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1. The Causes of the Global HIV/AIDS Epidemic

i) Origin of HIV/AIDS

HIV/AIDS was first recognized as a medical condition in the early 1980s, although it is now known that symptoms resembling the '*human immunodeficiency virus*' (HIV) that causes the '*acquired immune deficiency syndrome*' (AIDS) had been recorded by researchers as early as the 1950s.[1] In October 2008, the scientific magazine, *Nature*, carried an article in which it was reported that researchers in 1998 had isolated the HIV-1 sequences from a blood sample taken in 1959 from an African woman in Leopoldville (now Kinshasa), the capital of Zaire (now Democratic Republic of the Congo – DRC), implying that the virus has been around for at least 50 years.[2] Many uncertainties and conspiracy theories surround the origin of its HIV/AIDS and the evolution of the disease into a global epidemic: one 'theory' was that that the virus had originated from African monkeys and transferred to humans apparently through consumption of monkey meat; another was that the virus 'escaped' accidentally during experimentation on chimpanzees by American scientists working on an oral polio vaccine project in the DRC.

The earliest cases of AIDS were reported in the United States in 1981 when doctors noticed cases of an extremely rare disease linked to immune deficiency syndrome among homosexual men in the 'gay' communities mainly in New

[1] See John Iliffe (2006), *The African AIDS Epidemic: A History* (Oxford: James Currey) for a good account of the origin and earliest evidence of HIV in Africa.

[2] Heidi Ledford (2008) "Tissue sample suggests that HIV has been infecting humans for a century: 48 year-old lymph node biopsy reveals the history of deadly virus", *Nature News*, published online 1 October 2008 at www.nature.com/news/2008/081001/full/new.2008.1143.html

York and San Francisco. The first official report of this particular health condition was recorded in the weekly journal of the U.S Centers for Disease Control and Prevention (CDC) in June 1981.[3] Similar cases were later identified by U.S. doctors among other groups, mainly hemophiliacs and recipients of blood transfusion, and later among injecting drug users who shared needles. By then, it was apparent that immune deficiency syndrome was not restricted to gay men: previously labeled 'Gay-Related Immune Deficiency Syndrome (GRID), the disease was renamed 'Acquired Immunodeficiency Syndrome' (AIDS) by the CDC in 1982. In 1983, HIV was identified as the possible cause of AIDS, and by the mid 1980s, it was possible to test for the virus with reasonable accuracy.

Upon reading the June 1981 CDC report, some doctors in Belgium and France realized that they had encountered similar conditions among patients in central and western African countries since the mid 1970s. It was in Zaire in the early 1980s that the epidemiology of the heterosexual foundation of HIV/AIDS was first determined, laying the foundation for a generalized pattern of the epidemic that was to spread throughout Africa and beyond with devastating effects. A team of Western doctors, including Peter Piot from Belgium (who later became the first executive director of UNAIDS), had visited a hospital in Kinshasa in October 1983 to follow up on reports about an immune dysfunctional disease affecting men and women equally. The team reported their observations about the occurrence of AIDS among heterosexuals in Africa to medical institutions in the United States and Europe, and initial reactions ranged from suspicion to disbelief. It took quite some time to convince Western medical establishments

[3] CDC, "Pneumocystis pneumonia", *Morbidity and Mortality Weekly Report (MMWR)* 3:21(5 June 1981):250

about the validity of AIDS among heterosexual, and for the CDC to eventually agree to fund a research project, 'Projet SIDA' which was launched in Kinshasa in June 1984. The project was led by an American public health specialist, Jonathan Mann, who later became the first director of the WHO's Global Programme on AIDS (GPA) in Geneva.

ii) Initial response to HIV/AIDS by the international system

The initial response to HIV/AIDS by the World Health Organisation (WHO) was slow. Despite reports in the early 1980s of HIV infection cases by African member states, including statements by health ministers from the region at the annual World Health Assembly, the global health agency continued for some time to acknowledge the existence of HIV/AIDS as a new disease among specific groups in rich countries. Reports of HIV/AIDS among the general population in Africa were perceived as cases of sexually transmitted infections, and referred to a small unit at the WHO's headquarters in Geneva that dealt with this condition. It was much later in 1987 that WHO came up with an official determination of the cause of AIDS and acknowledged the disease as a major public health concern.[4] Before then, WHO had only cautiously endorsed separate research findings by two Western scientists, Dr. Luc Montagnier of the Pasteur Institute in France and Dr. Robert Gallo on the National Institutes of Health in the United States, around 1984 which confirmed that AIDS was caused by a retro-virus, HIV, and that the main modes of transmission were blood and semen. Until the mid-1980s, the WHO's role in addressing HIV/AIDS was essentially that of monitoring developments in member states,

[4] WHO, 'World Health Assembly Resolution of May 1987' in *Resolutions and decisions of the World Health Assembly and the Executive Board*, 3rd edition, 185-92 (Geneva: WHO).

reporting and sharing information on outbreaks, and providing guidance to countries on how to minimize the risk of infection.

By continuing to regard HIV/AIDS as a health problem of rich countries which could afford to respond effectively to the disease, the WHO missed the initial opportunity to act against the rapid spread of the epidemic in Africa and also in the Caribbean and to contain its explosion into a global problem. As we now know, failure by the international health community to appreciate the scale and potential catastrophe of HIV/AIDS, and delay in the emergence of a coordinated global response by the international system, was to have grave and profound consequences worldwide.

