets in already resource-poor settings, increasing children's vulnerability when their parents become ill or pass away (Hecht et al. 2006). A range of socio-economic, medical and nutritional factors determines Child mortality. Thus, effective strategies for this MDG will be ones that recognise both the interdependence between all the MDGs and the impact of the AIDS epidemic on them.

4.3 MDG 5: Improve maternal health

It is estimated that AIDS is responsible for 18 per cent of maternal deaths globally. MDG 5, which seeks to reduce the maternal mortality ratio by three

quarters, has seen the least progress of all MDGs. The number of maternal deaths per 100,000 live births has in fact declined at a rate of 22 per cent, slower than needed to meet the 2015 reduction target of 75 per cent (UNAIDS 2010). However, it is difficult to establish the precise relationship between maternal mortality and HIV. In Botswana, which has a high HIV prevalence, mortality decreased sharply between 1990 and 1995. Zimbabwe, with a lower prevalence, nevertheless experienced a significant increase in maternal mortality ratio (MMR) per 100,000 live births.

The net increase in maternal mortality since 1990 in certain Sub-Saharan African countries should be cause for alarm as it indicates an actual reversal of past gains (Hogan et al. 2010). In high prevalence countries such as South Africa, HIV/AIDS is the leading cause in obstetrics maternal deaths (Alban and Andersen 2007). Miscarriage, anaemia, postpartum haemorrhages and puerperal sepsis are all complications which women with suppressed immune systems have a higher risk of being exposed to. Studies in Zimbabwe and Malawi suggest that the risk of pregnancy-related death is eight to nine times higher in women who are HIV positive than in others (Hecht et al. 2006). In addition, the epidemic increases the burden on national health systems in general. This erodes their capacity, restricting the availability of resources to respond to maternal health needs. There are links between AIDS prevalence and the erosion of health-care services in the areas of antenatal care, birth deliveries, and rates of immunization for children (Case and Paxson 2009).

4.4 Difficulty reaching the MDGs in Sub-Saharan Africa

The sections above outlined how the AIDS epidemic is preventing many sub-Saharan African countries from achieving specific MDGs. Development is a

long-term, complex process, and in many regions socio-economic systems are already strained and fragile. The addition of an epidemic that decimates the young population depletes the workforce and orphans children drastically altered population demographics. The increased burden on social safety nets due to the epidemic has been a major challenge to development in many regions.

The AIDS epidemic is not preventing the realization of the MDGs across the entire globe, but it is in parts of sub-Saharan Africa. This is happening where prevalence is high and/or in mid-prevalence regions that lack the capacity and resources to respond (Whiteside 2010). In these regions, achieving the MDGs will require additional efforts, with emphasis on their interdependence and focused use of resources to address the AIDS epidemic.

5. The global response to the AIDS epidemic

5.1 Overview

The mobilisation of targeted resources and political action around one specific disease was unprecedented in global health. The formation of UNAIDS in 1996 marked the first time in history that a UN program was dedicated to one disease. In 2000, the UN Security Council held a special session on HIV/AIDS; never before had a specific health condition been recognised as a threat to global development and security. In 2001, the UN General Assembly also convened a global first, a special session on HIV/AIDS that resulted in time-bound commitments from member states to strengthen AIDS responses globally (aids2031Consortium 2011). The second special session, held in New York, in early June 2011 refocused global attention on the epidemic.

In light of these ongoing challenges to global development, the establishment of UNAIDS 1996 recognised the severity of the threat posed by the epidemic to the future capacity of developing countries to participate more equitably in the global arena. UNAIDS plays three important roles. Firstly it has a crucial task in surveillance, interpreting and acting on changes in the location or direction of the epidemic. Secondly, it must be an advocate for marginal groups and correctly targeted funding; it should track funding to ensure it is used efficiently and effectively. Thirdly, UNAIDS should function as an information broker, producing the best possible information, and packaging it in accessible ways. Especially in resource-poor countries information needs to be distilled and policy implications need to be identified (Whiteside 2010). Understanding systemic inequality as a structural driver of the epidemic, the critical task for UNAIDS and other global bodies spearheading the response will be to support interventions that empower individuals, communities and national governments with the resources, autonomy and capacity to address the epidemic as they best see fit. After assessing research and best practices in the field, over the last decade UNAIDS has moved towards such a response, where behaviour change is understood as contingent on social change (UNAIDS 1999; Panos Institute, 2003).

