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MDG6: AIDS and the Moral Economy of International Health Policy

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MDG6: AIDS and the Moral Economy of International Health Policy

Abstract

MDG 6, 'to combat HIV/AIDS, malaria and other diseases', is unique among the MDGs because it emerged in the context of unprecedented prior international mobilisation, especially around HIV/AIDS, thus both reflecting and facilitating an expanding international health agenda. MDG 6 built on the idea of 'health as development', originally articulated at the 1978 conference on primary health at Alma-Ata, but was profoundly shaped by the political traction and fund-raising successes of AIDS activism and the international AIDS response. This underpinned the expansion of MDG 6 targets to include antiretroviral treatment (ART), helped forge partnerships to reduce the prices of ART and essential medicine, thereby contributing to MDG 8 ('building partnerships for development') and, in high HIV-prevalence regions, also to MDGs 4 and 5 (maternal and child health). The moral-economic dimensions of the international AIDS response point to the importance of civil society mobilisation in shaping the AIDS and international health agendas. Continued support for civil society organisations is necessary for continued progress on global health.

Introduction

The Millennium Development Goals (MDGs) were developed as a tool for focussing attention on, and mobilising resources for, development. Yet there is some concern that they may have been used inappropriately as planning goals thereby distorting priorities. Is this the case with MDG 6 'to combat HIV/AIDS, malaria and other diseases'?

We argue that MDG 6 was unique in that it was the international AIDS response that wagged the MDG6 dog, not the other way around. Whether health or development resources were in some sense distorted in the process is moot, though we argue it is unhelpful to frame donor funding as a fixed pot of money to be allocated through rational economic planning. Rather, we show that normative and political concerns were crucial to understanding the unprecedented mobilisation around AIDS and that the moral-economy of AIDS

funding and the political-economy of AIDS activism hold lessons for the post-2015 agenda.

The paper begins with a discussion of the origins of MDG6- the idea of health-as-development pioneered at the 1978 Alma-Ata conference on primary health care- and the subsequent international mobilisation around AIDS. This is followed by a discussion of AIDS in the new millennium, in particular the reformulation of the health-as-development agenda by the World Health Organisation (WHO) Commission on the Macroeconomics of Health and the role of international organisation in support of universal access to antiretroviral treatment (ART). We show how the international AIDS response mobilised additional funding, forged innovative interventions and partnerships to reduce the price of ART and contributed to MDG 8 (building partnerships for development) and to MDGs 4 and 5 (maternal and child health) in countries with major HIV epidemics.

We conclude with a discussion of the moral-economy and political-economy of AIDS funding in the current era of international economic recession. We note that there has been a backlash against AIDS funding, but point out that most evidence suggests there have been synergies between AIDS funding, health funding and development objectives, especially in Africa. We argue that AIDS funding is driven by political and normative concerns and that it makes sense to use this impetus to leverage additional resources for health.

The international AIDS response helped translate global health goals into national practices in ways that the Alma-Ata resolutions did not. It thus holds lessons for the post-2015 agenda about the importance of including civil society organisations and assisting them where necessary to ensure that global goals become political and practical realities at national level. By way of conclusion, we warn that reducing all health targets to a single goal runs the danger of replicating the political-economic failure of Alma-Ata and reversing the gains made to global health policy and practice pioneered by AIDS. Maintaining disease-specific targets whilst building broader coalitions in support of general health and development offers the best opportunity to protect and promote global health in the post-2015 era.

The Origins of MDG 6

The MDGs first appeared in the UN's 'Road Map towards the implementation of the United Nations Millennium Declaration' (UN, 2001). They were drafted by a group of experts from across the UN, including the International Monetary

Fund (IMF), the World Bank and the Development Assistance Committee (DAC) of the Organisation of Economic Co-operation and Development (OECD). Their objective was to take the Millennium Declaration[1] forward by extracting clear targets and associated statistical indicators linked to an inclusive vision of development aimed at healing divisions over the structural adjustment policies of the 1980s (Jolly et al, 2005; Vandemoortele, 2011: 4, 8; Fukuda-Parr and Hulme, 2011). In so doing, they drew on notions of sustainable development first articulated in the Brundtland Report (UN, 1987) and the UNDP's first *Human Development Report* (1990), and on a series of UN conference resolutions from the 1990s.

The UN conferences helped mobilise around the idea of development as people-centred (pro-poor, rights-driven), entailing both economic and social improvement and respect for the environment. The right to health slowly emerged as a development issue during this process. Echoing the Rio Declaration of 1992,[2] the World Social Summit in 1995 stated that 'people are at the centre of our concerns for sustainable development and that they are entitled to a healthy and productive life in harmony with the environment'. It resolved, *inter alia*, to 'attain universal and equitable access to education and primary health' but no targets were set.[3] The agenda of setting targets was set in motion by a DAC/OECD summit in 1996 which argued for the need to address 'problems that respect no borders – from environmental degradation and migration, to drugs and epidemic diseases' (DAC 1996: 1). It developed six goals with clear indicators and deadlines including what were to become MDGs 4 and 5, namely to reduce child mortality by two-thirds and maternal mortality by three quarters. Despite mentioning epidemic diseases, no other health goals were set – the document merely observed that 'child mortality, as a measure of the availability of health and nutrition for the most vulnerable members of society, is a key indicator of the overall state of health in a society' (1996: 10).

The Millennium Declaration does not mention health, but the Road Map document that followed it highlights health as 'part of an essential strategy to achieve sustainable development' (UN, 2001: 3). In this regard, it drew on the health-as-development agenda articulated initially in 1978 at Alma-Ata by the first international conference on primary health care. The Alma-Ata Declaration[4] declared health to be a 'fundamental human right', and stated that inequality of health status especially between developed and developing countries was

[1] http://www.un.org/millennium/declaration/ares552e.htm
[2] http://www.unep.org/Documents.Multilingual/Default.asp?documentid=78&articleid=1163
[3] The Copenhagen Declaration: http://www.un.org/esa/socdev/wssd/text-version/agreements/decparti.htm
[4] http://www.who.int/publications/almaata_declaration_en.pdf

'politically, socially, and economically unacceptable'. Arguing that the 'promotion of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace' it called on governments, donors, international organisations and health workers to 'support [the] national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries'. The year 2000 was set as the target for achieving a level of health that allows all people to lead socially and economically productive lives.