Furthermore, from what we now know about the epidemiology of HIV/AIDS, it is obvious that we are confronted with a global epidemic for which there is no known cure or a successful vaccine against the virus. The destructive consequences of HIV/AIDS in terms of mortality and morbidity and impact on future generations have resulted in one of the worst humanitarian tragedies in the history of public health, as well as a major development challenge for some of the poorest countries in the world. From the experience so far of efforts to combat the HIV/AIDS epidemic, it has become clear that an effective response would require a *multi-sectoral* approach that transcends the domain of health. Such an approach implies multiple efforts by the major stakeholders at all levels – governments, donors, international and regional organizations, local authorities, the private sector, civil society and, last but not least, the people living with HIV/AIDS (PLWHA) themselves.

iii) The impact of globalization on the spread and control of HIV/AIDS

It can be argued that the current phase of *globalization* of the world economy has influenced both the spread and control of the global HIV/AIDS epidemic. Growing interdependence of economic interests between countries and the era of budget travel bought about by globalization have resulted in large increases in the movement of people and the pathogens they carry across international borders. This, in turn, facilitates the global transmission of infectious diseases and epidemics such as HIV/AIDS and the current outbreak of swine flu. In a world of unequal partners, globalization does not seem to be benefiting poor countries with marginalized economies – many of which are seriously affected by HIV/AIDS, This situation , to some extent, has been attributed to the management of globalization which is based mainly on decisions taken in key global economic institutions like the International Monetary Fund (IMF), World Bank and the World Trade Organisation (WTO) which are controlled by a handful of powerful countries from the North. For many poor and marginalized countries of the South, the outcomes of globalization as currently managed have resulted in anxieties rather than expectations and in global risks rather than global opportunities. HIV/AIDS has increased these anxieties and risks, at the same time as the adverse effects of globalization on economic growth and employment opportunities have limited the capacity of poor countries to confront the threat of HIV/AIDS on their economies and populations. While globalization has created opportunities for technological advances leading to the accelerated development of life-extending drugs and advanced therapies to tackle HIV/AIDS and other infectious diseases, poor and marginalized countries are less likely to benefit from such breakthroughs.

Analysis of the global response to HIV/AIDS from the perspective of global governance has highlighted the imbalances and tensions in the power relationship between the North and the South.[5] The South includes some of the poorest countries in the developing world which are also highly affected by the HIV/AIDS epidemic, but with limited resources to deal with the problem. In contrast, the North is made up of the developed and rich industrialized countries that have the resources and knowledge to ensure an effective global response, but are less affected by HIV/AIDS.

Attention therefore should be focused on the conditions and requirements for better management of globalization and arriving at fairer outcomes of the process in terms greater economic well-being and social justice for all. The market-driven process of globalization should be made more conducive to a more egalitarian style of economic development and a more broad-based pattern of social development. This would also require improved global governance of multilateral institutions, as is discussed in the last section of this paper.

iv) The link between HIV/AIDS and poverty

There is a two-way *causative* relationship between HIV/AIDS and poverty. *HIV/AIDS* can cause poverty at the household level, through loss of productive capacity and earnings due to illness or death and through

[5] See Franklyn Lisk (2008) "Towards a new architecture of global governance for responding to the HIV/AIDS epidemic" in *Worlds apart? Exploring the interface between governance and diplomacy* (eds.) Andrew Cooper et al. (Palgrave Macmillan); also Franklyn Lisk (2009) *Global institutions and the HIV/AIDS epidemic: Responding to an international crisis* (Routeldge)

additional expenditure on treatment and care of AIDS. *Poverty* can cause HIV to spread, such as when lack of income 'drives' women and girls to engage in risky transactional sex with multiple partners, and can cause needless deaths from AIDS through inability to afford the cost of treatment.[6] In sub-Saharan Africa where poverty is widespread, the adverse effects of HIV/AIDS on productive capacities and income-earning opportunities is making poor households become even poorer, and increasing poverty is in turn contributing to greater risk of infection and the spread of HIV. Poverty conditions also act as a constraint on effective response to the epidemic at national level. Low-income and resource-poor countries are likely to be less effective in responding to the threat posed by HIV/AIDS to their economies and populations than the rich industrialized countries. At the same time, failure to reduce poverty impedes progress in HIV/AIDS treatment and prevention programmes.

Understanding the bi-directional relationship between HIV/AIDS and poverty is critical to any global strategy for combating the global epidemic and its impact at all levels. The manifestations of poverty in unsustainable livelihoods and constraints on socio-economic development drive the poorer segments of the population towards higher risks of HIV infection, and leave resource-poor countries with reduced capacity to take action against the epidemic. Failure to effectively respond to HIV/AIDS undermines efforts to reduce poverty. Not surprisingly, the United Nations has identified the HIV/AIDS epidemic as a major obstacle to the achievement of the

[6] See Franklyn Lisk and Desmond Cohen, "Regional Responses to HIV/AIDS: A Global Public Goods Approach" in Poku, et al (eds.) *AIDS and Governance*, op. cit. for an analysis of the link between HIV/AIDS and poverty in Africa.

Millennium Development Goals (MDGs) which are time-bound targets established in 2000 to halve extreme poverty worldwide by 2015.

2. The Contours of the Global HIV/AIDS Epidemic

i) The 'exceptionality' of HIV/AIDS

HIV/AIDS has killed at least 25 million people worldwide since it was diagnosed as a generalized epidemic in the early 1980s. More worrying, is the fact that HIV/AIDS has continued as a killer epidemic for more than a quarter century and with no sign of abating; the '*longevity*' of HIV/AIDS is without precedence in the history of global public health. The epidemic has aptly been described by one expert as a "long wave event whose path is not easy to predict".[7] This makes HIV/AIDS '*exceptional*' and different from previous global epidemics or more threatening than recent outbreaks of deadly infectious diseases with the potential of a global epidemic , such as Ebola fever, the SARS epidemic, the avian flu and, currently, the swine flu.

Unlike other past and recent global epidemics, HIV/AIDS has been around as visible epidemic for nearly three decades without interruption, This is a considerably long period for the persistence of a single epidemic condition, and one with no sign of being brought under control, despite unprecedented international attention and substantial financial resources that HIV/AIDS prevention and treatment have received and continue to attract. Human behaviour plays an *exceptionally* important role in the spread of HIV/AIDS

[7] Tony Barnett, (2007) "HIV/AIDS, A Long Wave Event: Sundering the Intergenerational Bond" in Nana Poku, Alan Whiteside and Bjorg Sandkjaer (eds.), *AIDS and Governance*, (Aldershot: Ashgate)

compared to other health problems or medical conditions. In the absence of a cure or a vaccine, the prevention of HIV and the control of its spread depend crucially on the responsibility of individuals not to put themselves and others at risk of infection.

