Global Agenda-Setting in Multilateral AIDS Governance: Testing the Vanwesenbeeck Model

Line Viktoria Fineide

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Supervisor: Professor Pieter Fourie

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

Globally as well as nationally, AIDS is politically contested. Since AIDS was first identified in 1981 there have been several responses to the pandemic, reflecting AIDS' biomedical, political and social nature and implications. Although there are many ways to frame and approach AIDS, no single approach appears to be universally superior to any other, especially as these various approaches are essential for a comprehensive global response to the pandemic. However, these several responses can also represent contested constructs of how AIDS is inter-subjectively problematised based on different ontological understandings and epistemological preferences. The existence of such contested constructs suggests that multilateral AIDS governance is shaped by binaries and zero-sum games where the overall approach ought to be holistic. As such, some scholars claim that HIV is increasingly treated as something medical, and outside the context of overall development issues, sexual and reproductive health, human rights and structural violence. Recently, Vanwesenbeeck (2011) offered a simplified model of 'high-road' and 'low-road' solutions to the pandemic, problematising specifically the global policy/political response. Vanwesenbeeck's model suggests that biomedical, vertically distributed and asexual high-road approaches are prioritised at the expense of the more community oriented, sexual and rights-based low-road approaches. This, Vanwesenbeeck argues, is because current ideas and norms of the market, moralism and medicalisation are more aligned with the de-contextual, de-sexual and quantifiable characteristics of high-road approaches. This study tests the analytical utility of Vanwesenbeeck's model with a case study of the policy and political narratives emerging from the International AIDS Society's nine International AIDS Conferences from 1996 until 2012. The research question this study investigates is thus: Can Vanwesenbeeck's (2011) model of high-road and low-road solutions be identified in and illuminate the policy ideas, problem definitions and political binaries that play out in the discourse surrounding the biennial International AIDS Conferences between 1996 and 2012? This main research question is complemented by three sub-questions concerning 1) the strengths and limitations of Vanwesenbeeck's model, 2) the general trends and developments in global AIDS policy/political responses during, before and after the biennial International AIDS Conferences and 3) the impact of the Global Financial Crisis on the global AIDS response. Applying a qualitative methodology, the study finds that Vanwesenbeeck's model can both be identified in and elucidate the political discourses, policy implementations and binaries surrounding the International AIDS Conferences between 1996 and 2012, albeit not all. The analytical utility of Vanwesenbeeck's model is limited by oversimplification of the high-road/low-road binary and the exclusion of alternative ideas for high-road prioritisation, such as humanitarianism, securitisation/sensationalism and the neoliberal ideological link between medicalisation and the market, as well as negligence of the impact of the Global Financial Crisis.

Opsomming

Vigs is internasionaal sowel as nasionaal polities omstrede. Sedert Vigs die eerste keer in 1981 geïdentifiseer is, was daar al verskeie reaksies op die pandemie wat die biomediese, politieke en maatskaplike aard en implikasies van die siekte weerspieël. Hoewel daar verskillende maniere is om Vigs te beskou en te benader, blyk geen enkele benadering universeel superieur te wees nie, veral aangesien al hierdie verskillende benaderinge noodsaaklik is vir ’n omvattende globale reaksie op die pandemie. Tog kan hierdie verskillende reaksies ook as betwiste konstrukte beskou word van hoe Vigs intersubjektief op grond van verskillende ontologiese begrippe en epistemologiese voorkeure geproblematiseer word. Die bestaan van sulke betwiste konstrukte gee te kenne dat multilaterale Vigsbestuur deur binêre en nulsombenaderinge gekenmerk word, terwyl die algehele benadering veronderstel is om holisties te wees. Sommige vakkundiges beweer dan ook dat MIV al hoe meer as ’n mediese probleem hanteer word, buite die konteks van oorkoepelende ontwikkelingskwessies, seksuele en voortplantingsgesondheid, menseregte en strukturele geweld. Vanwesenbeeck (2011) het onlangs ’n vereenvoudigde model van sogenaamde ‘grootpad-’ en ‘smalpadoplossings’ vir die pandemie aan die hand gedoen wat spesifiek die algehele beleids-/politieke reaksie problematiseer. Vanwesenbeeck se model voer aan dat biomediese, vertikaal verspreide en aseksuele grootpadbenaderinge dikwels ten koste van die meer gemeenskapsgerigte, seksuele en regtegebaseerde smalpadbenaderinge gekies word. Dít, reken Vanwesenbeeck, is omdat huidige denke en norme met betrekking tot die mark, moraliteit en medikalisasie eerder met die kontekslose, geslaglose en kwantifiseerbare kenmerke van grootpadbenaderinge strook. Hierdie studie het die analitiese nut van Vanwesenbeeck se model getoets met behulp van ’n gevallestudie van die beleids- en politieke narratiewe uit die Internasionale Vigsvereniging se nege internasionale vigskonferensies vanaf 1996 tot 2012. Die navorsingsvraag van hierdie studie was dus: Kan Vanwesenbeeck (2011) se model van grootpad- en smalpadoplossings geïdentifiseer word in, en lig werp op, die beleidsidees, probleemomskrywings en politieke teenpole wat uit die diskoers by die tweejaarlikse internasionale vigskonferensies vanaf 1996 tot 2012 gespruit het? Hierdie hoofnavorsingsvraag is aangevul deur drie verdere vrae oor (i) die sterkpunte en beperkinge van Vanwesenbeeck se model, (ii) die algemene tendense en ontwikkelings in wêreldwye beleids-/politieke reaksies op Vigs gedurende, voor en na die tweejaarlikse internasionale Vigskonferensies, en (iii) die impak van die wêreldwye finansiële krisis op die wêreldwye Vigsreaksie. Met behulp van ’n kwalitatiewe metodologie het hierdie studie bevind dat Vanwesenbeeck se model wél geïdentifiseer kan word in, en lig werp op, sommige van die politieke diskoerse, beleidsinwerkingstelling en teenpole waartoe die internasionale vigskonferensies tussen 1996 en 2012 gelei het. Die analitiese nut van Vanwesenbeeck se model word egter beperk deur die oorvereenvoudiging van die grootpad-/smalpad-teenpole en die uitsluiting van alternatiewe idees oor die prioritisering van grootpadoplossings, soos filantropie, sekuritasie/sensasionalisme en die neoliberale ideologiese verband tussen medikalisasie en die mark, sowel as die verontagsaming van die impak van die wêreldwye finansiële krisis.

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Glossary

AAI	Accelerating Access Initiative
Act Up	The AIDS Coalition to Unleash Power
AIDS	Acquired Immune Deficiency Syndrome
ALP	AIDS Law Project
ART	Antiretroviral therapy
CDC	US Centers for Disease Control and Prevention
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
HIV	Human Immunodeficiency Virus
IAS	International AIDS Society
ICPD	International Conference on Population and Development
IR	International Relations
MAP	The World Bank Multi-Country HIV/AIDS Programme for Africa
MC	Male circumcision
MDG	Millennium Development Goals
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
PEPFAR	The President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
RCT	Randomised Controlled Trials
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
TAC	Treatment Action Campaign
TASP	Treatment as prevention
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

UNGASS	United Nations General Assembly Special Session
UNSC	United Nations Security Council
US	United States of America
WB	The World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

Chapter 1: Introduction

1.1 Background and rationale

The human immunodeficiency virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) have affected the world beyond imagination the last three decades, and still poses "one of the world's most serious health challenges" (UNAIDS, 2012:8). According to the newest statistics from the Joint United Nations Programme on HIV/AIDS (UNAIDS), 34 million people were living with HIV and 1.7 million people died of AIDS in 2011 (UNAIDS, 2012:14). Mostly attacking human beings at the prime of their lives, AIDS has structural implications beyond misery and death. It affects local communities, wipes out entire generations, makes children orphans, and puts pressure on economies where a decreasing sick workforce is demanding increasing health care. AIDS is human. It is widespread globally, can cross borders and affect anyone on its way, yet it is selectively cruel to the resource-weak. This makes AIDS an issue of global political and medical – as well as local and regional – human rights concerns (Greene *et al*., 2012:iv, 3; Heywood, 2009:15-16; OHCHR, s.a.).

AIDS can be dealt with in numerous ways, all of which are essential to fight it. Medically, scientists have for decades worked towards finding a cure for AIDS, and have made great accomplishments in developing antiretroviral therapy (ART), which has improved quality of life for people living with HIV, saved people from dying of AIDS-related diseases and prevented mother-to-child transmissions (MTCT) of HIV (WHO *et al*., 2011:5). Also, doctors are approaching HIV and AIDS with their medical expertise by caring for patients and distributing medicines. Politically, domestic governments have national plans and strategies, while organisations like the United States President's Emergency Plan for AIDS relief (PEPFAR) and UNAIDS, are examples of bilateral and multilateral approaches. Efforts have been made both to treat those already infected and to prevent the virus to from spreading further. The growing awareness and effectiveness in approaching the pandemic have reaped results. The number of new infections per annum decreased from 3.2 million in 2001 to 2.5 million in 2011 (UNAIDS, 2012:14). Access to health facilities and ART, although still lacking substantially in crucial regions, has increased (WHO *et al*., 2011:5).

This more effective response to HIV and AIDS has taken time; varying responses have also been difficult to coordinate as the disease engages many actors and cross over several disciplines, although the overall goal – to prevent people from dying of AIDS and acquire HIV – remains the same.

It is possible to identify contested constructs of AIDS as a political problem. These constructs include 1) medical and developmental problem definitions, 2) a treatment vs. prevention binary, and 3) human rights vs. public health, as well as 4) domestic and multilateral approaches.

Claims have been made that HIV is increasingly treated as something medical, and outside the context of overall development issues and sexual and reproductive health (SRH) (Germain *et al*., 2009:840-842; Vanwesenbeeck, 2011:291-292), although "[t]he importance of linking [SRH] and HIV is widely recognized" (WHO *et al*., 2009:1). Another concern is that the increased focus on treatment after the ART breakthrough in 1996 has overshadowed prevention efforts (Biehl, 2007:1085; Knight, 2008:172). Some critics have gone so far as to claim that "[f]rom the very beginning of the global response to the AIDS pandemic, prevention has been marginalised. Treatment has dominated" (Horton & Das, 2008:421). This accusation is not supported by policy documents like the 1998 Geneva Principle, which "provided for a balance between community and science" (Kallings & McClure, 2008:28), or the view that the 2004 International AIDS Conference was held in Bangkok to "recognize the effectiveness of Thailand's prevention programme" (Kallings & McClure, 2008:38). However, others argue that although prevention has been at the core of the agenda, more money has initially been distributed to treatment because it does not have to deal with cultural and political complexities that a focus on prevention provokes (Knight, 2008:87). The fact that Peter Piot, then Under Secretary-General of the United Nations (UN) and Executive Director of UNAIDS, emphasised at the 2002 Barcelona conference that "prevention and treatment should not be seen as competing aims" (Bliss, 2012:14, see also Knight, 2008:166) and that UNAIDS in 2004 issued a similar statement (Knight, 2008:172) indicates both that prevention has been on the agenda and that it is in increasing danger of becoming marginalised. Recently, significant scientific developments have led to an emphasis on 'treatment as prevention' in an effort to show the connection between the two (Bliss, 2012:16).

These constructed problem definitions and concomitant policy responses are a problem because the implication is that zero-sum games emerge where one side of a binary is being sacrificed for the other side to succeed, ignoring that there are many ways of equal importance needed to approach the pandemic. People are still getting infected and dying, which illustrates the growing concern that "[c]urrent strategies for HIV prevention, treatment, care and support will not take us to our ultimate goals" (UNAIDS, 2010a:3).

1.2 Problematising contestations

The construction of political and policy problems as indicated above is a topic in theories of public policy and International Relations (IR). Bacchi (2009) investigates how governments' public policies are (unintentionally) shaped by assumptions about what needs to be fixed. Policies assume a need for improvement, which indicates that there is something to repair in the first place – a clear understanding of what the 'problem' is (Bacchi, 2009; Howlett *et al*., 2009:4, 93). The response to this problem is dependent on how it initially is represented and problematised – or "call[ed] into question" (Dean, 2010:38). By acknowledging that problems are problematised and defined within a context we also acknowledge that there is an idea space limiting the scope of what the problem 'is' and what the 'solutions' might be (Osborne, 1997:74). In the process of simplifying problems and solutions to them, ideas about how problems are understood are taken for granted and "[o]nly part of a story is being told" (Bacchi, 2009:xii; see also Osborne, 1997:75). This questioning of the status quo and what it produces is also put forward on the international (and IR theoretical) level, by constructivists. Focusing on the relationship between materialism and ideas, constructivists interrogate how ideas and norms are affecting and affected by the inter-subjectivity of actors within the global structure, shaping interests and global policies. In other words, constructivists argue that international responses are not made in a vacuum of complete objectivity, but are moulded by ideas and ontological assumptions of 'how the world is' (Barnett, 2008:162-163; Finnemore & Sikkink, 1998:888-892; Hopf, 1998:176, 182; Reus-Smit, 2005:196; Wendt, 1992:398).

Focusing on multilateral responses towards HIV and AIDS, Vanwesenbeeck (2011) constructed a model that interrogates the global problematisation of the pandemic. Making a distinction between 'high-road' and 'low-road' solutions, she argues that biomedical, non-sexual, clinical and individualised high-road approaches have been prioritised at the expense of low-road approaches focused on sexual and reproductive health, sexuality, sexual HIV transmission, communities and care. This binary of problem definitions and response mechanisms is constructed despite the fact that both are needed in order to address the AIDS pandemic comprehensively. Vanwesenbeeck argues that high-road solutions receive more ideational and material support than low-road solutions because it is easier and more beneficial for donors and policymakers to treat people as patients than to acknowledge the sexual and cultural or political contexts of HIV/AIDS. This, she claims, is a response to current ideas of moralism, medicalisation and the neoliberal market, shaped by influential policymakers and donors' overall assumptions about the world. Differently put, high-road prioritisation is a consequence of how AIDS has been understood and problematised globally.