The Alma-Ata declaration took place within the context of growing support from developing countries for a 'new international economic order' involving enhanced access to developed country markets and significant redistribution of resources in favour of developing countries. This had been raised at the UN in 1974 and 1975 (6th and 7th UN Special Assemblies) but had generated only heated discussion and by the end of 1970s the industrialised countries had side-lined it (Jolly *et al* 2005: 11). In the 1980s, it was IMF/World Bank structural adjustment policies that dominated the international development agenda. But as it became clearer that they were failing to promote development (and indeed, were probably undermining it), the agenda opened up again to include consideration of the link between people-centred policies and development. One of these was health.

The health-as-development agenda pioneered at Alma-Ata was re-invigorated by the World Bank's 1993 World Development Report *Investing in Health* and the UNDP's *1996 Human Development Report* which argued for considerable investment in education health and nutrition as a prerequisite for human development (1996: 66). Woodling *et al* argue that the Word Bank sparked a 'game-changing rhetorical shift: a move away from viewing health as a *cost* governments face to seeing it instead as an *investment opportunity'* (2012: s148). But while this was indeed an important idea, it was not a new one and there is little evidence that it was as 'game-changing' as these discourse analysts suppose. Subsequent UN conferences did not emphasise health-promotion or disease-eradication as a pre-requisite for development: the 1995 World Conference on Women (Beijing) produced a single disease-related strategic objective (C3: to undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues) but no associated targets or indicators were developed;[5] and the 1994 Cairo

[5] Report of the Fourth World Conference on Women: http://www.un.org/womenwatch/daw/beijing/

Conference on Population and Development[6] mentioned AIDS in the context of morbidity and mortality and HIV prevention in the context of reproductive rights and reproductive health, but likewise came up with no associated indicators or targets.

This tepid level of commitment reflects the absence of political will and lack of energy on the part of the international donors to take the disease agenda forward – even though it was clear by mid-1990s that HIV was undermining health and development, particularly in high prevalence African countries (Mann, 1992; Mann and Tarantola, 1996). Part of the problem was that the HIV epidemic has complex socio-economic causes and that the multi-sectoral response needed to fight it was hampered by fragmentation and lack of co-ordination between the various UN agencies. Equally problematic was the infighting within the WHO over the size and operation of its Global Program on AIDS.

Jonathan Mann, the first director of the Global Program (1987-1990), was a successful fund-raiser but ran into bureaucratic obstacles as he bypassed WHO regional structures in his engagement with national HIV prevention programmes (Piot, 2012: 175-81). He was succeeded by Michael Merson who began a consultative process within the UN to create a new entity, UNAIDS, to focus and co-ordinate the UN's response to AIDS. Peter Piot, a medical scientist with experience working on HIV in Africa, was appointed its first director in 1994 but it took a further two years of negotiations with the 'co-sponsoring' UN agencies over structure and function before UNAIDS could begin operations in 1996 (Piot, 2012: 227-8).

UNAIDS was unique in the way that it worked across a diverse and lumbering UN system. When it eventually emerged it was, as Piot recalls, a 'taut little mammal in a world of brontosauruses' (2012: 232). It was also unique in that it had five non-governmental organisations (one each from Africa, Asia, Latin America, North Africa and Europe) on its board – a product of Piot's insistence that being accountable to 'the people' meant more than being accountable to governments or UN agencies. Both features are crucial to understanding the political and institutional success of UNAIDS in shaping and driving the AIDS response at national and international levels.

UNAIDS concentrated on working closely with national governments and on raising awareness of the scale and dangers posed to the world by AIDS. It prioritised obtaining good statistics (antenatal clinic survey data) and

[6] Report of the International Conference on Population and Development: http://www.un.org/popin/icpd/conference/offeng/poa.html

epidemiological estimates of HIV prevalence and demographic impact. This was important in enabling UNAIDS to convince the other UN agencies of the threat posed by AIDS. For example, Piot organised a seminar at the World Bank in January 1998 where he presented graphs showing changes in life-expectancy and deaths by age. He recalls that 'these images had a big impact on the World Bank, because economists could look at them and immediately understand the age-specific impact on productive people. We were finally speaking their language' (2012: 251). The following year, the World Bank launched its Multi-country HIV/AIDS Program (MAP), an emergency response which framed AIDS as a major threat to development in Africa because it 'kills so many adults in the prime of their working and parenting lives… decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities' (World Bank, 1999: 5).

UNAIDS broadened its advocacy work in the late 1990s to include the media, and to work with organised religion to reduce outright hostility to condoms (Piot, 2012: 267-70). This ground-up approach was supplemented by high level support from Kofi Annan, the UN Secretary General from 1997-2006. In December 1999, Annan convened a meeting with the major aid agencies and African ministers, activists and business leaders which, as Piot recalls, 'signalled to the donors that they needed to get their act together' and 'meant that Africa started slowly to take ownership of the AIDS issue' (2012: 271). The following year, Annan told the UN Security Council that the destructive impact of AIDS in Africa was equal to that of a war and that the socio-economic impact of AIDS threatened political stability (Annan, 2000). UN Security Council Resolution 1308 resolved that all peace-keeping operations were to have an HIV prevention component.[7] The following year the UN General Assembly held a Special Session on HIV/AIDS (UNGASS) where much of the debate focused on managing ART and HIV prevention services in Africa (Copson, 2003) and where it was accepted that HIV was a threat to human development and security.