The *exceptionality* of HIV/AIDS is also linked to the *multi-dimensional* characteristic of the epidemic. HIV/AIDS has profound and lasting non-health implications which include negative impact on development and threat to human and national security. In addition, the impact of HIV/AIDS on individuals and societies has given rise to complex legal and ethical issues that are linked to stigma and discrimination directed at sufferers of the disease and consequent violations of fundamental human rights principles. This multi-dimensional characteristic of HIV/AIDS, and the severity and longevity of its impact, have made the disease become ever more complex in terms of volatility, instability and dynamism and, hence, more difficult to contain.

HIV/AIDS has spread worldwide and evolved into global epidemic. According to the latest available statistics provided by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO, an estimated 33.2 million men, women and children worldwide are infected with HIV. Sub-Saharan Africa bears the brunt of the burden of the global HIV/AIDS epidemic: with just over 12 percent of the world's population, the region is nevertheless home to about two-thirds of the total number of persons infected with HIV worldwide, and accounts for nearly three-quarters of the global total of known AIDS-related mortality.[8]

[8] UNAIDS and WHO, *AIDS Epidemic Update, December 2007* (Geneva: UNAIDS, December 2007); UNAIDS, *2008 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, August 2008); UNAIDS, *AIDS Outlook/09* (Geneva: UNAIDS, November 2008)

Many Africans already infected with HIV and who do not have access o adequate treatment and care will certainly die from AIDS-related illnesses within he next 10 years, even if a cure for the disease were to be found now, Although there is now treatment for AIDS that can prolong the lives of those infected with the virus, access to such treatment on a sustainable basis is still beyond the reach of the vast majority of HIV-positive people in low-income countries.

Equally worrying, from the perspective of Africa's future and long-term development, is the fact that an estimated 15 million children in the region are orphans due to the loss of their parents to AIDS. Many f these are deprived of adult support and guidance for their development, and often left to fend for themselves under hazardous and risky conditions. In addition, about 700,000 babies in the region are born infected with HIV each year; this is altogether an unacceptable situation created by lack of access to existing medicines for preventing transmission of the virus from mother to child. The consequences of the impact HIV/AIDS on children and infants are to inter-generational deficits in future human capital requirements for sustainable development.

The significance of HIV/AIDS and its impact goes beyond the grim statistics presented above. HIV/AIDS is a unique epidemic with *exceptional* characteristics which amplify its impact on human well-being now and the threat it poses to human development in the future. The demographic, economic and social impacts of HIV/AIDS multiply from an infected individual to human groups – couples, families, households – leading to: rising infant, child and

adult mortality and plummeting life expectancy at birth;[9] destruction of livelihoods and increasing impoverishment; and disruption in the social structure of households and communities.

A distinct and again worrying feature of HIV/AIDS is the fact that the majority of those affected by the disease are from the working-age population. The disease disproportionately affects those in the prime of their productive lives who have critical economic and social roles in society. Given the very high mortality rates associated with HIV infection in developing countries, the economic and social consequences of AIDS-related deaths at household and national levels are bound to affect progress and sustainability of human and national development. Many poor countries are already incurring huge additional expenses to cope with the losses in labour productivity and national output caused by AIDS-related morbidity and mortality. The epidemic dissipates existing stocks of human capital and imposes huge strains on already limited national budgets. The impact of the epidemic on human capital constitutes a major *development challenge* for resource-poor, low-income developing countries, and further compounds existing challenges of poverty and underdevelopment. With no known cure for AIDS or a successful vaccine against HIV infection, the HIV/AIDS epidemic has the potential to change the course of global development in terms of the gap between rich and poor countries. This is on account of the differentiated impact of the epidemic between the global North and the global South, with respect to demographic

[9] AIDS has reduced life expectancy in sub-Saharan Africa from an average of 55-60 years at the start of the 1980s to 40-45 years in 2005, according to WHO/UNAIDS estimates.

parameters and socio-economic conditions, including the severing of vital connections between one generation and another.

In addition, as already noted, the impact of HIV/AIDS on individual and human groups has given rise to complex ethical, security, gender equality and human rights issues that need to be addressed. HIV-related discrimination is a violation of basic human rights and a breach of the fundamental principle of non-discrimination and the equality of all people, as enshrined in the Universal Declaration of Human Rights of 1948 and other human rights instruments. Human rights violations linked to HIV/AIDS are particularly serious in the context of the 'world of work' in terms of access to employment and income-earning opportunities.[10] There are also human rights implications with respect to the impact of the epidemic on vulnerable groups such as women, children and migrants which compound existing problems of discrimination, xenophobia and gender inequality.

ii) The "internationalization" of HIV/AIDS

The substantial attention given to HIV/AIDS on the international agenda in recent years has resulted in some of the biggest vertical programmes in the history of public health and healthcare focused on a single disease. Over he past decade, two well-resourced, specialized global institutions, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), have been established to bolster the global effort against HIV/AIDS. International partnerships involving private sector organizations and philanthropic foundations, such as the Global

[10] See Franklyn Lisk (2007) "A rights-based approach to addressing HIV/AIDS in the workplace: The Role and contribution of the ILO and its tripartite constituents", *Law, Social Justice and Global Development* 2007(1)

Business Coalition on HIV/AIDS and the Bill and Melinda Gates Foundation, are now major contributors to the global HIV/AIDS response. Global advocacy bodies, such as the International AIDS Society and the International AIDS Alliance have been created to promote and coordinate HIV/AIDS policy and action programmes, including lobbying for reduction in the costs of antiretroviral drugs. The World Bank has created special flexible and concessionary facilities o increase access of poor countries to financial resources for addressing HIV/AIDS. Since 2001, the UN General Assembly has convened a number of special sessions and high-level meetings devoted exclusively to HIV/AIDS, including summits of heads of states ad governments. One of the 8 Millennium Development Goals set by the UN Millennium Summit in 2000 concerns the control and reversal of the spread of HI/AIDS.