Vanwesenbeeck's (2011) model suggests that responses based on moral norms, exemplified by PEPFAR's initial emphasis on abstinence from sex, have negatively affected low-road solutions' emphasis on sex and sexuality. Moralistic norms also, according to Vanwesenbeeck, agree with contemporary ideas of non-sexual scientific fixes and medicalisation; approaches that are easier to implement and evaluate than more complicated cultural and political ones. Furthermore, ideas of medicalisation suit the pharmaceutical industry and the neoliberal market. Thus, Vanwesenbeeck argues, current problem definitions of HIV and AIDS brush low-road solutions under the carpet; medical high-road solutions win the constructed zero-sum game.

1.3 A thesis and a test

This study investigates the utility of Vanwesenbeeck's (2011) model and how policy ideas, problem definitions and constructed binaries play out in multilateral responses to HIV and AIDS. Vanwesenbeeck's argument is holistic, yet not without limitations, as she merely investigates changes in donor contributions without ever referring to the Global Financial Crisis or its effect on decreased HIV funding after 2008 (WHO *et al*., 2011:8). In this study, Vanwesenbeeck's model is tested through an examination of the International AIDS Conferences arranged between 1996 and 2012.

Initially co-organised by the US Centers for Disease Control and Prevention (CDC), Emory University and the World Health Organisation (WHO) in 1985 as a scientific meeting, the International AIDS Conferences have since 1988 been hosted and institutionalised by the International AIDS Society (IAS). The IAS' new mission for the conferences was holistic, and included socio-cultural as well as medical factors (Bliss, 2012:1, 4; Kallings & McClure, 2008:15), leading the biennial conferences to become comprehensive meetings that serve as important arenas for cross-levelled knowledge exchange, human rights activism, and debates within HIV and AIDS. Over the years, the conferences have witnessed frustration, accusations, and controversial disagreements, but also more recent scientific, economic, political and social developments within HIV (Bliss, 2012; Kallings & McClure, 2008). As such, these global AIDS conferences have become a theatre where disputes have raged, consensus has been sought and discarded, and policy alternatives debated; they provide a vivid forum for the development and contestation of the meta-discursive as well as actual political environment that informs AIDS problems and policy thinking at multilateral, international and domestic levels.

The International AIDS Conferences are, of course, only one among many responses to the pandemic, and cannot possibly account for all the events, developments, and responses within the field. However, they "are the largest assemblies of global health professionals focused on a single disease and among the largest regular global meetings of any kind" (Bliss, 2012:1). Moreover, the effects of the conferences are not limited to the meetings themselves; important civil society engagement and policy outcomes are happening outside the venues – during, before or after the event itself. Therefore, the International AIDS Conferences serve as a case study for the purposes of this research project. The conference dates are used as pinpoints in history to try to recognise important developments in multilateral AIDS governance, starting with the scientific breakthrough in Vancouver in 1996 – which provided encouraging news in the development of ART – up until the latest conference in Washington D.C. in 2012. A brief overview of the overall conference trends and events in this period can be viewed in the following table.

Table 1.1: IAS conference trends and key events

Year	Conference trends	Outside events	High-road	Low-road	Tendencies
1996 Vancouver	- ART breakthrough - Call for resources	- UNAIDS' first meeting			Building of institutions
1997					
1998 Geneva	- The Geneva Principle - Treatment vs. prevention - Treatment side effects - North-South				
1999					
2000 Durban	- Developing world - Access to treatment - Call for resources	- MDG - Accelerating Access Initiative (AAI) - Cheaper drugs			
2001		- UNGASS - Funding starts to increase - Doha Declaration - TRIPS			
2002 Barcelona	- Access to treatment - WHO '3 by 5': 3 million on ART by 2005 - Treatment vs. prevention - Increased participation by prominent leaders	- The Global Fund to Fight AIDS, Tuberculosis and Malaria's (the Global Fund) first meeting			Increased funding
2003		- PEPFAR's first launch			
2004 Bangkok	- Women in focus - Universal access to treatment, care and prevention - Call for funding → The Global Fund - Call for more scientific content				
2005					
2006 Toronto	- Treatment vs. prevention → treatment as prevention (TASP) - Prevention technologies - Pressure on pharmaceutical	- UN General Assembly Political Declaration on HIV/AIDS → access to treatment, prevention and care for all by 2010			

	companies - Call for more scientific content - Gender sensitive				
2007					
2008 Mexico City	- Universal access to treatment - Discrimination and stigma	- Global Financial Crisis - PEPFAR announce $48 billion commitment			Remedicalisation and eventual funding cuts
2009					
2010 Vienna	- The Vienna Declaration - TASP - Prevention technologies - Treatment 2.0 - Human Rights - Funding cuts				
2011		- HPTN 052 trial: TASP - UN General Assembly Political Declaration on HIV/AIDS → access to treatment, prevention and care for all by 2015			
2012 Washington D.C.	- The Washington D.C. Declaration: end AIDS - Scientific developments → TASP → eradiction of AIDS - Human rights - Call for resources				

The general tendencies and high-road/low-road trends referred to in this table are only suggesting an overall picture, and cannot convey a complex reality. For instance, high-road and low-road trends should not be understood as mutually exclusive. The greyed out blocks are only indicating which approach that is believed to be most dominant in periods of time. An updated version of this preliminary table can be found in Chapter 3.

As the table shows, despite the scientific ART breakthrough presented at the 1996 International AIDS Conference in Vancouver, the reality of medical side effects and limited access to ART ensured a continued low-road emphasis the following years, especially when it came to preventing the sexual transmission of HIV. Community involvement and increased attention to the situation in the developing world, which were accentuated at the conferences in Geneva and Durban, also underscore this low-road trend. At the same time, calls for more resources increasingly became a topic during the International AIDS Conferences in order to meet the opportunities and challenges posed by ART. This quest for funding was followed by a growing concern that treatment efforts would financially overrule sexual prevention approaches (Bliss, 2012:11-13; Knight, 2008:87). During this period prominent institutions were established to coordinate the global AIDS response, starting with UNAIDS in 1996; the Accelerating Access Initiative (AAI) made sure cheaper international drug prices were negotiated, and the Doha Declaration of 2001 increased the access to generic medicines by

respecting rights to public health over the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

During this period of increased funding, access to ART was increasingly on the agenda, exemplified by the WHO's '3 by 5' initiative to get three million people on treatment by 2005 (Bliss, 2012:13; Knight, 2008:166). The constructed divide between treatment and prevention continued to grow, but low-road solutions were still an important part of the agenda. For instance, the 2004 International AIDS Conference in Bangkok had a strong focus on prevention of sexual transmission and women's vulnerable position in the pandemic. However, during the Toronto International AIDS Conference in 2006, there were indicators that the 'high road' biomedical focus started to surpass the low-road agenda, as in addition to its emphasis on gender inequalities and violence new discoveries sparked discussions about biomedical prevention efforts and 'treatment as prevention' (Bliss, 2012:16; IAS, 2007:13-14; Kallings & McClure, 2008:38). This biomedical high-road trend is increasingly recognisable in the years to follow, emphasised by scientific breakthroughs like the HPTN 052 trial, confirming that ART can lower sexual transmission rates (IAS, 2012:7; WHO, 2012:6). Low-road solutions cannot be said to have diminished entirely from the agenda, but it is possible to recognise Vanwesenbeeck's model in what seems to be an increasingly medicalised high-road focus. Not elaborated upon by Vanwesenbeeck, however, is how access to funds can be a forceful factor affecting which ideas and approaches to adhere to. During 2009, and progressively more in 2010, HIV funding came to a halt in what is believed to be a reaction to The Global Financial Crisis (WHO *et al*., 2011:8). This global recession, therefore, should be taken into account in an analysis of Vanwesenbeeck's model.

1.4 Problem statement

Globally as well as nationally, HIV/AIDS is politically contested. In addition to the grand binary of biomedical vs. behavioural conceptualisations and responses, Political Science and its cognate disciplines have offered problem definitions emanating from Policy Studies and International Relations. Ostensibly, these conceptualisations frame the epidemiological and the programmatic challenges of the global epidemic, as well as appropriate responses to it; although there are many ways to frame and approach AIDS, no single approach appears to be universally superior to any other. Recently, however, Vanwesenbeeck (2011) offered a simplified model of 'high-road' and 'low-road' solutions to the pandemic, problematising specifically the global policy/political response. If Vanwesenbeeck's model can be accurately identified and applied in global political responses to the pandemic, it might have analytical utility by simplifying the complexity and narrowing the scope of effective and sustainable

policy responses. This study is elucidating and testing Vanwesenbeeck's model with a case study of the policy and political narratives emerging from the International AIDS Society's nine International AIDS Conferences from 1996 until 2012. This analysis is complemented by an interview with a key civil society informant (see Neuman, 2011:454) from the Treatment Action Campaign who was present at many of the nine conferences.

1.5 Research question and theoretical framework

The research question this study investigates is:

Can Vanwesenbeeck's (2011) model of high-road and low-road solutions be identified in and illuminate the policy ideas, problem definitions and political binaries that play out in the discourse surrounding the biennial International AIDS Conferences between 1996 and 2012?

Sub-questions supporting this primary research question include the following:

- What are the strengths and limitations of Vanwesenbeeck's (2011) model?
- What have been the general trends and developments in global AIDS policy/political responses as presented by policymakers, donors, civil society and multilateral organisations during, before and after the biennial International AIDS Conferences?
- Has the Global Financial Crisis affected the global AIDS response, and if so, in what way(s)?

The main focus of this study is Vanwesenbeeck's (2011) model of high-road and low-road responses to the HIV/AIDS pandemic. She argues that non-sexual, biomedical, ART-focused and individualised HIV responses – what she calls 'high-road' solutions – are prioritised by the global community at the expense of 'low-road' solutions that emphasise sexual and reproductive health, communities, prevention of sexual transmission, human rights and gender, despite the recognition that both approaches are needed to fight the pandemic. The Vanwesenbeeck model is theoretically contextualised in public policy problematisations (Bacchi, 2009) and IR constructivists' emphasis on how global policies are not based on objective truths, but shaped by ideas and norms obtained through inter-subjective interactions (Barnett, 2008:162-163; Hopf, 1998:176, 182; Reus-Smit, 2005:196). Importantly, this theoretical background is only used to illuminate important insights in Vanwesenbeeck's model, and is not used as prominent analytical tools in and of themselves. The findings are supported by a semi-structured interview with a key informant from civil society who attended many of these conferences.

1.6 Research design and methods

This study is descriptive and explanatory (Neuman, 2011:38-40). It is descriptive because it seeks to historically outline and describe how global AIDS agendas and policies have developed surrounding the International AIDS Conferences between 1996 and 2012. It is explanatory in the sense that it aims to test the utility of Vanwesenbeeck's (2011) model of high-road and low-road approaches for explaining this historical development. In so doing, the study engages explanatory research for interrogating "*why* things are the way they are" (Neuman, 2011:39, original emphasis).

The overall method applied in this study is qualitative. It is mainly based on interpretations of secondary sources accessed through Stellenbosch University's library and databases, as well as primary source reports and policy statements from the IAS and its conferences, multilateral organisations, governments and the global HIV/AIDS civil society. This information is complemented by primary data gathered from a semi-structured interview of a key informant who attended many of the International AIDS Conferences between 1996 and 2012. It must be stressed that the interviewee's informed experiences and reflections are only complementary to the overall findings in the earlier stages of the study, and are therefore not the principal source of information. The semi-structured interview is chosen in order to allow for a free flow of reflections and probing, while not getting off-topic (Flick, 2011:112-113). The interviewee is an experienced professional from the Treatment Action Campaign (TAC) and the former AIDS Law Project (ALP) in South Africa. The TAC has extensive experience with HIV/AIDS policies and mobilisation, and is accessibly situated in Muizenberg outside Cape Town. While this study could have benefited from more than one personal interview, this ideal is unfortunately unobtainable due to time constraints.

1.7 Limitations of the study

This study is affected by the limitations of qualitative methods in general. A qualitative approach is essential for this study in order to obtain an in-depth understanding necessary for an analysis of the discourse around a complex, multifaceted and sensitive topic. However, qualitative data are not as precisely accumulated or measurable as data from the more standardised quantitative or mix-method approaches (Neuman, 2011:174). Therefore, the overall analysis of agenda-setting in multilateral AIDS governance and the test of Vanwesenbeeck's (2011) model are affected by qualitative approaches' supposedly inferior ability to generalise or strive for 'objective truths' compared to their methodological cousins. Then again, the aim of this thesis is to gain insights in global AIDS agendas by analysing whether the themes, discourses and policy outcomes around and during the International

AIDS Conferences indicates a recognisable pattern aligned with Vanwesenbeeck's (2011) model, and qualitative research is well suited to such research.

Hence, as the research question also suggests, this thesis is working with two limitations concerning the case study itself and the timeframe of the study. As mentioned earlier, the International AIDS Conferences cannot represent the entire idea space of multilateral AIDS agendas and responses. They are, however, important meeting places where much of the contemporary AIDS agendas are discussed by multiple actors on various levels. The timeframe of the study, 1996 to 2012, is evidently also excluding information from before or after this time. There are two reasons why this timeframe is chosen. First of all, there have been 19 International AIDS Conferences in total, and to focus on all of them would compromise the quality of the analysis. Second, the years in focus are important markers for recent developments in AIDS responses. The year 1996 provided significant developments affecting global AIDS policies and responses, exemplified by the biomedical ART breakthrough and the establishment of UNAIDS. Also, Vanwesenbeeck (2011:290) starts her analysis around this time, with the acknowledgement of the Cairo Agenda in 1995. The last International AIDS Conference was held in Washington D.C. in 2012, which is also why 2012 is the last year of focus in this study. The limitations with Vanwesenbeeck's model itself are further discussed in Chapter 2.

1.8 Chapter outline

Chapter 1: Introduction. The aim of this chapter is to introduce the reader to the background and main discussions around the topic, to present the problem statement and research question, and to demonstrate the theoretical background and model. The research method used and the limitations of the study are also elaborated upon.

Chapter 2: Theoretical background and Vanwesenbeeck's model. This chapter aims to further elaborate on the background theories of public policy problematisations and IR constructivism for illuminating Vanwesenbeeck's (2011) model. A discussion of the model itself, including contributions and limitations, represents the main bulk of this chapter.