In addition to international political mobilisation, the epidemic has reshaped global health financing architecture, a process with profound implications for strengthening governance and health systems in recipient countries. With the creation of the Global Fund to Fight AIDS, TB and Malaria in 2002, the establishment of the U.S. Presidential Emergency Programme for AIDS Relief (PEPFAR) in 2003 and the World Health Organisation (WHO)'s launch of the "3x5" campaign to get three million people on treatment by 2005, significant

global resources were devoted to fighting HIV/AIDS through both vertical and horizontal programming. The focused global effort to address the epidemic and its drivers recognises the need for an exceptional response to the situation.

The epidemic is complex. It is experienced differently across the globe, its impact being determined by a function of prevalence, demographics and the capacity of local governments to provide adequate prevention, treatment and care (Whiteside 2010). It is inextricably linked to socio-economic drivers and conditions, which themselves must be addressed as broader development foci. Understanding that drivers of the epidemic are multi-layered and multi-sectoral necessitates an equally complex and context-relevant response. The high-level bureaucratic nature of institutions coordinating the response maintains the existing geo-political and global economic framework, which in itself could be argued to be a driver of the epidemic (Bradbury and Clark 2009).

5.2 Why are we still failing to respond?

Despite significant progress in controlling the AIDS epidemic in parts of the world, in many areas of Sub-Saharan Africa prevalence and incidence remain high and populations are still ill equipped to deal with the overwhelming impacts of the epidemic (UNAIDS 2010). Thirty years into this devastating epidemic, as a global community we must ask ourselves where we have failed to intervene and how our responses have been inadequate. MDGs will not be met in parts of Sub-Saharan Africa and in these circumstances AIDS must be treated exceptionally.

Many lessons can be learned from the successes and failures of the global response to date. The general policy approach has been critiqued as too vertical and top-down, resulting in forms of global governance that have neither

strengthened health systems nor promoted development. Overlapping roles and responsibilities of agencies and key players have resulted in inefficient and redundant use of funding and resources (Bradbury and Clark 2009).

The heavy focus on technical and biomedical interventions without critical analysis of and action to address the epidemic's underlying structural drivers reinforces the current distribution of power and resources. Birn (2005) outlines concerns that private-public partnerships such as the Bill and Melinda Gates Foundation have negative consequences for global health governance, financing a response that could effectively address structural drivers such as socio-economic inequality. At the time of its inception, the Gates Foundation was endowed with USD 26 billion, a larger annual health budget than the WHO. With this kind of money, it undoubtedly influences the global health (and HIV/AIDS) research agenda. Birn's critique is that this private foundation with great influence has placed too much emphasis on technological solutions to health issues, turning to a "narrowly conceived understanding of health as the product of technical interventions divorced from economic, social and political contexts" (Birn 2005).

In contrast to the principles of Alma Ata, which encouraged community participation, empowering approaches to development and equitable distribution of resources, the dominant response to the epidemic has been promoting individual behaviour change without building the supportive enabling environments to facilitate it (Campbell 2003). From micro to macro levels, it is necessary to understand the contextual determinants of behaviour change and facilitate the institutional transformation needed to support empowering and responsive interventions to address the epidemic and its drivers.

6. What is needed in global governance, moving forward?

6.1 The current global context

> The microbe is nothing, the terrain, everything.
>
> —Louis Pasteur

In strategizing action around HIV/AIDS we must account for context. One critical factor is the long-wave nature of the epidemic itself, and the social and economic impacts it will have in regions where it is exceptional (Barnett and Whiteside 2006). The positive and negative effects of ongoing globalization in today's world must be considered in any strategy. For example, social networking technologies may offer new ways to mobilize community action and enhance knowledge sharing, but they can also facilitate risk behaviours such as sex work solicitation (aids 2031 Consortium 2011).