HIV/AIDS is today prominent on the international agenda. This is reflected in declarations by the UN and the international community to take action against the epidemic, such as the Millennium Declaration (2000), the UNGASS Declaration of Commitment on HIV/AIDS (2001), the Political Declaration of the UN High-level Meeting on HIV/AIDS (2006), and recent G8 summit communiqué (2005, 2007, 2008). Concerns about the security implications of the global HIV/AIDS epidemic at the international level resulted in the historic debate on HIV/AIDS at he UN Security Council in January 2000, when for the first time a health issue was discussed at the Council. In addition, a number of initiatives and partnerships have emerged on the international scene specifically to help mobilize resources and provide technical assistance to countries for a strengthened and effective HIV/AIDS response. Funding from various sources for the global HIV/AIDS response has skyrocketed from US$300 million in 1996 to nearly US$ 10 billion in

2008. No other single global health problem or international humanitarian concern has received so much attention of financial resources from the world community.

The UN and the international donor community are largely in agreement on the need for more resources to address the daunting multiple challenges of the global HIV/AIDS epidemic. There has been an upsurge in international cooperation among rich and poor countries to support the global HIV/AIDS response. This has resulted in external transfers and subsidies from richer countries to fund HIV/AIDS responses in resource-poor and low-income countries, primarily because the epidemic is seen as a global threat. Mobilizing international support to control the spread of the global HIV/AIDS epidemic should be seen as a cost-effective investment on the part of rich countries, while at the same time could yield benefits to those poor countries facing deep and intractable development challenges due to the impact of HIV/AIDS.

3. The Multi-sectoral Response to HIV/AIDS

i) More than a health issue

The HIV/AIDS experience and lessons so far from initiatives and programmes to combat the epidemic at all levels clearly indicate that an effective response has to be grounded on a multi-sectoral approach, and supported by a broad-based cooperative effort involving multiple stakeholders including those infected and suffering from the diseases. This is a multi-dimensional task that requires the expertise of policy-makers from other sectors in addition to health. The non-medical dimensions of the epidemic include not only social and economic impact, but also culture, religion, human rights and politics. Because

of this multi- sectoral characteristic of HIV/AIDS, the response at the global level through the United Nations apparatus has avoided the usual single specialized agency/mandate model and opted instead for a *joint and co-sponsored* programme, the '*Joint United Nations Programme on HIV/AIDS' (UNAIDS)*, that involves the participation of several individual UN agencies (WHO, ILO, UNDP, UNESCO, WFP, UNFPA, UNODC, UNHCR, UNICEF and the World Bank) that collectively are perceived to be capable of responding adequately to the totality of the multiple problems and possible solutions to HIV/AIDS. The emerging consensus of the international community at the time of the establishment of UNAIDS by an ECOSOC resolution - following the demise of the WHO's Global Programme on AIDS (GPA) due among other things, to inter-agency rivalries – was that the coordination of the global response needed collective action by multiple stakeholders, based on the recognition of the multi-dimensional nature of the epidemic and its impact.

ii) 'Universal Access': The political economy of Prevention versus Treatment

At the June 2006 UN General Assembly High-Level Meeting on HIV/AIDS in New York, member states made a commitment to achieve as close as possible the goal of '*Universal Access'* to HIV/AIDS prevention, treatment, care and support by 2010. This commitment implies a comprehensive response to the epidemic, and brings into focus the 'choice' between *prevention* and *treatment* that many low-income countries may be faced with in the allocation of scarce financial and human resources for HIV/AIDS response. Prevention and treatment are two vital interventions of universal

access and essential components of a comprehensive and effective HIV/AIDS response package, which makes the decision all the more critical.

From the perspective of developing countries faced with this choice, it is important to understand how national political and economic systems affect the distribution and general quality of the health-enhancing HIV/AIDS services and interventions. This is particularly relevant to the important decision that national authorities have to take with respect to allocation of resources between 'alternative' needs. In a scenario of limited resources, and applying a neo-liberal economic model, this could involve a choice, or an *'either or'* decision based on market efficiency. But taking into account the MDG objective to control and reverse the spread of HIV/AIDS and its impact on development, and given the exceptional characteristics of the HIV/AIDS epidemic, we need to balance the human and economic benefits of life-prolonging treatment with the additional costs of providing such treatment in perpetuity (in the absence of a cure for AIDS), on the one hand ; and the economic and welfare gains of prevention through controlling and keeping down the number of new HIV infections with the future healthcare costs that arise from new infections, on the other, In this regard, it is important to understand and acknowledge some of the basic political economy forces that underline the economic, social and moral implications of the HIV/AIDS epidemic, as well as appreciate what it will mean for humanity if we make the wrong decision on the balance between prevention and treatment in addressing the challenges of HIV/AIDS.

The imperative of prevention

A strong case can be made to invest in HIV prevention as a priority in national response programmes, given that the incidence of new HIV infections annually adds to the existing HIV/AIDS burden which for many highly-affected and poor developing countries is already substantial and unaffordable. Failure to address prevention could augment the aggregate cost of treatment in the future and prolong the epidemic. Unfortunately, the tremendous attention given to treatment with the advent of antiretroviral (ARV) drugs and progressive reduction in the costs of these drugs in recent years has tended to divert attention and resources away from prevention efforts and in favour of treatment initiatives. This is particularly worrying, since there is no clear evidence that the coverage of treatment as currently offered in Africa, for example, is achieving a significant measure of success in the sense of bringing the epidemic under control. As Peter Piot, former executive head of UNAIDS, pointed out in support of boosting prevention efforts in HIV/AIDS response: "There are six new infections [globally] for every person receiving treatment,…[therefore] treatment is not going to stop this epidemic"[11].

The World Bank, in the context of its own HIV/AIDS response initiative, is in no doubt about the importance of prevention in a comprehensive response to the epidemic: "Preventing new infections should remain the highest priority for all countries – at all prevalence levels".[12] The World Bank has long affirmed that prevention and treatment should be seen as linked, and not as separate and competing interventions: "The more successful countries

[11] Cited in an article " Politics worries UNAIDS official as much as virus" by Sabin Russell in the *San Francisco Chronicle*, May 9, 2007

[12] World Bank, *Global HIV/AIDS Program of Action* (Washington DC, August 2005)

are at preventing new infections, the more feasible they will find it to provide treatment and care for those who are infected".[13] Hence, the World Bank has provided resources to several African countries to design and implement carefully planned prevention interventions, including investment in health and education systems and support for local-level and community-based life style and behaviour change initiatives targeted at vulnerable groups.