Chapter 3: Historical outline, 1996-2012. In this chapter the history of the International AIDS Conferences (from 1996 to 2012) and what has been discussed and occurred during, before and after these conferences are viewed in detail. The aim of this chapter is to highlight the main agendas recognised in this historical outline and to view these from different frameworks that illuminate various sides of how multilateral AIDS governance has developed. A few references are made already here to Vanwesenbeeck's (2011) model.

Chapter 4: Analysis of Vanwesenbeeck's model. This chapter presents an overall analysis of Vanwesenbeeck's (2011) model and its utility for explaining key events and historical developments as presented in Chapter 3. This analysis is complemented with inputs and quotes from an interview with a key informant from the TAC.

Chapter 5: Conclusion, and Future Agendas. This concluding chapter provides a summary of the study, the main points that can be drawn from the analysis of Vanwesenbeeck's (2011) model and specifically answers the research questions. This chapter also suggests focuses for future research.

1.9 Conclusion

This chapter introduced the background of the research topic, the challenges and questions under examination, the methodology that is used to investigate these questions, and the limitations of the study. This study investigates agenda-setting within multilateral AIDS governance by testing the utility of Vanwesenbeeck's (2011) model of high-road and low-road solutions by using the International AIDS Conferences between 1996 and 2012 as an historical case study.

Vanwesenbeeck argues that biomedical high-road approaches to the pandemic are prioritised at the expense of more contextual low-road approaches. The following chapter discusses this model after a brief elaboration of the theoretical background used to illuminate Vanwesenbeeck's points.

Chapter 2: Theoretical background and Vanwesenbeeck's model

2.1 Introduction

Since AIDS was discovered in the 1980s, there have been several responses to the pandemic on various levels. AIDS is of biomedical, political and social concerns. Scientists are constantly investigating how the HI-virus works in the human body to improve already existing biomedical interventions, or even develop a vaccine or cure. Also, HIV is physiologically discriminating certain groups over others, such as women and men who have sex with men (MSM), due to the nature of intercourse itself. Still, transmission of the virus is not only biological; it is also attached to social, political and cultural contexts. Sexual violence, for instance, and a lack of power to negotiate sexual matters are closely linked to the spread of the pandemic. It is therefore important that the global response to HIV and AIDS remains diverse. As Chapter 1 pointed out, some scholars argue that this is not the case. One of them, Vanwesenbeeck (2011), has made a model differentiating between the biomedical 'high-road' and the more sexual and community oriented 'low-road' when analysing multilateral AIDS responses. Her argument is that international policymakers and donors are, due to contemporary ideas of the neoliberal market, morals and medicalisation, prioritising high-road solutions at the expense of the low-road. This study is testing Vanwesenbeeck's model by using the nine International AIDS Conferences between 1996 and 2012 as historical markers. The aim of the study is to see if Vanwesenbeeck's model can be identified in and highlight the policies, binaries and ideas in the discourse before, during and after these conferences. The purpose of this chapter is therefore to discuss Vanwesenbeeck's model itself, as well as its limitations and strengths. Before this is done in the latter part of the chapter, the model is first theoretically contextualised within public policy problematisations and IR constructivism.

2.2 Theoretical background

Although Vanwesenbeeck (2011) does not explicitly state any theoretical preferences, her model can be illuminated in the constructivist framework of ideational and structural approaches. Expanding in the 1990s primarily as a reaction to exclusively materialist theories – specifically the conventional theories of neorealism and neoliberal institutionalism – and meta-theoretical critical theory, constructivism presented a challenge to understandings of ontology and epistemology. Constructivists reject a purely material ontology by emphasising how ideas are enforcing and reinforced by the physical world, thereby arguing that understandings of 'how the world works' are inter-subjective and not objective. They also

criticise theories conforming to solely positivist and/or meta-theoretical epistemologies, claiming that "research strategies should be question-driven rather than method-driven" (Wendt, 1992:423; see also Reus-Smit, 2005:188, 194-196). Constructivist ideas can be recognised in Vanwesenbeeck's model due to her theorising on how contemporary ideas and norms – referred to by her as forces of the market, medicalisation and morality – shape multilateral policy outcomes and how epistemological preferences are benefiting the one category of AIDS responses over the other. The theoretical background used in this study is thus rooted in the post-material ontology and pluralistic epistemology found in constructivist IR theory and in some constructivist-inspired public policy analyses (Bacchi, 2009). This section starts with the latter: a public health policy view that questions the process of policymaking itself and the identification of 'problems'. This can give insight to Vanwesenbeeck's model by illuminating how the understanding of AIDS as a policy problem (and thus the response) is affected by subjective ideas and belief systems. Further on, this is linked to the international level through an IR theoretical section on constructivism's view on ontology and epistemology, before the main section focuses on Vanwesenbeeck's model itself.

2.2.1 Public policy and problem representations

Domestically and internationally, there seems to be a constant presence of objective and intolerable challenges that need to be dealt with through policies. For instance, most people will not argue against the statement that HIV causes such a huge challenge that comprehensive responses are required. Hence it makes sense that "[e]arly works in the policy sciences often assumed that problems had an 'objective' existence" (Howlett *et al*., 2009:93) and why "the presumption that the purpose of policy is to solve 'social problems' remains a grounding premise in most conventional approaches to policy analysis" (Bacchi, 2009:x, emphasis removed). Also logically, in conventional public policy, the success of a policy is measured according to how effectively it managed to solve the problem, if it did. Conventional public policy, whether viewing policies as direct responses to existing problems or as more selective outcomes of negotiations among different interests, can be referred to as 'reactive' or 'positivist' because they are responding to 'objective' problems that are 'neutrally' evaluated within the same framework (Howlett *et al*., 2009:178-179; Osborne, 1997:173-174).

This process seems reasonable, yet a 'positivist' view on the role of policies also "assume[s] the existence of a 'problem' that needs 'fixing'" (Bacchi, 2009:xi). While certainly not arguing that responding to challenges is unnecessary, some scholars question the conventional

view on how policies take shape. They claim that in the conventional approach 'problems' are viewed as value-free and exogenous, existing in their own right and independent of social interactions. These scholars' argument is that what might seem as clear understandings of what a problem is and what the adequate solution(s) ought to be, actually are affected by how the 'problem' is represented in the first place (Bacchi, 2009:x-xi; Howlett *et al*., 2009:4). In other words, public policies are products of ideas of what needs to be fixed – of what the implied problem is. The identification of a 'problem' is shaped by taken-for-granted assumptions in policymakers' understanding of the world. This definition process – how 'problems' are problematised, or "thought about as 'problems'" (Bacchi, 2009:xi; see also Dean, 2010:38) – "is very much a socially constructed process since it involves the creation of accepted definitions of normalcy and what constitutes an undesirable deviation from that status" (McRobbie & Thornton, 1995, paraphrased in Howlett *et al*., 2009:93). According to this view, public policies are therefore shaped, albeit not deliberately, by how problems are initially understood, problematised and represented. Linked to Vanwesenbeeck's (2011) model the argument is not that AIDS is a constructed problem or that some understandings of AIDS are superior to others, but that current responses to the pandemic – what Vanwesenbeeck claims are primarily so-called 'high-road solutions' – are shaped within someone's understanding of the world and how AIDS works within it.

The notion of problematisation is important, for it recognises the significance of ideas; the construction of problems and policies are not simply shaped by actors' own material interests, but created in the ontological idea space of how a 'problem' is understood. Moreover, problematisation is not something one can merely avoid. To problematise issues is essential in order to create any policies at all; without making sense of an issue challenges would stay incomprehensibly complex. Simplification as a characteristic of problematisation can therefore be understood as a necessary good (Osborne, 1997:74-75). How AIDS is problematised is also deciding which policies not to pursue. 'Bad' policies are discarded. The downside of this simplification, as already implied, is that the understanding of the 'problem' and what it contains is (inter-)subjective, shaped within present assumptions of what is important and what can be excluded. This is again limiting the idea space from which policy decisions are shaped and affecting what is viewed as 'bad' policies (Bacchi, 2009:xii; Osborne, 1997:75). Bacchi's (2009:x) argument is therefore that the construction of 'problems' followed by their 'adequate solutions' is not exogenous and independent of ideas and society. Rather, 'problems' are unintentionally moulded by given assumptions; they are endogenous and a product of problematisations. Therefore, she states, "we are governed

through problematisations rather than through policies" (Bacchi, 2009:xi). Relating this to Vanwesenbeeck's (2011) model, the argument is that current understandings and problematisations of AIDS are excluding low-road solutions from multilateral policy responses.

2.2.2 Constructivism

Similar to these public policy theorists, IR constructivists are concerned with presuppositions and what is taken for granted, although their level of analysis is global. According to constructivists, ideas and norms do not exist in a vacuum; they are created and recreated through inter-subjective interaction. Emphasising the interrelation between these ideas and the materialistic world, contra the exclusively materialistic theories constructivism developed in reaction to, constructivists believe "that systems of shared ideas, beliefs and values […] have structural characteristics, and that they exert a powerful influence on social and political action" (Reus-Smit, 2005:196). According to constructivists, as well as policy analysts such as Bacchi (2009:5), the base of assumptions from where decisions and policies are made is shaped by ontological beliefs. Put differently, inter-subjective ideas and norms affect and are affected by numerous physical 'realities', forming and/or legitimising socially dependent materials. Constructivists refer to these phenomena as 'social facts'. The latter often have an unquestionable and natural legitimacy, although they are constructed by human interaction. They are much more than simply naturally existing 'realities'; their existence is ensured by ideas and norms. For instance, constructivists in IR claim that money, sovereignty and humanitarian interventions are 'social facts' (Barnett, 2008:165; Brown, 2005:49; Ruggie, 1998:856; Wendt, 1992:392).

'Social facts' also reinforce contemporary norms, ideas and identities. Due to the constructivist belief that "[i]dentities are the basis of interests" (Wendt, 1992:398), an interrogation of how these identities are constructed is important to understand international responses (Reus-Smit, 2005:197). In doing this, constructivists confront the neorealist and neoliberal institutionalist materialistic ontological assumption that fails to acknowledge the importance of idea accumulation. Constructivists interrogates the ontology of the status quo by questioning how and why 'social facts', often in the form of institutions, came into being instead of merely accepting their presence and exports as natural and given (Ruggie, 1998:855, 863). Hence, similar to Bacchi's 'problems', constructivists claim that interests and actions are endogenous – shaped by ideas and norms – not exogenous and self-evident. Exogenous materialistic rational choice explanations to global policies are therefore viewed as insufficient, as these leave out important parts of the decision making process and how global

actors – and rationality itself – are affected by ideas and norms that are often taken for granted (Finnemore & Sikkink, 1998:888-892; Reus-Smit, 2005:197-199; Ruggie, 1998:864; Wendt, 1992:392). Furthermore, the constructivist notion of 'norm cascades' can elucidate how norms are also accepted due to international pressure and the legitimacy of certain norm entrepreneurs (Finnemore & Sikkink, 1998). Global policies, therefore, do not exist independently of a net of social interaction and ideas; they are socially constructed.

An example of this point can be illustrated with Vanwesenbeeck's (2011) model: a rational choice explanation to the high-road/low-road divide and the claimed prioritisation to high-road approaches would naturally argue that the support of the high-road is grounded in the rationality of policymakers' informed decisions, whatever they are based in. A constructivist view, however, would look at the ideas and norms affecting policymakers' decisions. Vanwesenbeeck's argument that the market, medicalisation and morals are affecting high-road prioritisation suggests that ideas and norms are important in investigating how AIDS is understood as a policy problem, and therefore needs to be illuminated by a theory that acknowledges the complex relationship between ideas and materialism. Neorealists and neoliberal institutionalists' almost paranoid preoccupation with power relations and rational choice can, ironically, from a constructivist point of view be argued to be naïve for neglecting the importance of ideational forces behind global power relations.

When it comes to epistemology, constructivists are divided. It is not the purpose of this thesis to elaborate on this dispute. However, to claim that they are pluralistic would on a general level be a fair understanding of constructivists' relationship to epistemology and methodology. For the purpose of this study, the most important point to make here is that constructivists do not conform to one single approach when doing research. It is also worth repeating that constructivism developed in reaction both to the solely positivist causal explanatory epistemological approach and to the meta-theoretical epistemology's lack of focus on empirical findings (Reus-Smit, 2005:188, 194-196; Wendt, 1992:423).

This applies to Vanwesenbeeck's (2011) model because high-road and low-road solutions are separated in epistemological and methodological concerns. High-road solutions are more aligned with a positivist epistemology due to its links to biomedicine and the natural sciences. These solutions, including the less clinical parts of the high-road, are also much easier to measure through the use of quantitative methods, especially Randomised Controlled Trials (RCTs). Low-road solutions are, due to their emphasis on more complex cultural and political contexts, more aligned with a post-positivist epistemology that does not believe in causal

explanations as natural 'laws' for complex social phenomena. To get to the bottom of low-road approaches more in-depth qualitative research has to be done, which takes time and provides results that cannot be generalised to the same extent. Low-road solutions, therefore, have a very different relationship to the notion of 'evidence', 'knowledge' and 'causality' than high-road approaches. Vanwesenbeeck's emphasis on how both approaches are needed in the global AIDS response shows an inclination towards a constructivist pluralistic view on epistemology. The epistemological concerns mentioned here, linked to what Vanwesenbeeck argues is an increased 'medicalisation' in the multilateral AIDS response, are discussed further in the next section, which elaborates on Vanwesenbeeck's model, including its strengths and weaknesses.

2.3 High-road and low-road solutions: a model

After years of mobilising a global response towards AIDS, the results are promising; there is a decline in new HIV infections and ARTs are saving people from dying of AIDS (UNAIDS, 2012:14; WHO *et al*., 2011:5). Multilateral and cross-disciplinal efforts are essential in the continuation of this trend, as HIV and AIDS are of medical as well as of social and political concerns. However, the multifaceted nature of the pandemic also creates challenges of contested constructs of the overall AIDS policy problem. As Section 2.2 discussed, the understanding of AIDS as a problem is affected by inter-subjective ontological and epistemological assumptions rooted in ideas and norms. Inter-subjective problematisations of AIDS are thereby affecting what various actors think global policy responses ought to be. This is a problem because policies that are supposed to be equal and working towards the same goal – saving people from dying of AIDS and prevent further HIV infections – are suddenly in danger of working against each other, for instance by competing for funding (Germain *et al*., 2009:840).