The road to UNGASS was neither purely serendipitous nor the product of some idea whose time had simply come. It reflected the efforts of people, for example Richard Holbrooke, the US ambassador to the UN who put AIDS on the Security Council agenda. But even this is not the full story because AIDS activism and strategic intervention by UNAIDS helped set the stage upon which he walked. For example, Piot recalls how he learned that Holbrooke was planning to visit the Africa Great Lakes region in November 1999 and so mobilised his international networks to make sure that local activist groups and

[7] http://data.unaids.org/pub/basedocument/2000/20000717_un_scresolution_1308_en.pdf

people with HIV would cross his path and alert him to the severity of the problem – which they did, successfully (2012: 274).

Piot also acted decisively to ensure that an explicit AIDS goal was included in the list of MDGs – by telling John Ruggie, the main drafter of the Millennium Declaration, that he would not leave his office until he had agreed to include AIDS (2012: 286). But probably more importantly, UNAIDS had already developed the modelling packages and the statistical indicators (HIV prevalence, orphans, people in need of treatment etc.) that could, and were, included by the drafters of the MDG targets. The formulation of MDG6 was thus trailing rather than distorting the AIDS response.

MDG 6 broke the mould set by the UN conferences of the 1990s in that it highlighted the importance in eradicating disease as an essential part of a development agenda. It called for the halving of the spread of HIV/AIDS and malaria, and for a radical increase in the amount of global resources spent on AIDS, from the less than $1 billion then being spent on the disease to the UNAIDS desired target of $7 to $10 billion- Table 1 (UN, 2001). The Road Map touched on another goal that was also crucial to the AIDS response, namely ‘to encourage the pharmaceutical industry to make essential drugs more widely available and affordable by all who need them in developing countries’ and ‘to develop strong partnerships with the private sector and with civil society organizations in pursuit of development and poverty eradication’ (UN, 2001: 9). These became part of MDG 8 and it has been the AIDS response that has driven most progress towards this otherwise woefully neglected goal.

Table 1: MDG6 Goals in the UN Road Map document

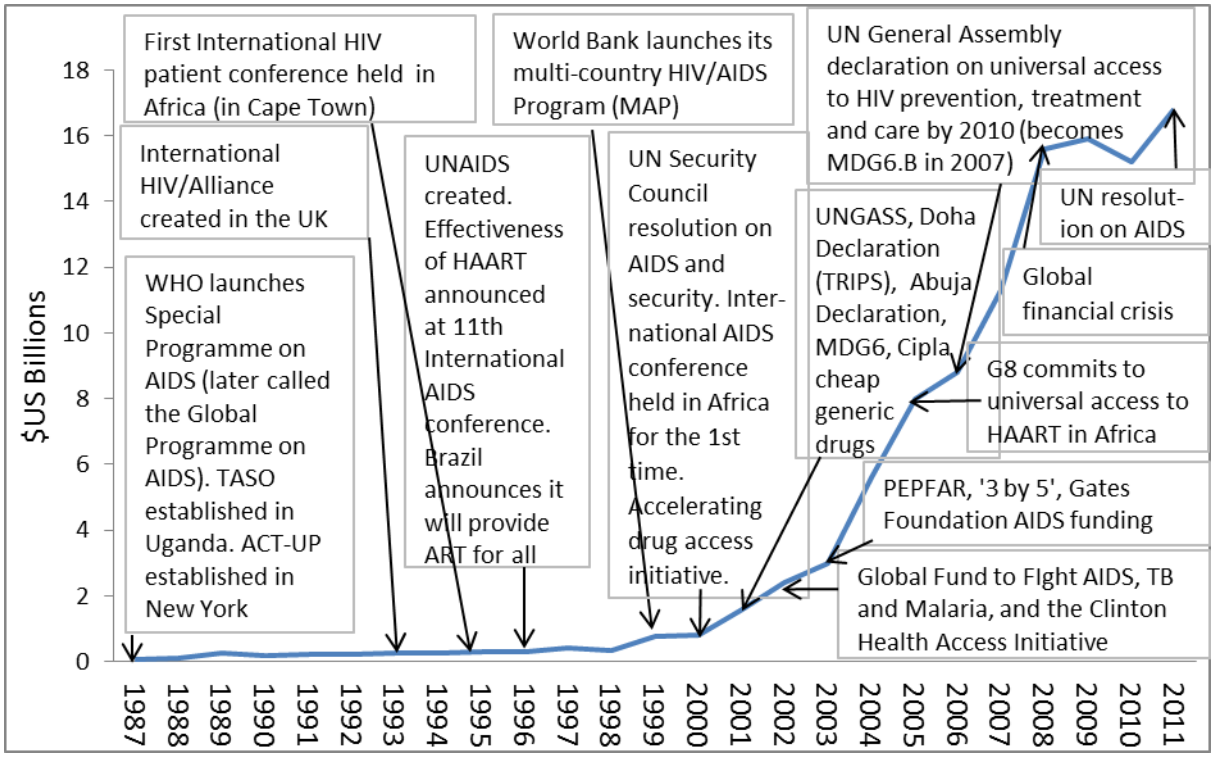
Goals	Strategies for moving forward
To have, by 2015, halted and begun to reverse the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity	• Achieving a target of $7 to $10 billion in total spending on HIV/AIDS from all sources, including affected countries; • Urging the international community to support the Global AIDS and Health Fund; • Strengthening health-care systems and addressing factors that affect the provision of HIV-related drugs, including antiretroviral drugs and their affordability and pricing; • Supporting and encouraging the involvement of local communities in making people aware of such diseases; • Urging national Governments to devote a higher proportion of resources to basic social services in poorer areas since this is crucial for preventing diseases; and • Supporting other initiatives based on partnerships with the private sector and other partners in development
To provide special assistance to children orphaned by HIV/AIDS	• Mobilizing and strengthening community and family-based actions to support orphaned and vulnerable children; • Ensuring that Governments protect children from violence, abuse, exploitation and discrimination; • Ensuring that Governments provide essential quality social services for children and that orphans and children affected by HIV/AIDS are treated on an equal basis with other children; • Expanding the role of schools as community resource and care centres.