It is worth pointing out, however, that expanding and sustaining effective prevention initiatives would require efforts that go beyond risk-reducing routine condom use and public education. Attention should also be paid to structural and cultural factors which increase vulnerability to HIV infection in different societies; in Africa, for example, these include unequal gender norms and relations, traditional values and beliefs, and the absence of vital and practical legal and policy frameworks for addressing HIV-related stigma and discrimination which could lead to violations of fundamental human rights.

The need to scale-up and sustain treatment

In the absence of a known cure for a deadly disease like HIV/AIDS, access to life-prolonging ARV therapy is the next best option for mitigating the impact on those infected, their families and communities. The vast majority of those in need of HIV/AIDS treatment in sub-Saharan Africa are not currently covered, largely because most governments in the region cannot afford the huge costs and logistics of assuring universal access to treatment.

[13] Ibid.

Level of treatment is estimated at less than 10 per cent of the total number of HIV/AIDS cases in the region, not even taking into account the incidence of new infections which has still not been brought under control. Delivering on the commitment on universal access to treatment is bound to be costly for low-income countries, taking into account that treatment will be life-long and that ARV drugs are constantly changing. Scaling up and expanding the availability of more effective ARV therapy in those countries will require predictable and sustained sources of finance to purchase drugs and to strengthen weak and over-burdened health services. Even then, the issue of equitable access to the latest ARV drugs adapted for income levels and living conditions in resource-poor settings is likely to remains a challenge for developing countries.

The availability of lower-priced generic medicines which would allow HIV/AIDS patients in poor countries to have access to treatment is central to affordability and equitable access. WTO agreements on protection of patents had been a major obstacle to the production and marketing of cheaper generic copies of ARV drugs. The most important agreement in this regard is the one on “Trade-Related Aspects of Intellectual Property Rights” (TRIPS) which took effect in January 1995, originally providing patent protection for pharmaceutical products for at least 20 years. While the Doha Declaration, which was adopted by the WTO in 2001, introduced flexibility to the TRIPS agreement including rights of member states to grant compulsory licenses for manufacturing and export of generics to address public health crises and national emergencies, most developing countries and particularly those seriously affected by the epidemic have not been able

to make effective use of compulsory licensing under the amended TRIPS due to lack of knowledge and resources. Furthermore, while progress has been made in driving down prices of certain ARV drugs, the availability f new and more effective next-generation medicines for treatment of AIDS and other opportunistic diseases s still a challenge for developing countries which lack the resources and technology to carry ut the necessary R&D. There are concerns that Western pharmaceutical companies may be less inclined o undertake R&D on new drugs for treatment of global diseases found mainly in developing countries, if they cannot be protected by and derive benefits from patent rights.

'Best Practice': Lessons from the Australian HIV/AIDS response

It is significant, being here in Perth, to single out **Australia** as a country that has been able to keep its HIV infection rate very low compared to other developed countries, precisely because it has developed and sustained a comprehensive response to the epidemic that included all aspects of the problem, including the urgency of the need to control and prevent the spread of the virus in the first instance. The spread of the virus has been contained in Australia because, as one observer who has been involved in Australian HIV/AIDS policy from the beginning puts it, "people made simple changes to risky behaviours, persuaded to do so by the timely mass distribution of honest and useful information about the nature of the virus and how its transmission from person to person can be prevented".[14] The Australian strategy has been to focus on the specific problem of preventing the

[14] Bill Botwell (2007) "Applying the paradox of prevention: Eradicating HIV" in *Griffith REVIEW Edition 17; Staying Alive*, Griffith University

transmission of HIV through practical and pragmatic methods, rather than "waging a war" against the human and social causes and consequences of the problem.

The Australian response to HIV/AIDS seems to have worked well. In 1982 when the virus was first reported in Australia, the country had roughly comparable rates of HIV infections and AIDS with the USA. Today, Australia's HIV prevalence rate is about 75 per thousand, compared with over 400 per thousand in the USA; while less than 30,000 persons are living with HIV in Australia, the corresponding figure for the USA is well over a million. Australia's incidence of AIDS per thousand is under 1.5 compared with about 15 per hundred thousand in the USA. Since AIDS was first diagnosed, about 7000 Australians have died from the disease compared with over 300,000 in the USA. Back in the mid-1980's, the Australian government adopted a comprehensive package that included prevention policies that were radically different from the fringe and extreme policies adopted in the USA that demonized the virus as "the wages of sin". For a long time, the US authorities refused to implement a policy of needle exchanges to provide injecting drug users with uninfected equipment, or to promote national sex education campaigns and endorse condom distribution. In contrast, the Australian government made use of graphic TV commercials and national campaigns to bring home to the entire population the hazard and multi-dimensional character of HIV/AIDS, and the fact that everyone was at risk. This paved the way for sustained long-term behavioural change.

Prevention and treatment are both vital and complimentary components of a comprehensive package to respond effectively to HIV/AIDS. Prevention could make treatment more affordable and sustainable by reducing the number of persons who will need treatment in the future. At the same time, ARV drugs and good healthcare delivery systems could be crucial not just for treating HIV/AIDS, but also in preventing infection and, as a result, decrease the prevalence of the disease.

4. Financing of the Global HIV/AIDS Response

The bulk of the money that finances HIV/AIDS prevention, treatment and care programmes worldwide comes from the rich industrialized countries of the North. The main donors are members of the OECD's Development Assistance Committee (DAC), and particularly the G7 group, and their contributions take the form of official development assistance (ODA) either directly to governments or indirectly through the UN system and other multilateral agencies. In addition, philanthropic foundations such as the Bill and Melinda Gates and Elizabeth Glaser and charitable arms of private sector pharmaceutical corporations such as Bristol Myers-Squibb and Pfizer have also been important contributors to the global HIV/AIDS response.