Vanwesenbeeck's (2011) model of 'high-road' and 'low-road' solutions interrogates how the AIDS pandemic has been problematised and responded to globally, arguing that ideas and norms are affecting policymakers and donors to prioritise 'easy' biomedical high-road approaches over more socially complex and sexualised low-road solutions. The theoretical background for how Vanwesenbeeck's model is understood in this study has been illustrated in the first part of this chapter, and the remaining part is devoted to the model itself. First, high-road and low-road solutions are explained separately, before exploring what Vanwesenbeeck believes the underlying ideas and norms are for high-road prioritisation – specifically medicalisation, morals and the market. During this latter section strengths and limitations of Vanwesenbeeck's model are also discussed.

2.3.1 High-road solutions

Vanwesenbeeck's (2011) cluster of high-road solutions incorporate AIDS responses where there is an individualised focus on people living with HIV as 'patients' and on finding a cure and/or vaccine. Thus, high-road approaches are biomedical, non-sexual, clinical and medicalised. They are typically understood as medical services provided vertically, or top-down, and "[i]n the context of the fight against AIDS, antiretroviral therapy (ART) is the typical high-road solution" (Vanwesenbeeck, 2011:289). The prevention technologies emerging around the 2006 International AIDS Conference (IAS, 2007:13-14) – biomedical and non-sexual prevention efforts exemplified by drugs to prevent MTCT, 'treatment as prevention' and male circumcision programmes – are also high-road solutions because of their biomedical (contra sexual) focus. Positively, solutions specifically focused on biomedical interventions are more universal than approaches associated with the more socially determined low-road. Compared to complex and varying cultural contexts, the individual human body's biological reactions are much easier to generalise. They are also more straightforward and short-term oriented in their goals (Vanwesenbeeck, 2011:290, 293-294). Methodologically, these scientific and widespread features make high-road approaches easier to study, implement and measure through positivist ideals and quantitative methods (Boyce *et al*., 2007:9; Horton & Das, 2008:421-422). Consequently, high-road approaches can be quickly evaluated according to measurable efficacy. Failed solutions can be discarded and replaced with more efficient ones. The approaches that have positive outcomes in so-called evidence-based research have material proof to back up their plea for donor support.

In this context it is important to remember that high-road solutions are biomedical, and therefore cannot by themselves portray the complex political and social sides of the AIDS pandemic. High-road approaches are inherently de-contextualising. They are often focused on groups believed to be in high risk of HIV infection, including commercial sex workers and injecting drug users. High-road solutions seek to clinically help these people, but do not target the social context they are coming from and living in, or the deeper structural reasons for why an infection happened in the first place (Vanwesenbeeck, 2011:290). High-road approaches are also de-sexualising; instead of working within the framework of sexual rights, which acknowledges not only reality but also natural aspects of sexuality, they promote sexual abstinence. This de-sexualisation has been institutionalised by, for instance, placing HIV/AIDS and sexual health in separate Millennium Development Goals (MDG) "as though HIV were transmitted by mosquitoes or waterborne parasites rather than by human sexual and reproductive behaviour" (Germain *et al*., 2009:842; see also Vanwesenbeeck, 2011:291).

High-road approaches' separation from cultural and sexual contexts makes them more straightforward and easier to measure, but is also the reason why they cannot stand alone in multilateral AIDS responses.

2.3.2 Low-road solutions

The approaches needed to balance out high-road solutions are in Vanwesenbeeck's (2011) model referred to as low-road solutions. Low-road solutions emphasise the significance of communities, strengthening of local capacities and the greater context of development in their AIDS responses. These approaches are horizontally distributed and relatively cheap (as compared to the top-down distributions of the more expensive high-road), focused on human rights, care, wellbeing, and sexual and reproductive health and rights (SRHR). "[C]omprehensive sexuality education and condom use promotion are typical low-road solutions" (Vanwesenbeeck, 2011:290), hence, they recognise that the majority of new HIV infections are transmitted through sexual activity (Boyce *et al*., 2007:2; UNAIDS, 2012:16). These sexualised and gender attentive low-road approaches aim to encourage dialogue and awareness of sexuality and sexual rights, especially among youths.

This contextualisation of AIDS within the overall global challenges of development, social justice, human rights and sexual and reproductive health and rights is also recognised in the Cairo Agenda following the 1994 International Conference on Population and Development (ICPD). The Cairo Agenda emphasises that overall human wellbeing and rights to make independent life choices are essential for global development (Greer *et al*., 2009:674). AIDS is seen as part of the greater context of sexual and reproductive health, such as women's rights to family planning and control over their own bodies (Germain *et al*., 2009:840), which is why Vanwesenbeeck (2011:290) exemplifies the Cairo Agenda as an institutionalised low-road approach. Hence, low-road solutions puts a framework around the pandemic's now widely recognised ties to power, discrimination and sexual violence (Jewkes *et al*., 2010:46; Petersen *et al*., 2005:1234).

Wanting to contextualise AIDS responses shows low-road approaches' view of HIV/AIDS as part of the bigger environment of health, care and wellbeing, and their commitment to long-term results. Therefore, issues of concern to low-road approaches are to create sustainable solutions and to avoid that programmes specifically focused on HIV take health personnel away from other health tasks, which has been a fear after HIV funding increased (Germain *et al*., 2009:841; Mangham & Hanson, 2010:89; Vanwesenbeeck, 2011:292; Yu *et al*., 2008). Likewise, and especially where AIDS has become generalised, high-road approaches are also

needed to ensure overall public health in a country. Unfortunately, South Africa under Thabo Mbeki's presidency is an example of the dire consequences of avoiding high-road solutions altogether, in this case the access to and distribution of ART (Chigwedere *et al*., 2008:412).

Fundamentally, both high-road and low-road solutions are needed to fight HIV and AIDS; the binary between them is constructed by ideas of what AIDS is. The ART breakthrough in 1996, where findings of how combinations of ART drugs can slow down the development of HIV in the body was presented at the International AIDS Conference in Vancouver, changed the future for numerous HIV infected people. What had been a death sentence now for many turned into a chronic disease. Also, "[i]n 2011, for the first time, a majority (54%) of people eligible for antiretroviral therapy in low- and middle-income countries were receiving it" (UNAIDS, 2012:51). The hope for finding a cure in the future is kept alive by intense scientific work and medical breakthroughs. These developments had not been possible without a high-road focused approach. However, although the global scale-up of ART has been impressive, a lot of people are still in need of treatment (Bongaarts & Over, 2010:1359; Horton & Das, 2008:421-422; UNAIDS, 2012:50). Significantly, saving people's lives does not take away the structural challenges that might have contributed to the acquiring of the virus in the first place. As already mentioned, there has been increasing attention and concern tied to sexual violence and its link to the pandemic (Vanwesenbeeck, 2011:292). Although the lifesaving qualities of ART are unquestionably appreciated in these instances as well, there are certain types of pathologies that these drugs, and other high-road solutions, are not able to address. Here, a rights-based low-road approach sensitive to context and discrimination proves its significance.

Not surprisingly, considered that models are simplifications of reality, high-road and low-road approaches are not as black and white as initially portrayed. There are also approaches that can be argued to be in a grey zone. For instance, Vanwesenbeeck (2011:290) classifies the distribution of condoms as an obvious low-road approach, whereas Parker (2013) refers to condoms as a form of biomedical (thus, high-road) prevention. Similarly, Vanwesenbeeck (2011:291) implies that microbicides – a gel currently under development where the aim is to apply it before sexual intercourse and lower the risk of HIV infection – is a high-road approach, despite it being designed for sexual purposes. Also, microbicides are believed to empower women who are not in a position to negotiate condom use with their partners, meaning that it is gender sensitive.

At first glance it can almost seem as if condoms and microbicides are one and the same: constructed items one needs to put on in order to protect oneself. However, the fact that microbicides can be hidden from sexual partners during intercourse – which is good if one is out of other options – also undermines the more general importance of sexual and reproductive health. It, for instance, does not challenge the possible abusive situation the user is in. In other words, it is a short-term solution. Condoms, on the other hand, although constructed and not necessarily always adapted to the abusive reality many people find themselves in, are so visible and (unfortunately often viewed as) awkward that it has to be somewhat negotiated. Also, the condom is an extremely effective and sexualised prevention method, an important part of sexual and reproductive health as it stops pregnancy and other sexually transmitted infections, often distributed along with sexual education and can be cheap and easily accessible. Therefore, distribution of condoms is here still viewed as a low-road approach, whereas microbicides is, despite its gender sensitivity, still understood as a high-road solution because of its short-term scope, biomedical base, and that it cannot be applied to the overall context of sexual health.

As of yet, there has not been any scholarly comment or criticism directed towards Vanwesenbeeck's (2011) model in itself, possibly because her article is still too recent. However, in acknowledging that how AIDS is problematised and understood globally is affecting multilateral policy outcomes identified in various contested constructs of AIDS as a policy problem, Vanwesenbeeck's model of the binary between different problem definitions and response mechanisms can potentially clarify the recent paths that global AIDS responses have taken. This is important because it questions how and why certain approaches are neglected in the light of others. It raises significant questions about who has the power to make such decisions and define others' fate. The next section discusses the ideas and norms that Vanwesenbeeck believes are fundamental for high-road prioritisation.

2.3.3 Underlying social forces, ideas and norms

Indeed, despite the recognition by global actors and scholars of the significance of low-road approaches (Berer, 2011:6; Boyce *et al*., 2007:1; Germain *et al*, 2009:840; WHO *et al*, 2009:1), Vanwesenbeeck (2011:290) argues that "in the case of HIV/AIDS, the balance [between high-road and low-road solutions] seems to be increasingly lopsided towards technological, biomedical solutions". The claims are that sexuality and sexual and reproductive health and rights (SRHR) have been taken out of the overall global AIDS agenda – for instance when separating HIV and SRHR in the MDGs – with an increasing focus on clinical solutions and treatment at the expense of prevention of sexual transmission (Biehl,

2007:1085; Germain *et al*., 2009:840-842; Knight, 2008:172; Vanwesenbeeck, 2011:291-292).

This prioritisation of high-road over low-road solutions, Vanwesenbeeck (2011:293) argues, is due to "socio-political, moral and economic forces and mechanisms", represented by ideas of "morals, medicalisation and markets". In other words, the problem contestation between high-road and low-road solutions is due to how AIDS has been understood and problematised within certain ideas, norms and assumptions. Figure 2.1 is an illustration of Vanwesenbeeck's model. It demonstrates the mutually affecting relationship between global AIDS agendas and multilateral AIDS responses, as well as high-road and low-road approaches' relationship with medicalised, market-driven and moralistic ideas and norms. Vanwesenbeeck argues that biomedical high-road approaches are prioritised at the expense of contextual and sexual low-road approaches because ideas of the market, medicalisation and morals are more aligned with the former than the latter. An understanding of these factors emphasised by Vanwesenbeeck is essential in order to further highlight the strengths and weaknesses of the model, and to later evaluate whether it can be identified in the discourse around the 1996-2012 International AIDS Conferences. This is discussed in the remaining part of this chapter.

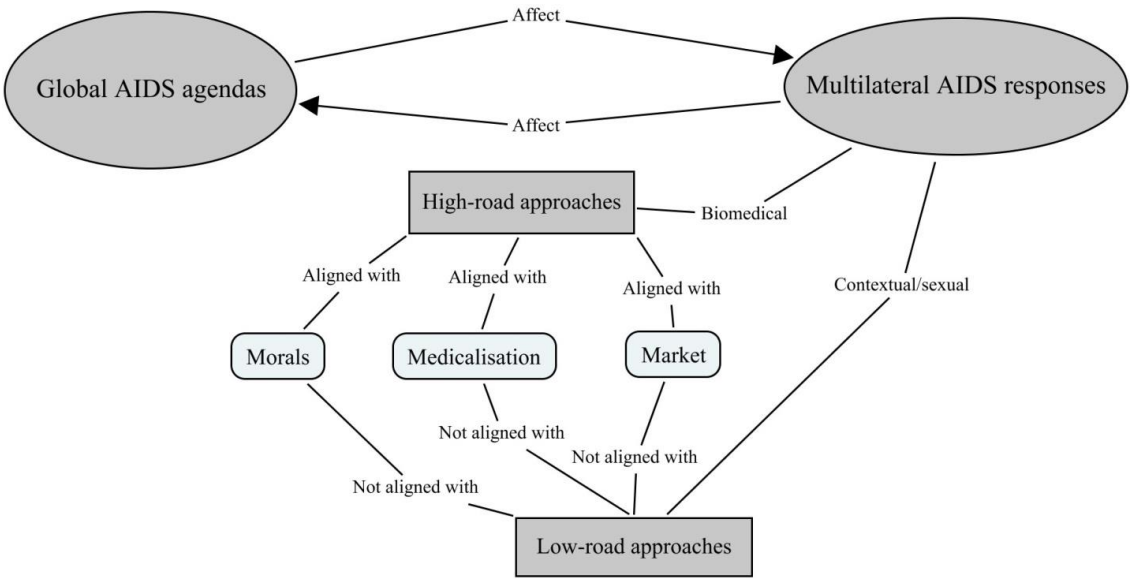

Figure 2.1: Vanwesenbeeck's model

The *morals* that Vanwesenbeeck (2011) refers to are mainly ideas and norms with a disapproving view of sexuality and sexual practices, especially among young adults. These norms affect how donors and policymakers understand AIDS as a problem and how they choose the 'appropriate' response. They also reflect global ideational power relations by

demonstrating whose norms are accumulated. Examples of influential global norm entrepreneurs who have been criticised for their moralism and anti-sex approaches are the Vatican and the President's Emergency Plan for AIDS Relief (PEPFAR) under George W. Bush (Berer, 2011:7; Vanwesenbeeck, 2011:293).