Sources: UN, 2001.

AIDS in the New Millennium: Antiretroviral Treatment and the Reshaping of MDG6

From 2000/1 onwards, the political environment and funding situation turned sharply positive for the AIDS response. Figure 1 (Merson *et al*, 2008; UNAIDS, 2012a; unpublished data from UNAIDS) highlights various milestones and shows that AIDS funding started trending upwards from 1999 with additional World Bank funding, but that the steep increases happened during the early and mid-2000s, especially after the creation of the Global Fund to Fight AIDS, TB

and Malaria (the Global Fund) and the US President's Emergency Fund for AIDS Relief (PEPFAR).



Sources: Merson *et al*, 2008; UNAIDS, 2012a; and unpublished data from UNAIDS.

Figure 1: Total Funding and Key Moments in the International AIDS Response

How much of the unprecedented increase for disease-specific funding can be attributed to, or can be seen as a consequence of, MDG6? Such counter-factual questions are difficult to answer because MDG6 became swept up in, and hence part of, the emerging international discourse that shaped the international AIDS response. Our reading of the various forces that came together to generate the unprecedented response to AIDS highlights the role of political, normative, organisational, institutional and biomedical factors as being the tail that wagged the MDG6 dog. But it is possible that MDG6 legitimated, at least for some donors, the evolving international agenda with regard to AIDS. Even so, it is worth noting that MDG6 was never an explicit mobilising or organisational focus for UNAIDS because it was always seeking to push the agenda beyond them. For example, in its 2010 publication: *MDG^6: Six Things You Need to Know about the AIDS Response Today*, UNAIDS lists the MDG6 AIDS targets but then immediately poses the bolder targets of zero new HIV infections, and

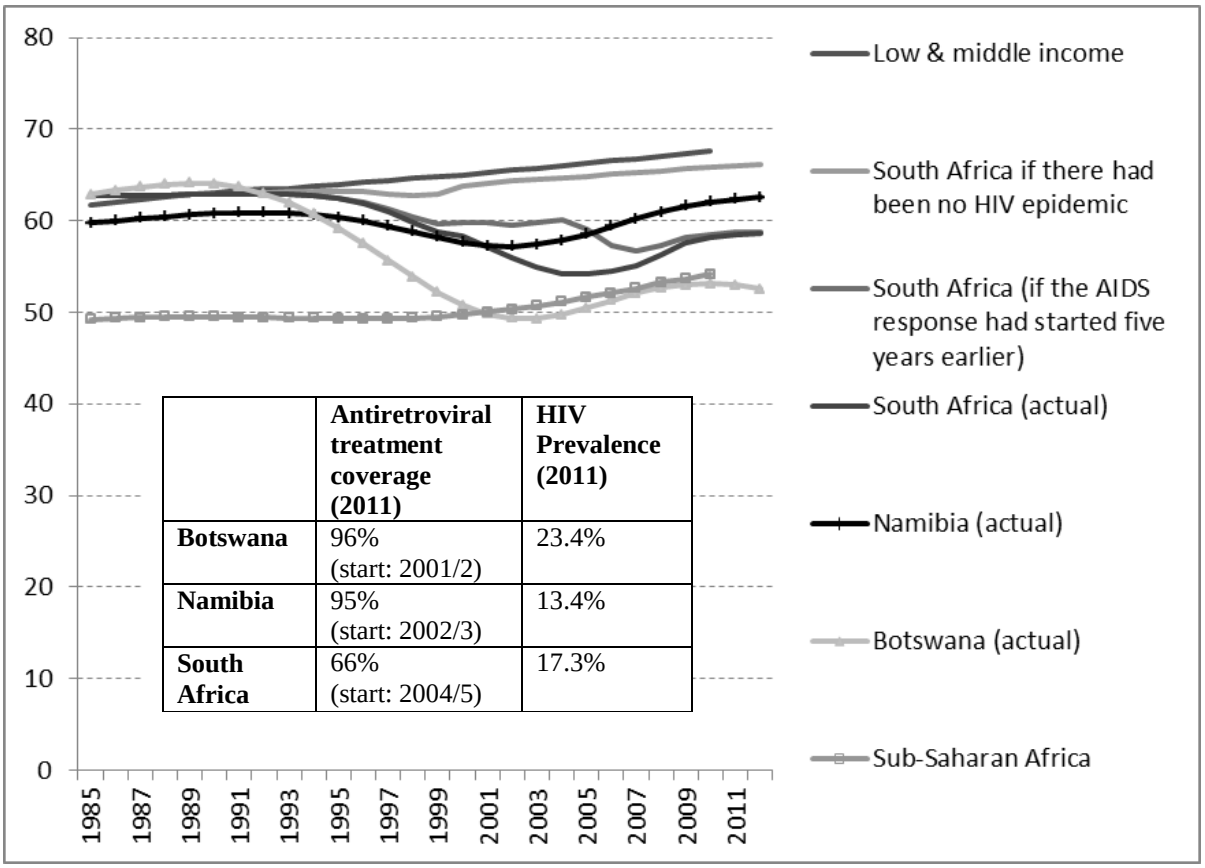
zero AIDS deaths (UNAIDS, 2010). Representing the 6 in MDG6 as an exponent is a clear representation of UNAIDS' attitude in this regard.

The impact of antiretroviral treatment is crucial to understanding the moral and political underpinnings of the international AIDS response. In 1996, the year UNAIDS started operating, ART turned HIV disease from a death sentence into a chronic disease. But the drugs were expensive (over $10,000 per person per year) and thus out of reach for people in developing countries. AIDS activism, which had initially framed HIV/AIDS as an 'exceptional' disease requiring a human rights approach to combat stigma, shifted its focus to the international stage, reframing HIV as exceptional for its impact on development (Smith and Siplon, 2006; Smith and Whiteside, 2010). Stephen Lewis, Kofi Annan's Special Envoy on AIDS in Africa from 2001 to 2006, described HIV as 'the most exceptional communicable disease assault of the twentieth century' (2009). Such discourse and activism added to the growing momentum around AIDS.