Ongoing and unforeseen effects of climate change will also have an impact on the social determinants of health (risk and vulnerability to HIV/AIDS). There are a number of pathways through which this could happen: drought and extreme weather events associated with climate change are expected to generate increasing numbers of climate change refugees, displacing the poor (and mainly rural) populations towards urban centres; ecological changes related to climate change may further degrade already fragile agricultural sectors, thereby worsening the well-documented effects of the epidemic on household food security and agricultural economies. Moreover, the increasing need to address the negative impacts of climate change may divert funding away from health systems and HIV/AIDS-specific programming (aids2031 Consortium 2011; Drimie and Casale 2009).

A major pathway through which climate change will impact upon the epidemic is through the distribution of infectious diseases that interact with AIDS, for example malaria. The increased burden of a disease such as malaria has implications for HIV transmission and vulnerability to AIDS at the physiological levels and to the capacity of national healthcare systems to cope with it (UNAIDS and UNEP 2008). This is not to suggest that climate change will increase the spread of HIV. But it will increase vulnerability, and, in areas where HIV is present, its incidence may rise. Armed with this knowledge, mitigation efforts may be put in place (Chazan, Brklacich and Whiteside, 2009).

As we write, the world is emerging from a global financial and economic crisis (which led to debt crises, rising deficits and subsequent budget cuts) that has made aid flows more unpredictable. Funding for HIV/AIDS in the coming years is likely to remain constant or decline, potentially jeopardizing the recent successful rollout of HIV treatment, along with that of many other HIV-related activities. It is important to acknowledge these contextual factors and the role(s) they play in shaping global policy and practice, as well as in influencing the micro-level environments where they are implemented.

We have outlined the devastating impact of the AIDS epidemic in parts of Sub-Saharan Africa. In short, the response to date has failed to address the underlying structural and social determinants of risk and vulnerability to the disease. As a result, MDG targets 3, 4 and 5 will not be achieved (Fourie and Schoeman 2010). The impact on the HIV response is clear. This signals that the MDGs should not be tackled in isolation from one another. Moving forward, both developing and developed countries must recognise and internalise the interconnectedness of the MDGs. Making progress on MDG 6 will allow us to work towards meeting the other MDGs and vice versa. We must look to future

data projections rather than adopting a reactive stance towards the epidemic. At the same time, we must not forget the importance of social determinants as obstacles to the MDGs; these cannot easily be changed using simple, one-time interventions.

Building on principles of an intersectoral approach and accounting for the current global context as outlined above, we recommend changes in two key aspects of global governance: what is prioritised and how it is prioritised. To effectively address the underlying structural factors of the AIDS epidemic, we need to re-evaluate the focus of the response and the process of how it is developed and implemented. When we can do this, as a global community we will be better able to support the development of resilient communities and contextually responsive HIV/AIDS-related interventions.

6.2 Shifting the foci of global governance: reorienting the prevention response

There is growing evidence that empowered community-led prevention strategies in HIV/AIDS (and other non-communicable diseases) are most likely to be successful (Campbell 2007; Gueye et al. 2005). We advocate a return to the principles of Alma Ata that emphasise health as a human right and a state of well being, not just as the absence of disease. Consistent with these principles, supporting community participation in primary health care will strengthen health systems, enhance community development, and build contextually appropriate programming for prevention and treatment of the disease.

We need to support communities and regional bodies to respond to the unique social determinants of risk and to the vulnerability of local populations. To do this, funding and partnerships are needed to address the short-term health and HIV/AIDS-specific needs. At the same time, global governance must

especially support economic development of severely affected nations so that local health financing becomes sustainable over the long term. The international community must prioritise and focus on countries where prevalence is higher than 10 per cent among the adult population. It must always remember that there are differentiated impacts of the epidemic on the MDGs.