The US government backed PEPFAR, has proved to be "one of the largest and most influential donor programmes of recent years" (Vanwesenbeeck, 2011:291) with a total sum of $63 billion pledged to fight the pandemic. In a high-road/low-road framework, PEPFAR's approach is undoubtedly high-road. The programme is mainly focused on pharmaceutical and biomedical solutions, for the most part treatment and to a lesser extent also biomedical prevention programmes. In many ways, PEPFAR has been a success. With the first $15 billion pledged PEPFAR managed to "provide[…] treatment to two million people in 15 focus countries, 12 of which were African" before the end of 2008 (Fourie, 2013:1). However, the initial policies associated with the organisation, especially the moral ones, have been controversial. The comparably smaller amount of the PEPFAR budget spent on prevention of sexual transmission has been accused of being moralistic because it is concentrated around abstinence of sexual activity (Bliss, 2012:15). Although sexual abstinence would drastically decrease one's chances of getting infected with HIV, critics argue that such moral approaches are unrealistic and depraving because they fail to acknowledge the normality of sex and sexuality, thereby also undermining the work of approaches focusing on this (Boyce *et al*., 2007:13-14; Vanwesenbeeck, 2011:291-292). Accordingly, PEPFAR initially failed to provide the facts about how one can protect oneself and was therefore "endangering the lives of the people they're supposed to be protecting" (Population Action International, 2007:1-2). PEPFAR's early focus mirrored government supported abstinence-only programmes in the US. These policies are kept despite the critics' claims that the approach is unsustainable, ineffective and "promote[s] myths and misconceptions about sexuality and sexual behaviour" (Marques & Ressa, 2013:124). PEPFAR's global AIDS policies are therefore an example of how a locally inter-subjective ontology and norms can play out in global agenda-setting and responses.

Further, ideas of *medicalisation* fit well with moralist norms because they allow for approaches that are more focused on science than the overall sexual context of HIV. However, medicalisation in itself does not emanate from moralistic preferences; the increased medicalisation Vanwesenbeeck (2011:293) refers to is a result of a (Western) need to quickly discover and evaluate solutions to challenges. Over the years there have been growing demands to evaluate the effectiveness of donor money (Austveg, 2011:27). This can be

associated with the growth of neoliberalism, privatisation and the "[r]einvention of [g]overnance" (Power, 1999:41) in the 1980s and beginning of 1990s, where much of the focus was on productive and cost-effective solutions, exemplified by ideas such as New Public Management. In order to evaluate productivity, it had to be measured. Through these evaluations organisational activity and policymaking could be legitimised, ensuring 'value for money' and 'quality'. This development is thus rooted in an epistemological assumption that evaluations and revisions are effective tools to make sure goals are reached (Power, 1999:10-11, 42, 52).

Following this logic, easy-to-measure biomedical high-road solutions are possibly more attractive in order to demonstrate effective use of time and money, so that the donors know they are supporting an approach that works. A popular way of figuring out what works, also when it comes to "defin[ing] the evidence base for HIV prevention programs and policies" (Padian *et al*., 2010:622), is to use evidence-based research through several Randomised Controlled Trials (RCT), also known as the metric 'gold standard'. These are scientific trials – based in positivism – aiming at eliminating the context in order to see the effect of what is researched (Fineide, 2013:133; Kippax & Holt, 2009:5). When it comes to biomedicine, focus on evidence-based research is a reasonable development: "[i]n health care, evidence-based medicine came as a reaction to the use of interventions that were ineffective or even harmful" (Austveg, 2011:27; see also Fineide, 2013:121). The encouraging biomedical discovery that ART can reduce the chances of getting infected through sexual transmission has also contributed to a medicalisation of the AIDS pandemic, arguing how biomedical approaches can be mainstreamed (Bliss, 2012:16; WHO, 2012:6). The particular challenge with the AIDS pandemic, however, is that it is not exclusively biomedical.

While 'easy to measure' sounds like an exclusively positive characteristic, it can also be an example of how dynamics "difficult to measure [….] [are] pushed aside for methodological reasons" (Finnemore & Sikkink, 1998:889). Taking it one step further, this can be linked to Power's (1999:51-52) claim that what is understood as effective in the end is socially constructed by the methodologically exclusive evaluation process itself. In other words, only measurable approaches can be labelled 'effective'. The effects of approaches directed at preventing sexual transmission of HIV, together with other culturally complex low-road approaches, have been difficult to measure (Horton & Das, 2008:421-422; Knight, 2008:78; Vanwesenbeeck, 2011:293). Hence, medicalisation of the AIDS pandemic is an issue of epistemological and methodological importance. This is a challenge because AIDS responses are thus chosen on the basis of how the pandemic has been problematised and defined within

the contemporary (scientific) framework. Already at the 2006 International AIDS Conference in Toronto, there were "warn[ing signals] of a trend towards the 'medicalization' of prevention as a 'quick technical magic solution'" (IAS, 2007:13). The consequences of an overly medicalised framework are that human rights-based, sexual, contextual and long-term low-road solutions are not prioritised although they are recognised as important for overall wellbeing and crucial to comprehensively combat the pandemic and to protect vulnerable people (Boyce *et al*., 2007:9; Vanwesenbeeck, 2011:293).

In their study done on HIV prevention research and RCTs, Padian *et al*. (2010:624, 627) found, not surprisingly, that RCTs give significant results for biomedical interventions, but have difficulties in measuring (low-road) behavioural approaches. These scholars believe that this is "attributable, at least in part, to issues related to trial design and/or implementation" (Padian *et al*., 2010:631). This relates to the distinction that Kippax & Holt (2009:5) make between "what works" and "what works in practice"; it is the efficacy and not the actual effectiveness of the approaches that are measured through RCTs. In other words, that some responses do not show any effect in RCTs does not mean that they do not have any effect in real life. This is important because research should be about finding out what can actually improve health and quality of life in reality, and not only what works on paper (Austveg, 2011:27; Fineide, 2013:122).

Vanwesenbeeck's last theme, *markets*, is presented as equivalent to the "neoliberal global political economy" (Vanwesenbeeck, 2011:293), which she argues is served by recent developments within global policy agendas. The argument is that biomedical high-road solutions are much more compatible with the interests of pharmaceutical companies. Because "[t]here is much more money to be made on the high-road" (Vanwesenbeeck, 2011:293), initiatives focusing more on care and general health are neglected on behalf of money-making drugs. This perception of the market's influence on the AIDS agenda reflects the idea that "[t]hose who have the gold, make the rules" (Fylkesnes *et al*., 2011:1911). The discussion of the market's presence in the AIDS pandemic is neither new nor unconventional. Despite cooperation from the pharmaceutical industry in reducing drug prices during the Accelerating Access Initiative (AAI), and their constrained obligations under the Doha Declaration, they are often accused of only bothering to invest where they can earn profit (Berer, 2011:6). Especially since the introduction of ART as a viable alternative to save HIV positive lives, the pharmaceutical industry has been the object of harsh critiques, activism and demonstrations, accused of profiting on the back of the pandemic. The International AIDS Conferences are good examples of occasions when such demonstrations have taken place (Bliss, 2012).

Although the role of the pharmaceutical industry and its greedy reputation should not be underestimated, by stating that "[t]here is not much money to be made with a human rights agenda", Vanwesenbeeck (2011:293) underplays the benefits of high-road solutions that many scholars, people living with HIV, and policymakers believe in. It is important here to draw a distinction between the pharmaceutical industry and other actors encouraging high-road solutions. To imply that high-road approaches are focused exclusively on money is too simplistic in a pandemic where the key efforts are on saving and improving people's lives. Also, it is important to recognise the pharmaceutical industry's contributions in the AIDS pandemic. For instance, big pharmaceutical companies, among them GlaxoSmithKline, Pfizer and Roche, are often some of the largest donors for the International AIDS Conferences (IAS, 2004:43). That said, these financial contributions might also affect the conferences as a whole, for instance through PR events and marketing. This is a topic for coming chapters to explore further.

Apart from a possible penchant for simplification, another significant limitation to Vanwesenbeeck's (2011) model is that she emphasises the material power of the market, yet she does not refer to the Global Financial Crisis that impacted most of the world since 2008. Funding for the Global Fund decreased drastically after 2008. In 2010 almost $400 million of what had been pledged to the organisation was not paid, and in 2011 this amount grew to $575 million. The United States, the Global Fund's largest donor, was in 2011 responsible for $423,355,000 of this amount (Bernescut, 2012:24-25). The conclusion that the global recession also affected the HIV pandemic financially is therefore not an unreasonable one (WHO *et al*., 2011:8). Although this fact might not change the overall model, it might have explanation value for why high-road solutions have been more popular after the Global Financial Crisis, even though they are more expensive. This is because in times of crisis, it seems logical to follow the solutions that are viewed as easier, more straightforward, and where the expenses can be justified in evidence-based research. As the preceding discussion stressed, these are current characteristics of high-road solutions. Furthermore, Vanwesenbeeck (2011) fails to see the ideational importance of the market. Neoliberalism is about more than making money; as an ideology it contains ideational as well as material power. This negligence of the ideological importance of the market is further elaborated upon in Chapter 4.

The underlying ideas and norms discussed here – the market, medicalisation and morals – and the fundamental ideas they accumulate and allocate are used for identifying high-road and low-road approaches and illuminate Vanwesenbeeck's (2011) model in the discourse and

developments around the International AIDS Conferences between 1996 and 2012. More specifically, the principles and actors of the neoliberal market and its complex role in the pandemic are investigated. The Global Financial Crisis is important in this regard, and used to highlight the relationship between neoliberalism and AIDS. The demands for evidence-based and scientific research, as well as the role of actors and donors with so-called moralistic objectives, are also examined and discussed in an attempt to identify the prominence of medicalisation and moralism. Importantly, what has been neglected from the overall discourse around the specific conferences is as significant as what has been prioritised. Here, activist opinions, demonstrations and criticism become especially important.

2.4 Conclusion

This chapter has discussed Vanwesenbeeck's (2011) model, the general differences between high-road and low-road approaches, the ideas and norms she believes are fundamental for high-road prioritisation, as well as some of the strengths and weaknesses of her argument. The first part of this chapter aimed to theoretically contextualise and illuminate Vanwesenbeeck's model within ideational and structural approaches of public policy problematisations and IR constructivism. The former emphasises how policies are necessarily and unintentionally problematised and constructed by assumptions of what the initial 'problem' is believed to be. The latter focuses on ontological and epistemological assumptions at the global level, and how inter-subjective ideas and norms shape the interests and decisions of policymakers. Together these theories highlight how ideas and norms construct the worldviews of policymakers and norm entrepreneurs, thereby shaping 'appropriate' policy outcomes and epistemological preferences. In the case of Vanwesenbeeck's model, ideas of moralism, medicalisation and the market are believed to shape multilateral AIDS responses by prioritising biomedical, non-contextual, and vertically distributed high-road solutions over the more human rights-based, contextual, and sexual and reproductive health-oriented low-road solutions. This is because, according to Vanwesenbeeck, high-road approaches match the sex negative, market-driven and quantitatively measurable preferences of current ideas and norms better than low-road approaches. As such, low-road approaches can be understood as too sexual, too unquantifiable, and too independent of the pharmaceutical industry – all in all too 'difficult' – to be prioritised by policymakers and donors. This chapter has discussed the relevance of these ideas, but also limitations in Vanwesenbeeck's model. Being a model, the high-road/low-road differentiation is inherently too simplistic. Besides this, Vanwesenbeeck does not adequately consider the impact of the Global Financial Crisis on policymakers' choices and ideas of 'appropriate solutions'. These elements are considered in the further

analysis, which explores whether Vanwesenbeeck's model can identify and illuminate the developments of global AIDS responses in the discourse around the International AIDS Conferences between 1996 and 2012. The main analysis of Vanwesenbeeck's model only appears in Chapter 4. Before this, Chapter 3 necessarily provides an historical overview of the key developments and tendencies before, during and after the biennial International AIDS Conferences emphasised in this study. Hence, the subsequent chapter provides the essential historical outline for the forthcoming analysis in Chapter 4.

Chapter 3: Historical outline, 1996-2012

3.1 Introduction

As previous chapters have shown, Vanwesenbeeck's (2011) model of the binary between high-road and low-road approaches claims that global and multilateral AIDS responses have become increasingly biomedical, vertically distributed and clinically individualised since the mid-1990s. This, she claims, is because of constructed ideas of the neoliberal market, morals and medicalisation, and how these norms are less compatible with sexualised, rights-based and socially dependent low-road approaches. The previous chapter discussed Vanwesenbeeck's model of these ideas as well as the theoretical background of policy problematisations and socially constructed worldviews and epistemological preferences. This study aims to test the utility of Vanwesenbeeck's model for identifying and explaining key events and developments around the biennial International AIDS Conferences between 1996 and 2012, however, the main analysis of Vanwesenbeeck's model in relation to these historical tendencies only appears in Chapter 4. The aim of this chapter is thus to first provide the historical outline necessary for the further analysis in the succeeding chapter. In doing so, different frameworks are discussed for trying to highlight various viewpoints and descriptions of how the global AIDS response has developed since 1996. The chapter starts with a brief contextualisation of AIDS responses before 1996, before discussing the periods recognised in Tables 1.1 and 3.1 – most specifically the 'building of institutions', 'increased funding' and the 'remedicalisation and eventual funding cuts' – in more detail.

3.2 Before 1996

This study focuses on the events around the International AIDS Conferences from 1996 – the year scientists at the International AIDS Conference in Vancouver presented the discovery that a combination of antiretroviral therapy (ART) drugs can hinder the development of HIV; a development claimed by some scholars to subsequently lead to an increased multilateral, monetised and medicalised AIDS response. Before focusing on the key happenings and discourses since then, however, this section briefly reviews global AIDS responses before 1996, to outline the context.

After AIDS first publicly manifested in 1981, the first International AIDS Conference was held in 1985 in Atlanta, as a scientific meeting. Science was at the core of the agenda until the International AIDS Society (IAS) was established in 1988 to coordinate and co-host the conferences. However, the pandemic was political from the start, absurdly exemplified by the lack of political reaction and discrimination against communities predominantly affected by

the disease at the time, such as men who have sex with men (MSM) and injecting drug users (Bliss, 2012:4-7; Kallings & McClure, 2008:10). Critics claim that the initial political neglect was in fact directly linked to this discrimination, as AIDS was associated with "people that were already stigmatized" (Ingram, 2013:438) and that the main interest therefore was, in the previous US Secretary of Health and Human Services' own words, to "'stop[…] AIDS before it spreads outside the risk groups, before it becomes an overwhelming problem'" (Margaret Heckler, quoted in Bliss, 2012:5). Hence, the general population's safety seemed more important than to help the ones already infected (Bliss, 2012:5).