Financing of the global HIV/AIDS response has skyrocketed over the past two decades, from just US $200,000 in 1986 to a projected total of about US $10 billion by the end of 2008. Africa has been by far the largest beneficiary of donor funds for the global HIV/AIDS response, with the region accounting for over three-quarters of total donor funding of the global

response in 2008. The appearance of major HIV/AIDS funding initiatives after 2000, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the US President's Emergency Plan for AIDS Relief (PEPFAR) and the World Bank's Multi-Country AIDS Program (MAP), has given a big boost to the global HIV/AIDS response.

i) Funding by bilateral donors

Until the advent of the Global Fund and the World Bank's MAP at the start of the present millennium, global HIV/AIDS financing was predominantly through bilateral channels. For example, throughout the 1990s, eight major OECD donor governments – the US, UK, France, Sweden, Denmark, Germany, Netherlands and Japan, plus the European Commission, accounted for over four-fifths of the total amount spent on HIV/AIDS in Africa. In line with the policy and pattern of bilateral aid, the selection of recipient countries is usually determined by the special interests of donor governments based on historical ties or strategic political or economic considerations. Unfortunately, the preferences of donor governments could influence, or worse still, even distort the orientation, resource allocation patterns and priorities of national HIV/AIDS responses.

The targeting of particular countries in a bilateral programme by a donor government is best illustrated in the *President's Emergency Program For AIDS Relief (PEPFAR)* initiative, which was announced by President George W. Bush in his State of the Union Address in January 2003 and

enacted by the US Congress in May 2003.[15] The PEPFAR initiative, which initially authorized the administration to spend up to US $15 billion over five years, is the most important bilateral HIV/AIDS response programme and the largest global health initiative directed at the epidemic. PEPFAR benefits only 15 'focus countries' (12 in Africa, two in the Caribbean and one in Asia), a mere fraction in relation to the total number of developing countries seriously affected by the HIV/AIDS epidemic. Also the recipients of PEPFAR money were required to orient their interventions to meet rigid guidelines and priorities provided by the donor government, including restrictions on the use of condoms to prevent the spread of HIV and on the purchase of generics. The selection of a small number of countries, and the countries selected, suggest that the choice by the donor government is based on political and other strategic considerations of interest to the USA, rather than on essentially needs-based criteria[16]. Nevertheless, PEPFAR money has made a huge difference to the HIV/AIDS response in Africa: when the initiative was launched in 2003, there were only about 50,000 Africans on antiretroviral (ARV) therapy; this number increased to an estimated 1.5 million in 2008 due largely to PEPFAR-funded programmes in the region. Both the outgoing Bush and the new Obama administrations have pledged additional resources in excess of US$ 50 billion for an extension of PEPFAR for another five-year period, 2009-2013.

ii) Funding through multilateral institutions

[15] 108th Congress, *An Act to provide assistance to foreign countries to combat HIV/AIDS, tuberculosis and malaria, and for other purpose*. Public Law (P.L.) 108-25

[16] Some of the neediest and worst affected countries in sub-Saharan Africa such as Zimbabwe, Lesotho, Swaziland and Malawi are not covered by PEPFAR, while assistance is provided to relatively better-off countries such as Botswana, Kenya , South Africa and Nigeria under the initiative.

The World Bank

Funding by the World Bank for HIV/AIDS project goes back as far as 1986 when the financial institution included an amount of US $150,000 for blood screening in Niger as part a health sector loan.[17] By 1989, the Bank was already financing various elements of national HIV/AIDS response including prevention strategies, epidemiological research and blood screening within the context of health sector projects in over a dozen African countries. During the 1990s, World Bank funding for HIV/AIDS response was expanded to include project activities outside the health sector, such as education and transport sector projects. The launching of the innovative *Multi-Country AIDS Program (MAP)* in September 2000 gave a big boost to World Bank HIV/AIDS financing.. The MAP became a central pillar of the new World Bank's HIV/AIDS strategy, which emphasized both he multi-sectoral characteristic and the development dimension of the epidemic and its response. The overall objective of the MAP is to provide resources to low-income countries that would dramatically increase access of their populations to HIV/AIDS services, and in the process build local capacity to address HIV/AIDS as a wider development and multi-sectoral challenge.

The lending requirements and related conditions for funding of MAP projects were deliberately made more flexible and less stringent than typical World Bank lending, to reflect the urgency and exceptionality of the epidemic and its potentially devastating impact. Simplified and fast-track procedures were adopted for the approval and disbursement of funds for

[17] World Bank, Project Database on HIV/AIDS Projects, http://www,worldbank.org

MAP projects, and allowance was also made within MAP projects for the funding of operating and recurrent costs and the provision of financial support for civil society-led activities. In addition, MAP resources were also made available to finance cross-border HIV/AIDS projects and interventions that cannot be supported through individual country projects.

Total HIV/AIDS commitments and disbursements by the World Bank from 1990 to the end of 2008 were estimated at nearly US $9.5 billion and over US $6 billion respectively for about 180 approved projects. Over two-thirds of total commitments were for projects in sub-Saharan Africa. In addition to its primary focus on HIV/AIDS, the MAP is regarded by the World Bank as a vital component of its strategy to fight poverty and underdevelopment.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)

The Global Fund came into existence in January 2002, with the support of the G7, as an innovative global health financing mechanism with a strong focus on HIV/AIDS. It is a public-private partnership between governments of both developed and developing countries, the private sector, civil society and associations of those affected by the diseases, and operates outside the UN system. Funding is provided to countries in the form of grants awarded on the basis of project proposals prepared by the country themselves and submitted to the Global Fund for review by an independent technical panel. The Global Fund has adopted a unique arrangement for project development and execution, which requires countries to constitute a broad-based and representative partnership known as the *'Country Coordinating Mechanism' (CCM)* for preparing grant proposals and monitoring project

implementation. Typically, the CCM should include representatives of the private sector, civil society including community and faith-based organizations and PLWHA, in addition to government officials.

The Global Fund depends on voluntary contributions from donor governments and philanthropic foundations for its resources. Since its inception, the Global Fund has received an estimated US $9 billion in contributions and pledges, most of this amount coming from the US, Germany, UK, Japan France, Italy and Canada. As at the end of 2008, the Global Fund had gone through eight rounds of grant approvals, and committed over US $10 billion to finance more than 550 projects managed by governments, NGOs and local-level community and faith-based organizations in more than 100 countries. This makes the Global Fund the primary multilateral mechanism for funding HIV/AIDS response programs globally.