6.3 Transforming the global governance for HIV/AIDS

As well as shifting the funding and prevention priorities, as highlighted above, the major institutions and actors involved in the global AIDS response must transform their structures and operating processes. Principles of self-determination and autonomy must embody the global HIV/AIDS response by increasing leadership and participation from the most severely affected countries. The global HIV/AIDS community must be more forward thinking, looking beyond its borders for ideas and challenges. It must be more creative when thinking about ways to make HIV/AIDS funding sustainable in the long run. We must devise innovative financing mechanisms to ensure that reaching the goal of universal treatment is financially sustainable. One idea is for the high-prevalence countries endowed with natural resources to ring-fence 10–15 per cent of revenues from such resources to finance ARVs (or other health-related goals) (Whiteside and Regondi 2011).

The HIV/AIDS community must be part of the movement calling for change in the existing international governance structures and financial arrangements. We need to learn from our mistakes and fight for a more stable and fair society, as uncertainty and instability affects vulnerable groups the most. This is particularly relevant with the experience of financial crisis. The most

marginalized members of society have felt cutbacks to global health financing most profoundly.

In an increasingly globalised economy operating within the unknown future effects of climate change, we cannot continue to support such dependence of some nations on others. Instead, we must encourage greater South-South cooperation and regional development. This could promote greater economic stability and resilience in the face of future changes to agricultural productivity related to climate change. As some members of the G20 gain prominence on the world stage and as their economies grow, their increased geopolitical weight becomes relevant, opening up opportunities for knowledge-sharing, development funds, cultural exchanges and greater ownership of the development process itself.

7. Conclusions

The AIDS epidemic is concentrated in the most marginalized populations across the globe. The evidence demonstrates the connections between risk and vulnerability to the disease and poor socio-economic conditions and inequality. We know the drivers of the epidemic, and we know what we need to do to address them. As a global HIV/AIDS community, we need to ask important questions about the political nature of the dominant response to the epidemic. We must support initiatives that empower communities to take control of the determinants of their own health and to ensure that the necessary infrastructure is in place to support such actions. Radical shifts in the distribution of power, financing and the valuing of knowledge originating from highly affected countries are prerequisites for these changes.

Promoting evidence-based interventions that address the underlying determinants of the epidemic through participation and social change is a long-term and intersectoral process. Participatory primary health care and HIV/AIDS initiatives can empower local governments, health workers and community leaders to address the relevant drivers and risk factors in their communities. Global health financing institutions must support local governments to define their own priority areas and strategies for action. In a post-colonial context, redistributing power in these partnerships is critical to ensuring contextually-appropriate (and thus more effective) interventions, and to supporting aid-recipient nations in broader processes of economic development.

It is unacceptable that thirty years into the AIDS epidemic, its impacts are still being so severely felt in the most marginalised populations and regions of the globe, particularly in Sub-Saharan Africa. We know what drives the epidemic and what needs to be done to address it, but we lack the political will to actually change things. Existing global governance and financing structures perpetually benefit the status quo and maintain the economic disadvantage of low- and middle-income countries. In some parts of Sub-Saharan Africa, the devastating impacts of the AIDS epidemic on the social and economic landscape have made the MDGs even more impossible to attain.

Despite these critiques, the MDGs and the structures of global governance that created them can change. Since institutions are comprised of nations, which themselves represent the communities of people who form the societies within them, they need not be static entities marching to the drum of antiquated notions of linear development and towards one, inevitable, Western ideal. Instead, global health governance can play a transformative role in altering the social conditions of the epidemic. The strength of global agreements such as the MDGs is that they

are a point of consensus amongst nations. Although such agreements risk loose generalizations about the issues, there is merit in nations coming together around their benchmarks. They can serve as starting points for the dialogue needed to effect change and to encourage transformative actions, from the level of the community through to geo-political frameworks.