An ART rollout had strong moral and political appeal for donors because it saved lives in a very immediate sense. This helped cut through the prevailing attitude within the donor community that aid flows should be kept at levels eventually sustainable by recipient countries – and a new form of international solidarity around health as a human right in need of sharply increased international funding appeared to be on the cards (Cometto *et al*, 2009). But there was another aspect to the argument in favour of rolling out ART in developing countries, namely that it was an investment in the sense that it would spur economic growth. The key document in this regard was the WHO Commission on the Macroeconomics of Health (chaired by Jeffrey Sachs) which argued that expanding the coverage of crucial health services – including the provision of ART – to the world's poor could 'save millions of lives each year, reduce poverty, spur economic development and promote global security' (CMH, 2001). ART thus offered hope not only to patients, but also to those concerned about development in Africa. Antiretrovirals not only saved the lives of working aged adults, but helped combat the HIV epidemic by reducing the infectivity of AIDS patients and assisting in the prevention of mother to child transmission (PMTCT).

This can be illustrated by a brief examination of the impact of HIV on life-expectancy – and of the impact of ART in reversing it. Figure 2 shows how life expectancy fell precipitously in the hard-hit Southern African countries of Namibia, South Africa and Botswana (effectively wiping out the impact of two decades of development on this important indicator) and then trended up again with the assistance of ART and PMTCP. The figure includes, for comparative purposes, an estimate using the ASSA2008 demographic model of what life

expectancy would have been in South Africa in the absence of the HIV epidemic. It also shows that if the government's HIV prevention and treatment programs had started five years earlier, i.e. not been delayed by President Mbeki's AIDS denialism, (Nattrass, 2007; Piot, 2012) life expectancy would have trended up earlier.



	Antiretroviral treatment coverage (2011)	HIV Prevalence (2011)
Botswana	96% (start: 2001/2)	23.4%
Namibia	95% (start: 2002/3)	13.4%
South Africa	66% (start: 2004/5)	17.3%

Sources: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/; Life expectancy at birth (total) http://data.worldbank.org/indicator/SP.DYN.LE00.IN?page=1

Figure 2: HIV, ART and Life Expectancy

The push for universal access to ART was given a major shot in the arm in 2003 when Lee Jong-wook, Director General of the WHO joined Peter Piot and Richard Feachem, Executive Director of the Global Fund, to declare the lack of access to ART in developing countries a 'global health emergency,' thereby launching the WHO's 'Treat 3 million by 2005' campaign (WHO, 2003).[8] The Gates Foundation[9] also announced that it was going to be allocating significant

[8] http://www.who.int/3by5/en/

[9] Information on the Gates Foundation's HIV strategy is available here: http://www.gatesfoundation.org/hivaids/Documents/hiv-strategy-overview.pdf

resources for HIV prevention – and even more importantly, the United States launched PEPFAR, a five year spending program (renewed in 2008) committing $15 billion ($10 billion of which was new funding) to the global fight against AIDS. Over half was earmarked for treatment.

This injected new energy into efforts to reduce drug prices. Early efforts, notably by UNAIDS and the French government to facilitate lower priced ART for developing countries were overtaken by the Clinton Foundation's Health Access Initiative to bring pharmaceutical companies, donors and developing countries together to bring drug prices down, create combination pills and expand access to ART.[10] This, coupled with the entry of the Indian firm Cipla into the market for generic drugs, resulted in the cost of ART in developing countries plummeting to $350 per patient per year in the early 2000s and to less than $100 in recent years (Piot: 2012: 310-314). In this regard, the international AIDS response has made more progress than any other international initiative on MDG8.E, i.e. 'In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries'.

Falling treatment costs, together with pilot projects facilitated by UNAIDS, Médecins Sans Frontières and the Global Fund, show that an ART rollout was feasible and effective and made the goal of universal access to treatment in developing countries both desirable and affordable to donors. It is in this context that the inclusion by the 2005 World Summit of an additional MDG6 target (and its adoption by the UN in 2006 and implementation in 2007) i.e. MDG6.B: universal access to antiretroviral treatment by 2010, should be understood. As shown in Table 2, MDG6.B expanded the health agenda to include treatment targets. But this was more of a response to, than a catalyst of, the push for universal access that was already well under way.

[10] For information on the Clinton Health Access Initiative see: http://www.clintonfoundation.org/main/our-work/by-initiative/clinton-health-access-initiative/about.html

Table 2: Changes in MDG 6: Combat HIV/AIDS, malaria and other diseases

2003 – 2007		**2008 – present**	
Goals	**Indicators**	**Goals**	**Indicators**
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18.HIV prevalence among 15-24 year old pregnant women; 19. Condom use rate of the contraceptive prevalence rate 19a. Condom use at last high-risk sex 19b. % of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS 19c. Contraceptive prevalence rate 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14	**Target 6.A:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years; 6.2 Condom use at last high-risk sex; 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS; 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
		Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. prevalence and death associated with malaria; 22. proportion of population in malaria-risk areas using effective malaria prevention and treatment measures; 23. prevalence and death rates associated with tuberculosis; 24. proportion of tuberculosis cases detected and cured under directly observed treatment short course.	**Target 6.C:** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Sources: United Nations Statistics Division, 2003- 2007.

Vandemoortele (one of the drafters of the MDGs), argues that MDG6.B and the three other additional targets added in 2006/7[11] were the product of attempts by 'several players' to 'misappropriate the MDGs in order to gain support for a specific strategy, agenda or point of view' (2009: 356). According to this view, the MDGs were never intended to be a means of imposing specific policies – like treatment targets – on national governments. But in the case of AIDS, the reshaping of MDG6 simply reflected changing international norms about what national governments ought to be doing – although admittedly, MDG6.B also provided ammunition to AIDS activists to hold their governments to account.