Apart from blunt discrimination, Ingram (2013:439) argues that AIDS was neglected as part of domestic and international organisational changes brought forward by neoliberal ideas and values in the 1980s and 1990s where health in general was deprioritised. Neoliberalism's role in global AIDS responses is a prominent and complex one and is discussed in greater detail below. However, in the 1980s and early 1990s, there were certainly also other sources influencing AIDS responses. The lack of scientific success to find a treatment or a cure sparked reactions within communities to modify behaviour and to effectively reduce risk and prevent the spread of HIV. Examples of such culturally attuned reactions are the development of 'safe sex' approaches and efforts to rejuvenate, even "eroticising", male condoms (Parker, 2013; Rochel de Camargo *et al*., 2013:780). Later on, focus on and theories regarding sexual behaviour became influential, ranging from comprehensive sex education to programmes on abstinence (Giami & Perrey, 2012:353, 355; Parker, 2013).

Importantly, the International AIDS Conference in Stockholm in 1988 was the first to recognise these more social sides of HIV by going beyond an exclusively biomedical content. This was in line with the IAS' mission to include international and multilateral approaches on human and legal rights, politics, economics, discrimination and prevention on the agenda at the conferences. In the years following the IAS' establishment the conferences were characterised by reactions to and the consequences of controversial policies, protests and activism, scientific engagement and frustration. With an effective cure still out of sight, both treatment and prevention efforts intensified in the beginning of the 1990s (Bliss, 2012:8-10).

3.3 The International AIDS Conferences (1996-2012) and surrounding discourse

Table 3.1: IAS conference trends and key events – expanded

Year	Conference trends	Outside events	High-road	Low-road	Tendencies
1996 Vancouver	- ART breakthrough - Call for resources - Mobilisation of activists - The situation in the developing world - Critique of pharmaceutical companies	- UNAIDS' first meeting			Building of institutions
1997					
1998 Geneva	- The Geneva Principle - Treatment vs. prevention - Side effects of treatment - North-South divide in access to ART				
1999		- The World Bank's Multi-Country HIV/AIDS Programme for Africa (MAP)			
2000 Durban	- Developing world - Access to treatment - Call for resources - Denialism and the scientific link between HIV – AIDS - Link between AIDS and governance	- Accelerating Access Initiative (AAI) - Cheaper drugs - MDG - AIDS discussed in UNSC → Resolution 1308 and securitisation			
2001		- UNGASS → Declaration of Commitment on HIV/AIDS - Funding starts to increase - Doha Declaration – TRIPS - IAS' first Conference on Pathogenesis and Treatment			
2002 Barcelona	- Access to treatment - WHO '3 by 5': 3 million on ART by 2005 - Treatment vs. prevention - Increased participation by prominent leaders - Call for resources	- The Global Fund's first meeting			Increased funding
2003		- PEPFAR's first launch: $15 billion			
2004 Bangkok	- Women in focus - Universal access to treatment, care and prevention - Call for funding → The Global Fund - First time for the Global Village, the Leadership Programme and the Youth Programme - Call for more scientific content - Call for evidence-based policies				
2005					
2006 Toronto	- Treatment vs. prevention → treatment as prevention (TASP)	- UN General Assembly Political Declaration on HIV/AIDS → access to			

	- Prevention technologies – male circumcision - Pressure on pharmaceutical companies - Call for more scientific content - Gender sensitive - Discrimination - Strengthening of health systems - Human rights	treatment, prevention and care for all by 2010			
2007		- Male circumcision recommended by WHO and UNAIDS for prevention purposes			
2008 Mexico City	- Universal access to treatment - Discrimination and stigma - Combination prevention - TASP - Against criminalisation	- Global Financial Crisis - PEPFAR announce $48 billion commitment			Remedicalisation and eventual funding cuts
2009					
2010 Vienna	- The Vienna Declaration – injecting drug users - TASP - Prevention technologies - Treatment 2.0 - Human Rights - Discussion of and reaction to funding cuts	- Global Fund replenishment meeting			
2011		- HPTN 052 trial: TASP - UN General Assembly Political Declaration on HIV/AIDS → access to treatment, prevention and care for all by 2015			
2012 Washington D.C.	- The Washington D.C. Declaration: end AIDS - Scientific developments → TASP → eradication of AIDS - Human rights - Call for resources				

As Table 3.1 suggests it is possible to identify three main tendencies in global AIDS responses between 1996 and 2012 – 'building of institutions', 'increased funding' and 'remedicalisation and eventual funding cuts' – although it should be noted that these tendencies are somewhat overlapping and not mutually exclusive. After the important biomedical discovery of highly active antiretroviral therapy (HAART) in 1996 there was increased emphasis on the structural global inequalities amplified by the pandemic, and particularly with regards to access to ART. Civil society activists pushed for a global response to this challenge. Table 3.1 also indicates that the period between 1996 and 2002 showed an increased political engagement towards AIDS. This is demonstrated by the institutionalisation of global AIDS responses, such as with the establishment of UNAIDS, the incorporation of AIDS in the Millennium Development Goals (MDG) and the UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001.

From 2002 towards 2008 this political engagement and global social justice activism reaped results in form of increased funding for global AIDS responses. Some expressed concerns that most of these funds were directed towards treatment efforts, especially as further biomedical discoveries came to the fore, consequently overshadowing focus on prevention of sexual transmission of HIV. Table 3.1 further indicates that these concerns were justified as the years after 2007 saw a remedicalisation – back to the initial scientific focus in the 1980s – of the pandemic, where biomedical prevention technologies and 'treatment as prevention' (TASP) became substantial parts of multilateral prevention efforts. This remedicalisation seems to have continued even after funding for global AIDS responses flatlined and decreased after 2008 and the Global Financial Crisis. These main trends and tendencies are important for analysing Vanwesenbeeck's (2011) model in Chapter 4, and are explored in fuller detail below.

3.3.1 Building of institutions, 1996-2001

As indicated, 1996 was a significant year of change for the AIDS pandemic. There was finally a breakthrough in scientific research, presented at the XI International AIDS Conference in Vancouver: highly active antiretroviral therapy (HAART) was discovered. These combinations of ARTs demonstrated the potential of slowing down the development of HIV in the human body, and even averting the emergence of AIDS. Following this astonishing information the conference experienced a revived sense of optimism. At the same time, many attendees were concerned with the high prices of the drugs and the inability for many people, especially from the developing world, to access them. Activists demanded more involvement and funding from international policymakers, and questioned the pharmaceutical companies' materialistic objectives (Bliss, 2012:11; Kallings & McClure, 2008:28).

Some scholars view this breakthrough in ART research as the start of a more biomedical global response to the pandemic, a response they claim is viewed by scientists as the more obvious solution to AIDS after a (too long) pit stop with behavioural approaches and their limited triumphs (Giami & Perrey, 2012:355; Rochel de Carmargo *et al*., 2013:780). Parker (2013), however, although also under the understanding that AIDS responses increasingly became more biomedical, argues that behavioural AIDS approaches were initially replaced with more structural explanations in the first part of the 1990s. Underlying a structural approach is the idea that inequalities are caused by external factors. According to this view the unequal global spread of AIDS – negatively affecting the developing world – was affected and amplified by structural vulnerability and violence. The additional unequal global distribution of lifesaving HAART sparked a humanitarian global justice movement in the

fight for equal access to these drugs. Governments in the developing world, such as those in India and Brazil at the time, challenged pharmaceutical companies and their understanding of the patents laws agreed upon in the World Trade Organisation's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in order to ensure cheaper drug access to their HIV-positive citizens (Harrelson, 2001:190-192; Marques *et al*., 2005:472-474). Similar moves were also recognisable in civil society engagement. For instance, the South African Treatment Action Campaign (TAC), which had access and rights to ART on its main agenda, was established in 1998 (Fourie, 2006:130; Low *et al*., 2010:3). As such, structural inequalities and unequal access to ART sparked activism in the developing world and globally. Thus, global justice and medicalisation in the form of increased allocation of drugs went hand-in-hand, indicating that biomedical high-road approaches were intertwined with rights-based low-road approaches. This has explanation value because it can give a more nuanced picture of why multilateral AIDS policies eventually became more medicalised than simply the development of biomedical solutions such as ART.

There are indeed signs from the first half of the 1990s that more structural explanations and solutions started to gain popularity. The UN Development Programme's (UNDP) Human Development Report from 1994 suggested a shift from national to human security; a people-focused approach that emphasises structural threats, like environmental change and disease, and their potential to disrupt human beings' wellbeing and even put them in danger (UNDP, 1994:22-23). The year 1994 was also when the International Conference on Population and Development (ICPD) was arranged in Cairo, leading to the recognition of the Cairo Agenda in 1995. This agenda emphasised the complex relationship between development and the state of the world population, arguing that overall human wellbeing and the right to lead one's own life enhances development. In this case, AIDS was placed within the greater context of sexual and reproductive health and rights (SRHR), especially with regards to women and family planning (Germain *et al*., 2009:840; Greer *et al*., 2009:674; MacIntosh & Finkle, 1995:225; Vanwesenbeeck, 2011:290-291). At the time, the agenda was widely acknowledged by the 179 governments participating, and it was expressed that the ICPD "had been a conference with no losers" (MacIntosh & Finkle, 1995:224).

With these structural developments and apparent satisfaction with the ICPD conference in mind, Germain *et al*. (2009:841) state that "[t]he timing was certainly perfect" when UNAIDS was established in 1996 to use the Cairo Agenda as a basis for a global AIDS response. However, "AIDS advocates and researchers had long been committed to a different agenda and UNAIDS was to go its separate way" (Germain *et al*., 2009:841), avoiding horizontal

health care approaches and sexual and reproductive health in their framework from 2001, and consequently contributing to the de-sexualisation of HIV. This statement of UNAIDS' almost anti-structural approach is not supported by Parker (2013), who claims that UNAIDS, among other organisations at the time, had people supporting structural approaches amongst its staff. These different perceptions of UNAIDS might reflect the controversy around the establishment of the organisation itself. By 1996 many UN agencies had their own distinct AIDS policies. An agency to coordinate these efforts, one of the purposes of UNAIDS, was thus necessary. However, this also led to conflict and institutional jealousy between the agencies UNAIDS was supposed to coordinate, as "UN agencies were not interested in being 'coordinated' or managed by an upstart, new-fangled program with few resources to offer" (Behrman, 2004:170). Efforts to coordinate UN's approaches to the pandemic were thus slow in the first couple of years after UNAIDS' establishment, leading to inconsistent or confusing messages from and between UNAIDS and various other UN agencies (Behrman, 2004:171). Hence, Germain *et al*.'s (2009) claim that UNAIDS embarked on a de-contextual approach might also reflect the compromises UNAIDS officials had to make in order to achieve respect and allocate funding for the organisation and the pandemic, such as pushing the challenge of AIDS in the UN Security Council (UNSC) and thereby framing AIDS as an urgent security issue rather than one of global health. The significance of AIDS being discussed in the UNSC is further explored below.

Nevertheless, Germain *et al*., (2009) do have a point in the sense that "funding for reproductive health as a proportion of health aid dropped from 30% to 12%" (Greer *et al*., 2009:674; see also Greene *et al*., 2012:90) from 1994 to 2008, just as money started rolling in for the global AIDS response. One of the main objectives with this chapter is to interrogate developments like these in global AIDS responses between 1996 and 2012 and to put them into context. The information obtained here is then used as background material for the analysis of Vanwesenbeeck's (2011) model in Chapter 4.

Despite the Vancouver conference's good news regarding HAART, the mood at the XII International AIDS Conference in Geneva in 1998 was more sober. This was due to the realisation of the many side effects of ART as well as an overall discussion about the developing world's lack of access to these expensive drugs, accompanied by depressing but important statistics from UNAIDS revealing the spread and extent of HIV (Behrman, 2004:176; Knight, 2008:86-88; Pavia, 1998; Volberding, 1998). Approaches directed towards prevention of sexual transmission were still believed to be effective and important responses to AIDS, especially while HAART was still in its nascent phase. However, there was a

recognition that these types of contextual approaches were more difficult to research and prolong, as they need to take culture and sex into consideration. Thus, already a fear was expressed that an increased focus on ART post-1996 would overshadow the importance of prevention efforts (Bliss, 2012:11-12; Knight, 2008:87). Hence, despite the Geneva Principle's emphasis on combining science and community approaches (Kallings & McClure, 2008:28), a constructed treatment vs. prevention binary was starting to take form. This supports Vanwesenbeeck's (2011) model because the concern that treatment is prioritised at the expense of prevention of sexual transmission efforts mirrors Vanwesenbeeck's claim that high-road approaches outshine low-road approaches.

The inequality between the global north and the global south with regards to access to ART stressed both in Vancouver and in Geneva is essential in Parker's (2013) understanding of the structural approach towards AIDS and further developments in global AIDS responses. This is because the emphasis on the structural injustice of the world created an environment where straightening out these inequalities in access to drugs became top priority for many activists and members of national and transnational civil society. That these global inequalities were enhanced by principles of the neoliberal market – for instance how patents for ART drugs were owned by pharmaceutical companies in the developed world, making it difficult for low-income countries to access them – did not make the case better. The idea that someone was profiting from other people's tragedies was, and still is, a provoking one. Thus, "[a]ccess to ART quickly became a flashpoint for international mobilization" (Ingram, 2013:439) and eventually laid the grounds for the "scale-up" of global funding towards AIDS responses (Parker, 2013).

The XIII International AIDS Conference in Durban in July 2000 is acknowledged as a crucial point towards this development. More than ever the conference highlighted the dire situation of the pandemic in the developing world and the needs and possibilities to improve global access to ART. The topic sparked strong engagement and activism – with the South African activist group Treatment Action Campaign (TAC) in front – and encouraged cooperation across north-south divisions. While prevention had remained at the forefront for many actors and donors even after the ART breakthrough, the conference in Durban made the need to escalate global ART access more visible and better understood (Abdool Karim, 2006:N7; Bliss, 2012:13; Knight, 2008:110, 112).