Shifting the foci and processes of global governance for health to embody principles of equity and self-determination is critical to achieving the MDGs in Sub-Saharan Africa and to addressing the root drivers of the AIDS epidemic. Only when we have mobilised the global political will to support these social changes will we begin to see any real positive effects. The challenge to the international HIV/AIDS community is to take a stand for equity in global development as a prerequisite for getting the epidemic under control.

Works cited

aids2031 Consortium. (2011). *AIDS: Taking a Long-Term View*. Upper Saddle River, NJ: Pearson Education.

Alban, A., and M. Andersen. (2007). "HIV/AIDS' Spread and Impact on other Health-Related Millennium Development Goals." *Danish Medical Bulletin* 54 (2): 163-6.

Allen, T. (2004). "Introduction: Why Don't HIV/AIDS Policies Work?" *Journal of International Development* 16: 1123–1127.

Barnett, T., and A. Whiteside. (2006). *AIDS in the Twenty-First Century: Disease and Globalisation*. Basingstoke: Palgrave.

Birn, A.E. (2005). "Gates' Grandest Challenge: Transcending Technology as Public Health Ideology." *Lancet* 366: 514–19.

Bradbury, J., and J. Clark. (2009). "The Millennium Development Goalposts: Researching the Score on and off the Field." *Journal of Health Management* 11 (2): 391-404.

Campbell, C. (2003). *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail.* Cape Town, Indiana Press: James Curry.

Campbell, C., Y. Nair, and S. Maimane. (2007). "Building Contexts that Support Effective Community Responses to HIV/AIDS: A South African Case Study." *American Journal of Community Psychology* 39 (3–4): 347–363.

Case, A., and C. Paxson. (2009). *The Impact of the AIDS Pandemic on Health Services in Africa: Evidence from Demographic Health Surveys*. Princeton, NJ: Research Program in Development Studies and Centre for Health and Wellbeing, Princeton University.

Chazan, M. (2008). "Seven 'Deadly' Assumptions: Unravelling the Implications of HIV/AIDS among Grandmothers in South Africa and Beyond." *Ageing and Society* 28(7): 935-958.

Chazan, M., M. Brklacich, and A. Whiteside. (2009). **"**Rethinking the Conceptual Terrain of AIDS Scholarship: Lessons from Comparing 27 Years of AIDS and Climate Change Research." *Globalization and Health* (**5**) 12. doi:10.1186/1744-8603-5-12.

Drimie, S., and M. Casale. (2009). "Multiple Stressors in Southern Africa: The Link between HIV/AIDS, Food Insecurity, Poverty and Children's Vulnerability Now and In the Future." *AIDS Care* **21**(S1): 21–26.

Flow Communications. (2008). *Community Conversations: Enhancing Communities' Capacity to Respond to HIV/AIDS*. Johannesburg: Flow Communications, Nelson Mandela Foundation.

Fourie, D.J., and R.E. Schoeman. (2010). "The Effects of HIV/AIDS on the Achievement of the Millennium Development Goals in Sub-Saharan Africa." *Journal of Public Administration* 45 (1.1): 236-260.

Global Health Watch. (2008). "From Alma Ata to the Global Fund: The History of International Health Policy." *Social Medicine* 3 (1): 36–48.

Gueye, M., D. Diouf, et al. (2005). *Community Capacity Enhancement Strategy Note: The Answer Lies Within*. New York. UNDP, HIV/AIDS Group, Bureau for Development Policy.

Hecht, R., A. Alban, et al. (2006). "Putting It Together: AIDS and the Millennium Development Goals." *PLoS Medicine* 3(11): 1992–1998.

Hogan, M.C., K.J. Foreman, et al. (2010). "Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5." *The Lancet* 375: 1609–1623.

Kallings, L.O. (2008). "The First Postmodern Pandemic: 25 Years of HIV/AIDS." *Journal of Internal Medicine* 263: 218–243.