By 2005, when the G8 committed to doubling aid to Africa and providing universal access to ART in Africa, the world economy had enjoyed strong growth for over half a decade. Pledges to end global poverty and provide universal access to ART resonated as utopian, but achievable, given sufficient and on-going global solidarity. Unfortunately, the 2007/8 global financial crisis inaugurated a tougher funding environment. Even so, in 2011, the UN produced a further political declaration on AIDS, committing member states to scale up HIV prevention and treatment efforts.[12] It continued to describe AIDS as a global emergency, a human catastrophe, and a development disaster requiring an exceptional response. And, in an indication of how the international AIDS response has shaped political attitudes and promoted a more inclusive human rights agenda, it mentioned, for the first time in any UN political declaration, men who have sex with men, injecting drug users and sex workers as groups disproportionately affected by HIV.

The 2011 UN Declaration also called on donor countries to allocate at least 0.7% of their national income to aid, and African countries to meet the Abuja target (set by the Organization for African Unity in 2001 at a conference in Abuja, Nigeria) of allocating 15% of their national budgets to health.[13] While these objectives are economically achievable and some progress has been made towards achieving them (UNAIDS, 2012b), the international political climate for expanding resources for AIDS is challenging and there are clear signs of donor fatigue. This is impacting on the post-2015 international development agenda, and on AIDS funding specifically.

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[11] http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/About.htm

[12] Resolution adopted by the General Assembly, sixty-fifth session, agenda item 10: 65/277. "Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS." Available: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf

[13] The Abuja Declaration: http://www.who.int/healthsystems/publications/abuja_declaration/en/index.html

The Moral-Economy of AIDS Funding

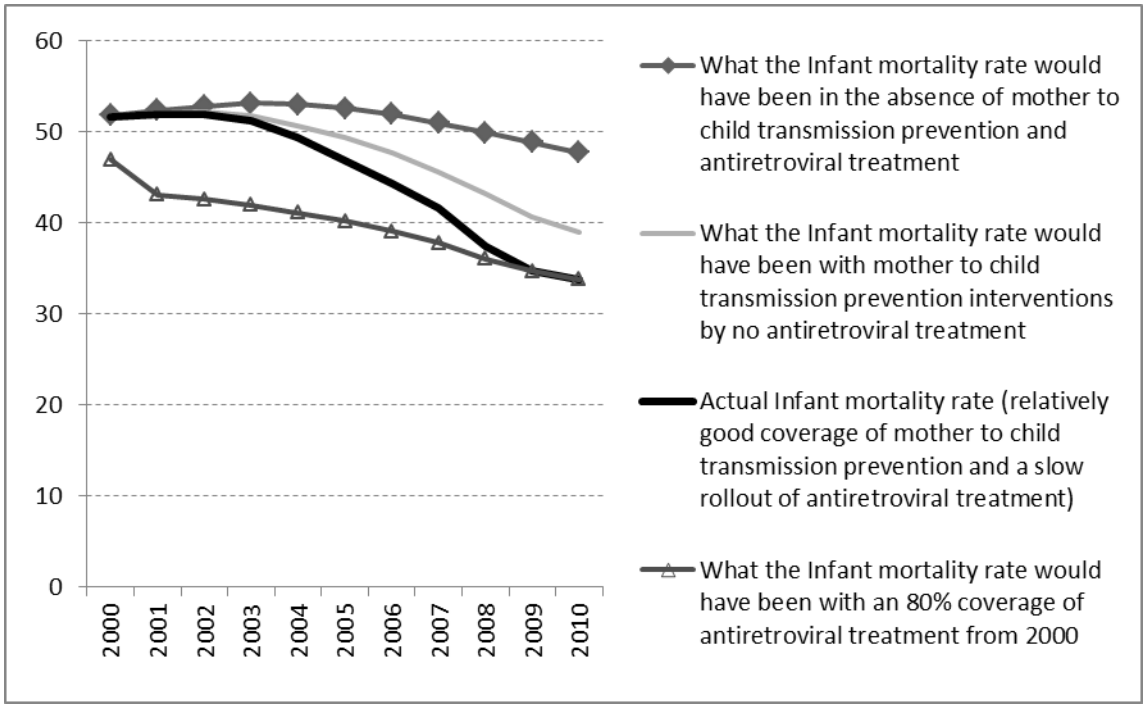
One of the problems with the way that AIDS was framed as a general threat to human security and development was that the negative impact on development was true only for Africa, and specifically for Southern Africa, the epicentre of the epidemic. As shown in Figure 2, the drop in life expectancy in Botswana, Namibia and South Africa was not mirrored in aggregate for low- and middle-income countries and is barely perceptible for Sub-Saharan Africa as a whole. Expanded ART access in developing countries outside the high HIV prevalence African countries was best articulated as a matter of human rights, but as the health-as-development agenda gained traction for the AIDS response, the distinction became blurred in the rhetoric around AIDS.

An unfortunate consequence of this is that the discourse of AIDS exceptionalism was increasingly decried as exaggerated. According to Altman and Buse:

> 'The political reality is that AIDS cried wolf too often, and the more dire warnings have failed to materialize. In most parts of the world, AIDS is not a security or development crisis, and the perception that the response has received too much attention and funding is growing' (2012: 132).

This has fed into a broader backlash against funding for AIDS within development circles and the notion that the strong early response to AIDS came 'at the expense' of other health initiatives has hardened into a stylized fact in the minds of many influential commentators (see for example Easterly 2006; England 2007a, 2007b; Garrett, 2007; Bongaarts and Over, 2010). But while AIDS funding certainly grew at unprecedented rates, it is worth noting that, from the mid-2000s, other health-related funding also rose in absolute terms. There are indications that AIDS may have displaced donor dollars for malaria in some cases (Lordan *et al*, 2011) and that essential health services were affected in countries where the density of health-care providers was low (Grepin, 2012). However, the rise in health spending overall appears to have more than mitigated such effects (Shiffman, 2008) and funding for malaria rose from less than US$100 million in 2000 to US$ 1.71 billion in 2010 (WHO, 2012a: 15). Furthermore, as the international AIDS response matured beyond its initial emergency phase, UNAIDS and the Global Fund deliberately sought greater synergies within the public health sector (such as stream-lining HIV and TB treatment services) which meant that the distinction between funding for AIDS and funding for health services became increasingly difficult to draw in any meaningful way.