While the procedures adopted by the Global Fund for the approval of proposal and award of grants to countries are designed to ensure national ownership and broad-based local participation, concerns have been raised about the possibility that grant proposals being promoted or influenced by specific vested interests which may not reflect national priorities or consensus among the various stakeholders represented on the CCM. There have also been long delays between commitment and disbursement of funds, contributing to implementation problems that have affected Global Fund projects in a number of countries. The fact that the Global Fund was originally conceived as a financing instrument and not an implementation

agency, meant that from the onset the institution had to confine its activities to mobilization and disbursement of funds and leaving it to others to decide on how efficiently the money is spent or otherwise. It may no longer be out of context to think that the Global Fund, in addition to raising funds, may also need a functioning system on the ground at country level to ensure that its grants are well spent.

iii) Philanthropic foundations and business corporations

Private philanthropic foundations and charitable arms of business corporations, particularly pharmaceutical companies, are also sources of funding for the global HIV/AIDS response. This type of funding has contributed much to the development of new and innovative scientific and technological breakthroughs in HIV/AIDS prevention and treatment - critical areas that are vital to the global response but may not be attractive to donor governments because the results may be controversial or less predicable and longer-term in nature. For example, foundations have been associated with the funding of efforts to develop a successful HIV vaccine and an effective microbicides for use by women which could significantly lower the risk of the transmission of HIV through sexual intercourse. UNAIDS estimated that contributions from private foundations and business-supported charities to HIV/AIDS programmes worldwide were in the region of US $400 million annually in 2006 and 2007. Most of the major foundations and businesses contributing to the global HIV/AIDS response are based in the US (e.g. Bill and Melinda Gates, Kaiser Family, Rockefeller, Elizabeth Glaser, Bristol-Myers Squibb, Pfizer), where tradition

and law supports a high level of philanthropic activity than in other developed countries.

iv) 'Making the money work': Issues of cost-effectiveness and efficiency in HIV/AIDS financing

Despite the substantial increase in the financing of the global HIV/IDS response over the past decade, there is little evidence that the spread of the epidemic is being controlled and reversed globally, according to conclusions of the 2006 and 2008 UN General Assembly High-level meetings on HIV/AIDS. Analysis of global HIV/AIDS financing have revealed gaps in both disbursement and implementation processes, which raises questions about how efficiently is available money being put into use on the ground. At the same time as large amounts of committed HIV/AIDS money remain unutilized, there are claims by international agencies, affected governments, international NGOs and AIDS activists that huge funding gaps exist in relation to what is needed to bring the epidemic under control globally.

HIV/AIDS financing is thus characterized by the paradoxical situation in which large amounts on unspent money - both commitments and disbursements - co-exist with huge funding gaps. Concerns about too much money going to HIV/IDS to the detriment of other development needs have opened up key debates in HIV/AIDS financing.

Proponents of the view that too much money is going into HIV/AIDS have argued that the epidemic is receiving a larger share of total health spending than its contribution to the burden disease justify, and that this is at the

expense of other killer diseases and having negative effects on health system and development needs.[18] They have challenged the claim that HIV/AIDS is exceptional, and maintained that there is little evidence that the massive investments in fighting the disease are having a positive impact on its spread. They argue that the large amounts of money going to HIV/AIDS may not only be failing in terms of controlling its spread, but may well be making overall health conditions in developing countries worse.

UNAIDS and other key stakeholders, as to be expected, have reacted with anger to calls for a shift of focus and funds away from HIV/AIDS. Senior officials of UNAIDS have argued that current spending is in fact not enough, and pointed to the "fact that only about 3 per cent of African adults living with HIV are receiving treatment at present", and without treatment they will certainly die.[19] UNAIDS and its supporters contend that there are unmet needs in the global HIV/AIDS response which reflect the exceptional nature of the epidemic in terms of its impact both as a public health crisis and a humanitarian tragedy, as well as its unforeseen and constantly changing challenges.

While a case can be made for more money and improved human resources to mitigate the devastating impacts of HIV/AIDS and threat posed to

[18] See, for example, Roger England, "Are we spending too much on HIV/AIDS ?" *British Medical Journal*, 17 February, 2007; ibid, "The dangers of disease specific programmes for developing countries", *BMJ*, 2007; ibid, "The writing is on the wall for UNAIDS", *BMJ*, 10 May , 2008; James Chin, " How billions are wasted on AIDS prevention: The myth of a general AIDS pandemic" *Campaign for Fighting Diseases, International Policy Network*, London, January 2008; Laurie Garrett, "The global health Challenge", *Foreign Affairs*, January-February, 86:1, pp.14-38.

[19] Paul De Lay, Robert Greener and Jose Antonio Izazola, "Are we spending too much on HIV ?", *British Medical Journal*, 17 February 2007; Paul De Lay, et al, "AIDS remains an exceptional issue", , *BMJ*, 10 May 2008; UNAIDS, *2008 Report on the global AIDS epidemic*, Geneva, 2008.

livelihoods and sustainable development in the Third World, it is equally important to stress the need to use available and new money effectively and efficiently. Peter Piot, the former Executive Director of UNAIDS, has on numerous occasions stated that the major challenge in the financing of the global HIV/AIDS response is not finding the money but *"making the money work"*[20] There may not be enough money available to meet the unmet needs of the global HIV/AIDS response, but there is evidence that the money that is available is not being spent as fast as it is committed and that money that is spent is not having an optimal impact on the problem.

Policy and action are needed to increase the efficiency and effectiveness of HIV/AIDS financing. Particular attention should be paid to measures to improve absorptive capacity of affected developing countries to handle and utilize large inflows of aid coming in for HIV/AIDS, which in some cases are in excess on the entire health budget of a country. Improved monitoring and tracking of HIV/AIDS spending is required to address efficiency and governance-related problems at country level. There is a need for improved coordination among donor governments and agencies at national and international levels to avoid costly duplication of efforts and to ensure that money provided is well spent on the ground.