Kautz T., E. Bendavid, J. Bhattacharya, and G. Miller (2010). "AIDS and Declining Support for Dependent Elderly People in Africa: Retrospective Analysis Using Demographic and Health Surveys." *British Medical Journal* 340. doi: 10.1136/bmj.c2841

Kim, J., B. Lutz, M. Dhaliwal, and J. O'Malley (2011). "The 'AIDS and MDGs' Approach: What is it, Why does it Matter, and How Do We Take it Forward?" *Third World Quarterly* 321 (1): 141–163.

Kumar, M., and E. Burman. (2009). "Editorial." *Journal of Health Management* 11 (1): 1–14.

Labonte, R., and R. Torgerson. (2005). "Interrogating Globalization, Health and Development: Towards a Comprehensive Framework for Research, Policy and Political Action." *Critical Public Health* 15 (2): 167–170.

Millennium Indicators Database: http://mdgs.un.org/unsd/mdg/. Accessed 23 June 2011.

Newell, M., H. Brahmbhatt, et al. (2004). "Child Mortality and HIV Infection in Africa: A Review." *AIDS* 18 (Suppl. 2): 7–34.

Nutbeam, D., and E. Harris (2005). *Theory in a Nutshell: A Practical Guide to Health Promotion Theories*. North Ryde, NSW: McGraw-Hill.

Panos Institute. (2003). *Missing the Message? 20 Years of Learning from HIV/AIDS*. London: Panos Institute.

Smith, J., and A. Whiteside. (2010). "The History of AIDS Exceptionalism." *Journal of the International AIDS Society* 13 (47). doi:10.1186/1758-2652-13-47

Stillwaggon, E. (2002). "HIV/AIDS in Africa: Fertile Terrain." *Journal of Development Studies* 38: 1–22.

UN. (2000). *World Population Prospects: The 2008 Revision* (CD ROM), ST/ESA/SER.A/283. New York: United Nations Department of Social and Economic Affairs.

UN Millennium Project 2005. Halving hunger: it can be done. Task Force on Hunger. London and Sterling, VA: Earthscan Publications, 2005

UN Population Division. (2009) *World Population Prospects: The 2008 Revision* (CD ROM), ST/ESA/SER.A/283. New York, United Nations Department of Social and Economic Affairs.

UN Population Division. (2005) *Population, development and HIV/AIDS with particular emphasis on poverty: The concise report*. New York, United Nations Department of Social and Economic Affairs.

UNAIDS. (1999). *A Communications Framework for HIV/AIDS: A New Direction*. Geneva: UNAIDS and Penn State University Press Joint Publication.

UNAIDS. (2010). *UNAIDS Report on the Global Epidemic 2010*. New York.

UNAIDS, and UNEP. (2008). *Climate Change AIDS: A Joint Working Paper*. Nairobi, Kenya: UNAIDS and UNEP Joint Publication.

UNDP. (2011). Human Development Indicators Database. UNDP. Online database: http://hdr.undp.org/en/data/explorer/ (Accessed June 27 2011)

UNDP. (2005). *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals—Overview*. UN Millennium Project. New York: United Nations Development Program**:** 74.

Vandemoortele, J. (2002). *MDGs: 10 Frequently Asked Questions*. Cairo: WHO—Regional Office for the Eastern Mediterranean. Online resource: http://www.emro.who.int/cah/mdg-about.htm

Walley, J., J.E. Lawin, et al. (2008). "Alma-Ata: Rebirth and Revision 8, Primary Health Care: Making Alma-Ata a Reality." *The Lancet* 372 (9642): 1001-1007.

Whiteside, A. (2010). *Is AIDS Exceptional?* Programmatic Response Working Group, Aids2031. Working Paper.

Whiteside, A., G. George, et al. (2003). "Through a Glass Darkly: Data and Uncertainty in the AIDS Debate." *Developing World Bioethics* 3 (1): 49-76.

Whiteside, A., and I. Regondi. (2011). MDG Taskforce Global Poverty Summit: MDGs and HIV/AIDS: http://www.povertydialogue.org/2011/01/27-mdgs-and-hiv-aids/. Accessed 24 June 2011.