Precisely because the international AIDS response was multi-sectoral in nature, it benefitted many of the other MDGs (UNAIDS, 2011). For example, in high HIV prevalence countries, PMTCT and ART had a significant impact on infant mortality (MDG 5). Figure 3 shows that in South Africa, such interventions had a marked reduction in infant mortality (compared to the no-intervention scenario) and that if the AIDS response had been faster, so would have been the reduction in infant mortality. Other studies have similarly pointed to synergies between the AIDS response and improvements in maternal and child support services and general health-systems strengthening (e.g. Jerome and Ivers, 2010, Price *et al*, 2009, WHO Maximising Positive Synergies Collaborative Group, 2009, Nattrass and Gonsalves, 2010, UNAIDS, 2011).



Source: Own projections using the ASSA2008 model. Available: http://aids.actuarialsociety.org.za/ASSA2008-Model-3480.htm

Figure 3: Infant mortality in South Africa: with and without PMTCT and ART.

Note also that even if it would hypothetically have been better, in some sense, for funding to have flowed directly to other objectives, there is no guarantee that this would have happened and the chances are that it would have simply fallen in aggregate. Donor funding is not driven by neoclassical cost-benefit calculus, rather it is a moral economy shaped by values and politics. This is most obviously the case with regard to the United States which is not a typically

generous international donor yet provides 59% of all donor funding for AIDS to low- and middle-income countries, and over one and a half times as much as the rest of the OECD to combatting sexually transmitted diseases in Africa (Nattrass, 2013). US commitment to AIDS funding has remained strong even after the 2007/8 financial crisis when international public health funding from other OECD countries slackened. This is because AIDS, unlike other development causes, had strong bi-partisan political support of the kind unlikely to be replicated easily for other health or development objectives.

This is an important point with implications for how we think about the allocation of development resources. Specifically, it makes no sense to argue that AIDS funding should be reallocated to other priorities when it was precisely because AIDS was seen as a moral and political priority that the resources were raised for it in the first place. Rather, donor funding should be understood as a moral economy of resource allocation, and that in the case of AIDS funding, it is probably more strategic for the wider development community to work with the international AIDS response to ensure greater synergies between AIDS and other development objectives, and to leverage additional resources on the back of it.

Lessons for the Post-2015 Agenda: Taking Political-economy seriously

A recent WHO discussion document calls for a single health goal for the post-2015 era: 'universal health care' with a single indicator: life expectancy (WHO, 2012). The idea is that countries should design and implement interventions appropriate to their disease profile and level of development (WHO, 2012b). This has distinct echoes with the Alma-Ata declaration which left the design and delivery of primary health care dependent on what 'the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'. Unfortunately, as the fate of the Alma-Ata primary health care agenda attests, there is no guarantee that this will be effective.

Improving health outcomes is as much a political challenge as it is a technical/planning challenge (Buse *et al,* 2007). For example, in the absence of national and international mechanisms to hold national governments to account, funds for general budget support are all too easily misappropriated or shifted to other purposes (Unwin, 2004; De Renzio, 2006). As an evaluation of World Bank health funding concluded, 'the most pervasive lesson from the Bank's

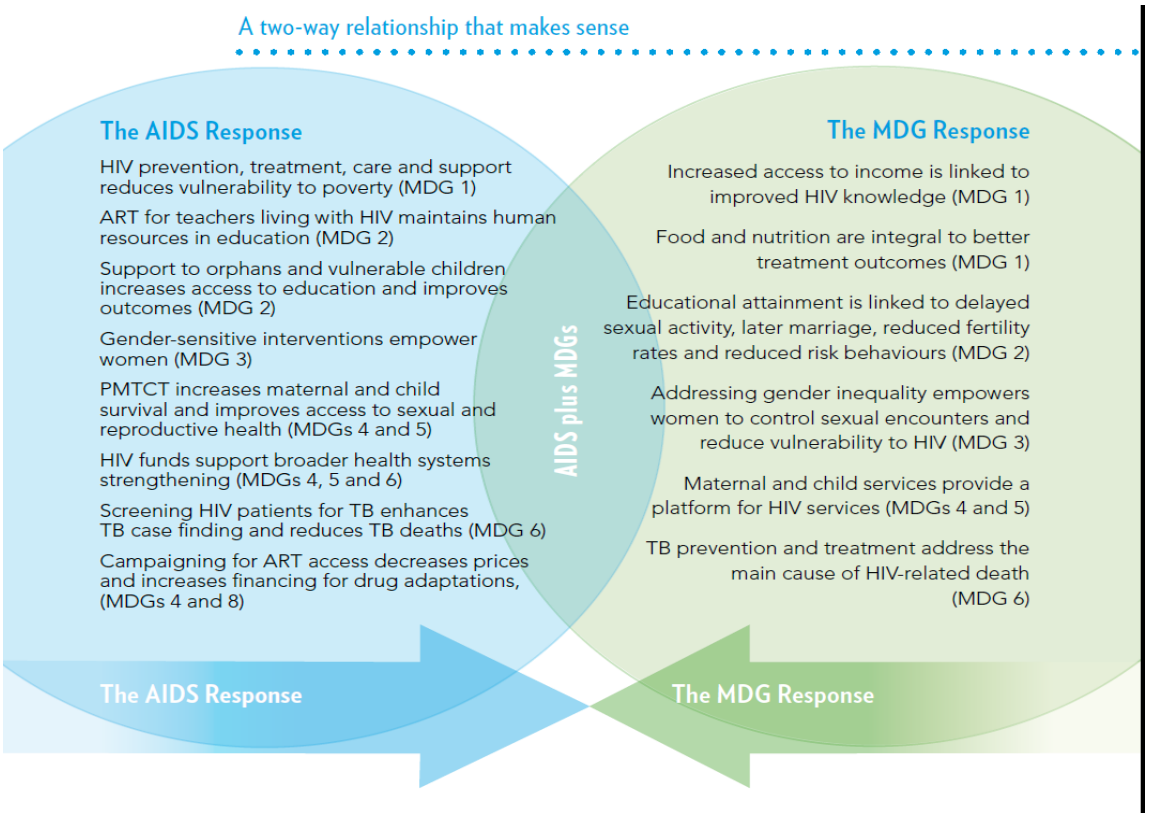
experience with health reform is that failure to fully assess the political economy of reform and to prepare a proactive plan to address this issue can considerably diminish prospects for success' (World Bank Independent Evaluation Group, 2009). The Alma-Ata Declaration's weak blandishments about the need for 'political will' and to involve people in the planning and implementation of health care remained mere words on a page.