The conference in Durban therefore led to a re-evaluation of the international handling of AIDS, as it was recognised that "AIDS is a crisis of governance" (UNAIDS, 2001:7). In other

words, it was made clear that it is the leaders on various governance levels' responsibility to make sure that all efforts are made to curb the pandemic. Indeed, in the setting around the Durban conference, this became underscored in two ways: first through criticism of the South African government's handling of the pandemic, and second through the international society's increased engagement. The following part first discusses the former, and then the latter of these situations, both of which might have contributed to or can serve as examples of eventual high-road prioritisation.

Poor leadership claims were raised when Thabo Mbeki, South Africa's president at the time of the Durban conference, and his Minister of Health, Manto Tshabalala-Msimang, infamously questioned the link between HIV and AIDS, and therefore also the effect and relevance of ART. This so-called AIDS denialism has later been estimated to have cost thousands of South African lives (Chigwedere *et al*., 2008:412), not only because the government rejected to distribute ART but also because of the inaccurate ideas about AIDS that they spread. In response to their policies, the Durban Declaration, stressing that the "empirical evidence for the link between HIV and AIDS was 'clear-cut, exhaustive, and unambiguous'" (Knight, 2008:110), was issued and signed by 5,000 HIV researchers. AIDS denialism does not only reflect the importance of leadership, however. It also is a good example of the importance of science. Denialists had supporters from far outside South Africa and in 2007 Pedro Cahn, then president of the IAS, stated that the IAS "supports an evidence-based approach" and therefore "has a unique responsibility" (Cahn, 2007:2) to defy the claims and actions put forward by AIDS denialists. Hence, just like evidence-based research is important in medicine in order to avoid harmful practices (Austveg, 2011:27) it has been used within AIDS research to avoid and delegitimise harmful approaches. This increasing need for, and subsequently also the legitimisation of, evidence-based research in multilateral AIDS responses can illuminate why quantifiable and measurable high-road approaches have been increasingly prioritised at the expense of more complicated low-road approaches, as the former are easier to monitor and evaluate through evidence-based research than the latter. Furthermore, it also supports Vanwesenbeeck's (2011) claim that medicalised ideas – such as the focus on evidence-based research to monitor and evaluate approaches in the first place – have contributed to this development.

Although not evident during the conference in Durban, it is worth mentioning here that during the same period the IAS went through some changes. Their election in 2000 resulted in the first Governing Council to consist of more clinicians than people of basic science or social science background, "reflecting the new era of [ART] after 1996" (Kallings & McClure,

2008:15). Also, in 2001 they arranged their first conference on Pathogenesis and Treatment, attracting more than 3,000 medical scientists (Susman, 2001:N19). In contrast to the International AIDS Conferences these conferences are exclusively scientific, and included also biomedical prevention into their scope from 2007 onwards (Cahn & McClure, 2006). Hence, although still focused on low-road approaches around 2000, the increased legitimisation and importance of evidence-based research and biomedicine is unmistakable.

As for the global response to AIDS, many interesting and significant changes happened at the time of the Durban conference. Certain initiatives specifically addressed the global inequalities regarding access to ART, such as the Accelerating Access Initiative (AAI) from May 2000 and the 2001 Doha Declaration. The AAI, an outcome of negotiations between UN agencies and five pharmaceutical corporations, drastically reduced the costs of ART to developing countries hard hit by AIDS. This pressure on the pharmaceutical industry was further enhanced by the Doha Declaration, which emphasised that the WTO TRIPS agreement should not be a hindrance to public health, and therefore that production of generic AIDS drugs should be allowed and more readily available despite patent ownerships (Knight, 2008:122, 125). The Doha Declaration – directly challenging the pharmaceutical industry's patents – was thus crucial as the industry was reluctant to approve the production of cheaper generic products, despite the scale of the AIDS pandemic. This pharmaceutical resistance can be exemplified by how the South African government's Medicines and Related Substances Control Amendment Act of 1997 (Republic of South Africa, 1997:5), which would enable parallel-import of medicines and local production of cheaper generic ART drugs, was met with a lawsuit by several pharmaceutical companies despite being allowed for in the initial WTO TRIPS agreement (Fourie, 2006:148-149). The lawsuit charges were eventually dropped in 2001, after immense public protests (Alsegård, 2004:16; Ingram, 2013:439-440).

A commitment to AIDS in general was also discussed at the highest international levels. These include the World Bank's (WB) Multi-Country HIV/AIDS Programme for Africa (MAP) of 1999 (Ingram, 2013:441; World Bank, 2013), the 55/2 United Nations Millennium Declaration from September 2000 (UN General Assembly, 2000) – what later became publicly known as the Millennium Development Goals (MDGs) – and the UN General Assembly Special Session (UNGASS) on HIV/AIDS from 2001. UNGASS is a good example of how political commitment to the AIDS pandemic reached new heights. The Declaration of Commitment, being the forerunner of the 2006 Political Declaration on HIV/AIDS, engaged international and multilateral actors to "prevent new HIV infections, expand health care access and mitigate the epidemic's impact" (UNAIDS, 2007:9), working towards the MDG

deadline in 2015. Although cooperation towards such a high-profile commitment proved challenging taking into consideration some of the actors' moral judgements regarding sex and sexuality (Knight, 2008:133), UNGASS has been said to be, together with the later establishment of the Global Fund in 2002, one of the most important factors leading to increased global funding for AIDS (Fylkesnes *et al*., 2011:1911). Thus, the period of institution building with regards to the AIDS pandemic does not only illustrate the increased political engagement for the AIDS pandemic, it was also significant for the development and funding of future global and multilateral responses. Table 3.2 provides an overview of many of the most significant institutions established between 1995 and 2003 with regards to the AIDS pandemic.

Table 3.2: AIDS-related institutions established between 1995 and 2003

Institutions	Year
WTO TRIPS	1995
UNAIDS	1996
World Bank MAP	1999
Accelerating Access Initiative	2000
MDG	2000
The Gates Foundation	2000
UNGASS	2001
Doha Declaration	2001
The Global Fund	2002
PEPFAR	2003

These developments – activism and success against the neoliberal pharmaceutical market industry and increased international political commitment – are seen as an essential part of the search for increased funding to curb the pandemic (Ingram, 2013:440; Kallings & McClure, 2008:36; McInnes & Rushton, 2011:123; Parker, 2013). Parker (2013) emphasises the humanitarian vision of the access to treatment movement and the consequent global understanding of the link between AIDS, vulnerability and inequality. While Ingram (2013:440-442) understands that this sort of mobilisation can be understood as an attack on the neoliberal system itself in the quest for health and welfare, he adds the irony that these AIDS activists have simultaneously re-legitimised the system by using neoliberal values by enhancing market competition in order to access health. Neoliberal responses would still be used to respond to and finance AIDS through market dynamics, multilateral, philanthropic

and non-governmental organisations and corporations, making it acceptable to supporters of the market to view AIDS as something that needs to be dealt with outside of current neoliberal norms. In global responses to AIDS, the market has indeed been an important, but also necessary, actor. This supports Vanwesenbeeck's (2011) claim that market forces shape multilateral AIDS responses because, according to this view, no matter the humanitarian intentions the pandemic is still undeniably dependent on the neoliberal market. Simultaneously, then, the pandemic must also be tied to the financial status of this market, something Vanwesenbeeck does not mention despite the significance of the Global Financial Crisis. These issues are further elaborated upon in Chapter 4.

According to some scholars, however, it was not only AIDS' position in, or outside of, the neoliberal market that helped the funding flow. In 2000, AIDS was discussed in the UN Security Council (UNSC), leading to the adoption of Resolution 1308. In this meeting and the following resolution, the UNSC discussed AIDS as a threat to national security – in other words as a problem with implications beyond human security (McInnes & Rushton, 2011:121). The symbolic meaning of this event is significant, and exemplifies a shift where the discussion was not only about the structural effects on AIDS, but AIDS' effect on structure. To get the message of the possible implications of the pandemic across, AIDS was linked to political instability and its negative effect on states, social wellbeing and the economy. This framing of AIDS as a security issue was put forward by high-profiled people, among them UNAIDS' Peter Piot, to underscore the need for a comprehensive reaction to the pandemic. AIDS was therefore more easily accepted as an exceptional emergency than a disease within sexual health. This is exemplified by how the securitisation of AIDS was reflected at the UNGASS meeting the following year, and was widely adopted by many actors in the international community (Ingram, 2013:440-441; McInnes & Rushton, 2011:121-122). Importantly, therefore, is not only the notion of how AIDS is positioned within the neoliberal market, but also the recognition that how AIDS has been problematised has affected how and when international responses came. In this case, the treatment of AIDS as something exceptional laid the grounds for increased funding for ways to deal with it.

This is significant, because so-called 'HIV-exceptionalism' enhances high-road approaches, linked to how the pandemic is separated from sexual and reproductive health in the MDGs and treated in the same funding stream as other non-sexual diseases – more specifically tuberculosis and malaria – through the Global Fund (Germain *et al*., 2009:842; Vanwesenbeeck, 2011:291). The way HIV-exceptionalism developed as indicated above might therefore suggest one way high-road approaches have been forced on global AIDS

responses while trying to accumulate much needed funding. As Table 3.1 indicates, the securitisation of AIDS happened before funding for AIDS responses started to drastically increase around 2001-2002, which supports the argument that the securitisation of AIDS was a necessary and/or contributing factor to increased funding. This is further discovered in Chapter 4.

3.3.2 Increased funding, 2002-2007

At the XIV International AIDS Conference in Barcelona in 2002, calls for more resources to increase access to treatment in the developing world was still a hot topic, and the US government was especially pressured by activists to get more involved. The political commitment to the pandemic continued to grow, and more high-profile political leaders started to attend the conferences. Earlier that year the Global Fund to fight AIDS, Tuberculosis and Malaria was established, which, although actual funding was slow in the beginning, proved in the following years to be an effective multilateral funding mechanism. Now, at the Barcelona conference, the WHO announced its '3 by 5' initiative, aiming for 3 million people on ART by 2005 (AIDS 2002 Conference News, 2002; Bliss, 2012:13; Kallings & McClure, 2008:36). This overall focus on treatment made commentators remind people of the still many serious side effects with ART (Zuger, 2002), and that prevention programmes are both working, needed and should not compete with treatment (Knight, 2008:166; Piot, 2002).

After the conference, at the beginning of 2003, the United States launched PEPFAR – "the largest bilateral aid programme in the world to fight HIV/AIDS" (Kallings & McClure, 2008:36) – promising $15 billion to the pandemic and thereby forcing other countries to step up their game as well (Bliss, 2012:14). With the development of MAP, the Global Fund, and now PEPFAR, as well as the commitments and pledges made by many world leaders, funding for AIDS responses became easier and started to increase drastically. However, scholars claim that when distributing these funds treatment was usually the main priority, and prevention efforts were increasingly left behind (Bertozzi *et al*., 2008:841; Germain *et al*., 2009:842). Again, there is a sign that a binary between high-road and low-road approaches is emerging.

PEPFAR's contribution to get more people on treatment is undisputed – it has helped millions of people to access ART (Fourie, 2013:1) – yet the programme has been criticised for its controversial and moralistic policies (Bliss, 2012:15). PEPFAR's funds are mainly distributed through bilateral agreements, and the organisation has a lot to say in terms of how its donor money is spent by the receiving country. Religiously rooted, the first launch of PEPFAR was,

apart from its main priority in non-sexual biomedical interventions, focused on abstinence in its prevention programme. Critics claim that programmes based on abstinence denies not only sexual health and rights, but also the reality that for many women sex is not always negotiable (The Lancet, 2004:303-304; Population Action International, 2007). It must be said that PEPFAR funds have been used to distribute a significant amount of condoms (Knight, 2008:171), however, these are claimed to have been stigmatised by reserving them for people engaging in 'high-risk activities' (Population Action International, 2007). What is questionable and relevant for this research study, and is further elaborated upon in the subsequent chapter, is not the values of PEPFAR itself (although controversial), but rather how much this proclaimed moralism has affected trends and events within the global AIDS agenda over time. Considering that moralistic approaches are believed by many to be less effective, the continued existence of such approaches within a framework where evidence-based research is increasingly demanded can highlight how certain ideas and power-positions affect AIDS agendas.

Far away from PEPFAR and claims of moralism, the XV International AIDS Conference in Bangkok in 2004 was a celebration of Thailand's prevention programme, which had successfully reduced a substantial number of new HIV infections with its campaigns promoting consistent condom use and enhanced public information and awareness. The Thai government at the time also initiated access to ART and programmes focused on prevention of mother-to-child transmission (PMTCT) (Kallings & McClure, 2008:38). While, as Chapter 2 indicates, condoms can be viewed as a biomedical intervention, their sexualised nature validates their placement within the cluster of low-road approaches. Thailand could thus show to a prevention programme focused on both low-road and high-road approaches. At the conference, women's vulnerable position in the pandemic was a topic of great concern. Furthermore, acknowledging the major developments made in the global AIDS response since Durban, the Bangkok conference was focused on continuing to push for worldwide access to treatment, care and prevention. In doing so, more funding was called for, but this time more specifically to the multilateral Global Fund. Heated protests again emerged over overpriced drugs and the newly established PEPFAR's controversial policies (Bliss, 2012:15; IAS, 2004:35; Kallings & McClure, 2008:39). Emphasising the importance of connecting the conferences with the local community, engaging leaders, and including young people in discussions, the conference in Bangkok was the first to arrange the Global Village, the Leadership Programme, and the Youth Programme. This commitment underscores the conference's holistic approach. In fact, the subsequent conference report says that "[o]ne of

the great lessons [from Bangkok] was that 'one size does not fit all', that treatment and prevention plans have to be tailored to local conditions" (IAS, 2004:49). The need for cooperation between diverse AIDS responses was also stressed by high-profile AIDS figures Peter Piot and Helene Gayle (IAS, 2004:19).