5. Global Governance and HIV/AIDS Response

i) The need for a new architecture of global governance for responding to HIV/AIDS

[20] See, for example, UNAIDS, *Making the Money work: UNAIDS Technical Support to Countries*, Geneva, 2008; ibid, *Making the Money Work through greater UN support for AIDS responses: The 2006-2007 Consolidated UN Technical Support Plan for AIDS,* Geneva, 2005

Existing arrangements and mechanisms for promoting the necessary international cooperation in HIV/AIDS response are linked largely to the functioning of the multilateral system. Specifically, as already mentioned, these arrangements are allied to the role of key global institutions such as the World Bank, IMF and WTO which have decision-making authority over international finance, economic and trade matters and, hence, influence on the flow of resources and technical assistance from the rich to poor countries. This brings into focus the governance structures of global institutions in terms of power relationships between the North and the South. Existing governance structures represent obstacles to effective response by developing countries to global health problems that affect their overall development prospects. Imbalance in decision-making power and authority between the North and South makes it difficult for developing countries to influence decisions concerning the mobilization of additional financial resources and the use of generic drugs may be required for an effective response to the impact of the HIV/AIDS epidemic on their populations and economies.

Changes and adaptations to the governance structures of global institutions, ranging from greater flexibility in application of rules to assist weaker states, to the giving of more voice to developing countries with the aim of a more balanced representation in multilateral decision-making and processes, are therefore required.[21] Reforms to global governance structures should not only recognize common interests of members, but also diversities and

[21] See Franklyn Lisk, " Towards a new architecture of global governance or responding to the HIV/AIDS epidemic" in Andrew F. Cooper, Brian Hocking and William Maley (eds.) *Global governance and Diplomacy: Worlds apart ?* (Palgrave Macmillan, 2008)

differentiated responsibilities among nations of the global community in general, and particularly countries of the North and South.

To avoid the drawbacks of the current system of global governance, the ideal governance structures of global institutions should be both fair in terms of democratic representation and efficient with respect to decision-making. In the specific context of HIV/AIDS response, the need for improvement in global governance should focus n the decision-making processes and mechanisms of global institutions which at present put developing countries as group at a disadvantage and limits their capacities to respond effectively and in a timely fashion to the epidemic and its impact. The link between global governance and effective HIV/AIDS should be analyzed as an endogenous and bi-directional relationship, implying that improved governance would not only lead to more effective HIV/AIDS response, but that good governance would also be enhanced by lower prevalence of HIV/AIDS at national level. However, the most appropriate correction of deeply entrenched imbalances in institutional governance structures at the global level might require a radical and comprehensive approach international system reform, which may not be feasible and practical within an acceptable period for both geopolitical and economic reasons.

What, therefore is being proposed by way of a new architecture of global governance for HIV/AIDS response is the application of certain conditions and modifications that could make the organization and management of global governance more responsive to the needs of developing countries, rather than proposing the replacement of the current system by completely

new institutional frameworks and operational arrangements. There are a number of key requirements that should be met in order to ensure that the new architecture of global governance is appropriate to the demands of an effective global response to HIV/AIDS.

First, the new architecture should aim at giving developing countries more say and influence on decisions concerning financial flows, debt repayments, and international trade agreements pertaining to the production and marketing of essential medicines for HIV/AIDS and other diseases found predominantly in the developing world. Second, the new architecture should pay more attention to the effects of globalization on the capacities of poor countries to respond to threat of the epidemic. Third, it should include elements that are responsive to the economic and social needs of poor and marginalized countries, as well as reflect the scale of the HIV/AIDS epidemic as a wider international development issue. Fourth, the new architecture should include elements that enhance the ability of developing countries to implement strategies and policies to address HIV/AIDS and poverty simultaneously and in an integrated manner. Fifth, the main operational mechanism of the new architecture should be a comprehensive international agenda that covers aid, trade macroeconomic management, and on that recognizes the need to provide developing countries with much needed technical assistance within a fairer global system, and to enable them to participate competitively in the global economy and to build effective institutions to improve governance at national level.

6. Conclusion: International Cooperation and the Global HIV/AIDS Response

We have argued that **c**hanges and innovations in global governance are required to enhance the capacity of poor countries to respond effectively to HIV/AIDS. These innovations could be grounded on the economic concept of 'global public goods', given that HIV/AIDS threatens everyone globally and therefore it is in the common interest of all countries to work towards coordinated and effective responses to HIV/AIDS and other global epidemics. There are compelling reasons, both on moral and pragmatic grounds, why there should be greater cooperation between the developed countries of the North and the developing countries of the South in HIV/AIDS response, as sketched out above in the proposal for a new architecture of global governance.

HIV/AIDS is now a global epidemic from which even the richest and most advanced countries are not immune. Increased movement of people and the pathogens they carry across national borders and between continents as a result of globalization is a factor in the spread of HIV and other infectious diseases. It is thus in the interest of the international community to support the development of new drugs to treat outbreaks of deadly infectious diseases and to make such drugs available to all countries. Investment in the development of new drugs to treat global infectious diseases like HIV/AIDS is a global a public good, and, accordingly, there should be flexibility in the application of the WTO's TRIPS agreement to facilitate access to essential medicines in developing countries.

Controlling the spread of HIV/AIDS and averting its devastating social and economic consequences should remain on the international agenda as a priority. From the standpoint of a global public goods approach, there are mutually supporting arguments for funding and otherwise supporting HIV/AIDS responses in poor countries by donor governments: Control of the HIV and other global epidemics could yield 'spillovers' or external economic and social benefits from which all countries could gain. A strong case can be made for subsidies and external transfers from richer nations to ensure that effective HIV/AIDS policies and practices are in place and implemented by poorer countries. The alternative is for the epidemic to spread unimpeded globally, and for richer countries to face the probability of much higher economic and social costs as a consequence of the spread of HIV infection to their own populations. Self interest should thus lead richer nations to seek to support, through resource transfers, the implementation of cost-effective responses to HIV/AIDS in developing countries that are experiencing mature epidemics and facing deep and intractable development challenges.