The problem with using life expectancy as the single country target is that the relationship between government policy and the performance of the indicator is indirect, and subject to substantial measurement error. It is thus less useful than disease-specific targets for holding governments to account. Furthermore, by moving away from AIDS-specific targets, it threatens to undermine the role of the only effective citizen-driven health lobby ever to emerge in developing countries: AIDS activism.

It would be less risky to adopt a more pragmatic approach which builds on the energies, organisations and institutions created by the AIDS response to expand health care delivery at national level. This, as UNAIDS has pointed out in its 'AIDS plus MDGs' analysis, has the potential to enhance progress on the other MDGs precisely because combatting AIDS requires a multi-sectoral approach (Figure 4). And by linking the struggle for ART with demands for a better health-care system, new dynamism can be injected into the broader global health agenda by involving networks of AIDS activists to hold governments to account.

It is important to remember that because HIV disease is a chronic illness, ART patients have an on-going incentive to fight for ART *and* more effective health systems. As Yu *et al* noted in an assessment of the evidence of the relationship between AIDS spending and health systems:

> 'AIDS activists increasingly advocate for the right of access to universal primary health care. They have also changed the dynamics between health care providers and clients, thus helping prepare health systems for the delivery of chronic care, which requires much more give-and-take between care providers and their clients than does the delivery of acute care. Indeed it is the activism for AIDS that has created solidarity about health as a concern for humanity, and as part of the evolving paradigm on globalization' (Yu *et al*, 2008).



Source: UNAIDS, 2011: 4.

Figure 4: Synergies between MDG6 and the other MDGs

More recently, Mark Dybul, Executive Director of the Global Fund, told civil society organisations that they were essential to the partnerships needed to address global diseases: 'We need your active role in creating, building and sustaining the movement that we need to defeat AIDS, TB and malaria….. Partnerships are what make the Global Fund effective.'[14] Indeed, as the UN Road Map document noted back in 2001, a key objective of the MDGs was to 'trigger action and promote new alliances for development' (page 55, Annex paragraph 3). The Global Fund helped achieve this by requiring funding to be channelled through 'country co-ordinating mechanisms' involving government and civil society representatives,[15] and UNAIDS deliberately worked with both national governments and domestic and international AIDS activist organisations.

This has assisted citizens to become more effective in their engagement with the state. As Keck and Sikkink point out, global activist networks have helped

[14] Press release available from: http://health.groups.yahoo.com/group/internationaltreatmentpreparedness/message/23280
[15] http://www.theglobalfund.org/en/ccm/

domestic actors achieve greater leverage over the national governments by bringing international pressure to bear (1998: 12). De Waal makes a similar point, noting that African governments now find themselves in 'new webs of accountability' as citizen activists diversify their channels of influence (2006: 58-9). This was very much the case for the South African government, which found itself on the losing side of a political battle fought by activists linked into international networks and supported by institutions like UNAIDS (Grebe, 2011). And, even in countries like Brazil and Thailand with government's committed to addressing the AIDS epidemic, vigilant national and international activist networks helped keep political momentum going for the fight (Nattrass, 2008; Nun *et al*, 2012).

UNAIDS devotes substantial resources to monitoring progress towards a range of targets, and country reports are available on the UNAIDS website. As the International Development Law Organisation observes, this 'provides the opportunity to track States' compliance with international commitments on HIV, and identify obstacles and areas for increased support'. Additionally, the 'post-2015 development agenda on health should ensure that such monitoring of the global HIV response continues' (IDLO, 2012: 3).

Such monitoring will not be effective in the absence of clear disease-specific targets. Furthermore, it will make it harder for activists to advocate for improved service delivery without them. By framing universal access to treatment as an important international moral and developmental objective, international targets such as MDG.6B and the '3 by 5' campaign provided ammunition for domestic political activists to hold their governments to account. For example, an editorial in the *Lancet* in May 2005 opined that 'Without South Africa on board, with its 837,000 people affected by HIV/AIDS and its leadership position within Africa, 3 by 5 is but a pipe dream'. This prompted the South African health minister to release figures showing that the long awaited ART rollout was gaining pace. She said:

> 'I don't want to be pushed or pressurized by a target of three million people on antiretrovirals by 2005… WHO set that target themselves. They didn't consult us. I don't see why South Africa today must be the scapegoat for not reaching the target'.[16]

But the fact that South Africa had been singled out clearly rankled the government and the combination of international and domestic pressure

[16] Report from the Kaiser Family Foundation, May 6, 2005. Available on: http://www.thebody.com/content/art8436.html

eventually resulted in the South African government changing its policy on AIDS (Nattrass, 2007; Grebe, 2011).

A lesson for the post-2015 agenda is that global health goals should be set in ways that reflect and support efforts of citizens and governments to improve health and development outcomes. Reducing MDG6 to a single, inevitably nebulous, target is not as helpful as disease-specific targets where the role of government intervention in assisting their achievement is clearer. Furthermore, maintaining support for advocacy organisations and civil society groupings, and keeping their representatives on the boards of international organisations like the Global Fund and UNAIDS, is crucial not only to MDG6, but to MDG8 as well.

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