Although some commentators noted that the development of the conferences from scientific meetings to a "political circus" (Altman, 2004) was a necessary good, not everyone was pleased with Bangkok's political focus. Some scientists disagreed with what they perceived as a chaotic development of the conferences, claiming that "this large forum appears to have become irrelevant to the science of AIDS" (Laurence, 2004). Indeed, some scientists started to become attracted to other, more scientific, AIDS meetings instead (Kallings & McClure, 2008:28), despite the fact that important scientific discussions – for instance about emerging biomedical prevention approaches – were present at the conference (IAS, 2004:12). Because of the believed importance of a contextual image of the pandemic, the conference report states that "while a few commentators expressed disappointment at the prominence of 'politics over science' in Bangkok, they may have been missing an important point" (IAS, 2004:4). Considering these features of the Bangkok conference, it did not seem as if high-road approaches were going to squeeze out low-road approaches any time soon.

Simultaneously, the increased involvement of different governments and actors created a fear of duplicated responses towards AIDS. While an increased amount of actors were necessary to accumulate enough money to deal with the pandemic comprehensively, this also eventually sparked the need for some kind of coordination of approaches in order not to create more harm than help, and for funds not to be wasted (Garrett, 2007:14-15). Hence, a UN based standardisation was requested in order to get an overview of cost and efficiency of approaches (Bliss, 2012:14), and there was also an increased demand for links between evidence and policies (IAS, 2004:12-13). Importantly, efforts to curb the pandemic were (and still are) donor dependent. This, according to Garrett (2007:21-23), promotes approaches that are specifically directed at sensational diseases stirring strong emotions, and are thus "tied to short-term numerical targets" (Garrett, 2007:15) undermining the importance of the overall health system. While these multiple disease specific efforts certainly needed coordination to ensure efficiency, such standardisation can also be argued to be shaped by ontological and epistemological understandings, especially as donors prefer short-term targets and feel more comfortable knowing that their funds are spent wisely and based on evidence, like suggested above. Both disease specific and evidence-based approaches are more aligned with quantifiable high-road approaches and are further discussed in Chapter 4.

Figure 3.1 indicates financial pledges from donor countries and actual disbursements between 2002 and 2012. As the figure shows, funds pledged and disbursed grew drastically after 2002, illustrating the need for coordination of efforts. Significantly, the figure also indicates how actual distributions flatlined and decreased after the implications of the Global Financial Crisis reached the pandemic after 2009, a development which is further explored below and important for the analysis of Vanwesenbeeck's (2011) model.

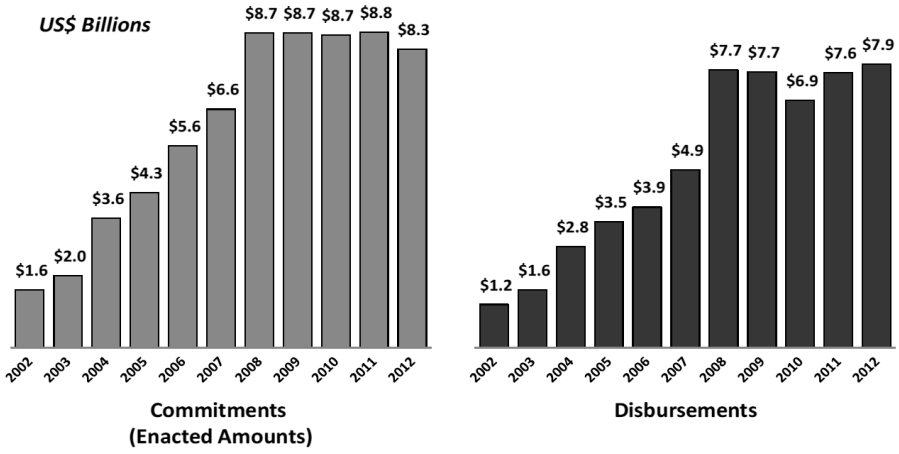

Figure 3.1: International HIV assistance from donor governments: commitments and disbursements, 2002-2012 (Kates *et al*., 2013:2).

With AIDS already high up on the emergency and security agenda, the United Nations General Assembly High-Level Meeting on AIDS was arranged in the beginning of June 2006. Here, the UN General Assembly Political Declaration on HIV/AIDS was adopted. This declaration reiterated the MDGs from 2000 and the Declaration of Commitment on HIV/AIDS from the UNGASS meeting in 2001, and emphasises the vulnerable position of women and children in the pandemic, the importance of human rights and sexual and reproductive health, the structural implications of poverty and the need for international, multilateral and domestic engagement and political commitment. The declaration's objective was to encourage the global community to 'scale-up' their efforts and achieve worldwide availability to treatment, care and prevention by 2010 (UN General Assembly, 2006). It also "[r]eaffirm[s] that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic" (UN General Assembly, 2006:4).

Later that year, in mid-August, the XVI International AIDS Conference was arranged in Toronto. Similar to the Political Declaration on HIV/AIDS, the Toronto conference presented a comprehensive and multifaceted picture of the AIDS pandemic and the global response. The

conference was gender sensitive; the links between gender inequalities, violence and transmission of HIV were widely discussed and recognised, although some attendees claimed that little was said on how to care for vulnerable women already infected (IAS, 2007:12-13). At the same time, biomedical discussions were more prominent than in a while due to recent developments in scientific research – more specifically the posted possibility of using treatment as prevention (TASP). ART use by people living with HIV was discovered to reduce the chance of transmitting HIV sexually. By scaling up treatment efforts the constructed binary between treatment and prevention was thus in the scope of being bridged, according to TASP enthusiasts (Bliss, 2012:16; IAS, 2007:11-12). With this in mind the possibility that "[p]roviding universal treatment access could potentially save billions of dollars over time" (IAS, 2007:12) was one of the arguments to encourage further research on the topic.

Referring more to the new TASP regime than an integration of various approaches, prominent world figures Bill and Melinda Gates of the Gates Foundation talked about the importance of realising the symbiosis between prevention and treatment in the fight against AIDS. Showing how the conference's gender sensitive and biomedical focus coincide, Melinda Gates spoke out for the many vulnerable women in risk of infection and how continued development of biomedical microbicides can help empower them. Furthermore, the Toronto conference highlighted new evidence-based studies on how male circumcision (MC) can lower the risk of contracting and passing on the HI-virus (IAS, 2007:10). These findings led to a recommendation by WHO and UNAIDS in 2007 to implement the practice (Giami & Perrey, 2012:356). Hence, although "many conference delegates and members of the media [viewed the International AIDS Conference in Toronto as] the conference of prevention" (IAS, 2007:10), discussions on prevention had started to take a new turn and were more concerned with the current and future situation of prevention technologies (IAS, 2007:10-11). This is important, because the emergence of the TASP model is a strong indicator of a more biomedical approach and the increasing appearance of high-road solutions.

Indeed, several scholars see the development of TASP and MC as a clear sign of an increasingly medicalised AIDS response. Using MC as an example, critics argue that the approach is 'top-down' – as high-road solutions are – in the sense that the medical intervention is "carried out *on* individuals and societies […] as opposed to *with* those affected" (Rochel de Camargo *et al*., 2013:780, original emphasis), effectively removing "the 'human factor'" (Giami & Perrey, 2012:357) and thereby increasing the reliability of the intervention. Unlike behavioural solutions, biomedical approaches are not dependent on

human's sexual modification. Hence, MC is not as effective as condoms but the approach is easier to control (Giami & Perrey, 2012:358). This is linked to how medical research and RCT aim to remove the effect of context, as emphasised in Chapter 2. Similarly, biomedical approaches are also easier to implement than trying to change structural conditions of AIDS, such as inequality and sexual violence (Parker, 2013). The notion that de-contextualised and de-sexualised biomedical approaches are easier to measure should therefore not be underestimated, especially, as is discussed later, when funding suddenly becomes scarce. Absurdly, however, is the good point that biomedical approaches also are dependent on a change in behaviour in order for people to actually access and use them. Behavioural and biomedical approaches are therefore somewhat united in individualism (Giami & Perrey, 2012:357-358), as opposed to structural explanations (Parker, 2013).

Expressing similar views, not everyone in Toronto agreed with TASP and MC being exclusively positive developments. Some researchers and actors of civil society expressed a fear that prevention technologies would be the easy individualised solution that in effect would ignore vulnerable populations' need for empowerment and create a trend where political and structural difficulties in AIDS responses are not effectively dealt with at the hands of medicalisation (IAS, 2007:13-14). However, in addition to the conference's focus on the feminisation of the pandemic and gender sensitivity, and despite the discussions on prevention mainly being biomedical, there were visibly other low-road approach focused discussions. For instance, concerns were raised over HIV's exceptional position in scale-up efforts, and the possible negative effects this could have on funding for other diseases and resources left to focus on general health. Indeed, binaries between short-term, vertical and HIV specific vs. long-term, horizontal and cohesive services in health were recognised, although optimists highlighted how an HIV-specific approach is dependent on a strengthening of health infrastructure in general and therefore might not be harmful (IAS, 2007:22-23). Nevertheless, despite the diverse topics at the conference, or perhaps because of it, the content was criticised by actors who requested more scientific presentations in both quantity and quality (Bliss, 2012:16).

The efforts made to scale-up global funding for AIDS and access to treatment reaped benefits. Between 2003 and 2005 people accessing ART in the developing world grew from 400,000 to 1 million (Abdool Karim, 2006:N7), and more than $30 billion had been pledged to the Global Fund between 2002 and 2011 (UN General Assembly, 2011:3).

3.3.3 Remedicalisation and funding cuts, 2008-

The year 2008 started well in terms of funding: PEPFAR announced to commit $48 billion in its second round (Bliss, 2012:17). At the XVII International AIDS Conference in Mexico City later that year discrimination and stigma among people living with HIV was on the agenda, as well as a continued emphasis of the need for universal access to treatment (Bliss, 2012:17; Kort *et al*., 2008:5). Due to the close 2010 deadline of 'universal access', participants suggested how the International AIDS Conferences could monitor the progress and hold policymakers accountable for their promises (Kort *et al*., 2008:6). Continuing the health systems debate from Toronto, most speakers in Mexico City argued that approaches specifically addressing HIV are strengthening the rest of the health system in general, thereby concluding that HIV-exceptionalism in health care did not affect other health issues negatively – rather the opposite (Kort *et al*., 2008:5). From this point of view, Vanwesenbeeck's (2011) emphasis on the difference between vertically distributed high-road approaches and horizontal low-road approaches might not be real in terms of neglecting infrastructure for health. However, although certainly affecting each other, it might be useful in this debate to separate between strengthening infrastructure and improving health care. In the light of the top-down medical interventions discussed above regarding de-contextualising interventions, vertically distributed solutions might improve infrastructure, but also change how health systems work and what they prioritise. If they are becoming increasingly biomedical this is supporting Vanwesenbeeck's point in the sense that short-term and individualised approaches are prioritised on behalf of making local health services self-sustainable and adapted to their local context.

Also significant for the conference in Mexico City was the coining of the term 'combination prevention' and the emphasis on combining behavioural, structural and biomedical prevention approaches. According to the IAS report after the conference, this prevention strategy aims at taking structural factors, "such as gender inequality, homophobia and the criminalization of drug use and sex work" (Kort *et al*., 2008:5) into consideration with behavioural and biomedical solutions in the designing of a more long-term approach towards HIV prevention. At first sight this seems like the combination of high-road and low-road solutions that Vanwesenbeeck (2011) requests. Parker (2013) and Giami and Perrey (2012:356-357), however, argue how combination prevention efforts are constructed within overall biomedical approaches and the belief that these can deal with structural factors as well, such as how microbicides empower vulnerable women without actually taking care of the structural situation. Supporting their argument about biomedicalised combination prevention is the

increased focus on RCTs confirming the effects of TASP, and the notion that the 2008 conference "became known for the 'marriage' of treatment and prevention" (Kort *et al*., 2008:5). However, this development might less be a consequence of a rational choice based neglect of structural, cultural and sexual approaches in general as much as there is an ideational change in what is perceived as constructive solutions exemplified by an increase in demands for measurement, accountability and evidence-based research, which, as already argued, is difficult to use on contextual approaches.

At the XVIII International AIDS Conference in Vienna, discussions evolved around human rights for injecting drug users – emphasised in the Vienna Declaration – and further development of prevention technologies (Bliss, 2012:18). In efforts to scale-up funding for the latter, Treatment 2.0 was launched with emphasis on the implementation and further development of TASP, prevention technologies and prevention of mother-to-child transmission (IAS, 2010:23).

Hence, concerns were raised at the conference about funding, but within a different context than earlier as "[a]lthough 2008 saw the highest levels of resource allocation for HIV and AIDS yet, donors are now curtailing or flat-lining HIV funding" (IAS, 2010:2). By the end of 2008, the Global Financial Crisis was a fact (Germain, 2010:xi, 19), and its implications on funding for health and HIV is recognised by several actors (Fourie, 2013:3; IAS, 2010:8; UN General Assembly, 2011:3; WHO *et al*., 2011:7-8). Important actors were hit hard. The Global Fund, for instance, had to have a replenishment meeting in October 2010 as a consequence of not receiving all the money they had been pledged (UN General Assembly, 2011:3-4). Having less money to work with, how the existing funds are distributed becomes an issue of concern (Fourie, 2013:3). How these resources are distributed in the end is, according to Ingram (2013:448), affected by neoliberal principles of 'scarcity' in the sense that funding for AIDS approaches need to be rationalised by their efficacy and comparability – in other words how cost-effective they are.

With this in mind, high-road approaches' eligibility with neoliberal principles of efficacy, quantifiable measurement and need for monitoring and evaluation, might be able to explain why easier-to-measure biomedical high-road approaches have been prioritised during a time of economic crisis, despite them being more expensive in the outset. Vanwesenbeeck (2011), in this view, is not emphasising the importance of the Global Financial Crisis enough in her model. On the other hand, Ingram's (2013:446) argument is based on a belief that the tensions between developmental and biomedical approaches did not become a problem until resources

became scarce. Hence, if arguing that the separation between high-road and low-road approaches happened much earlier, the Global Financial Crisis or neoliberal scarcity in general cannot explain why high-road approaches seemed to be dominant when resources were still abundant, or even increasingly influential as resources increased as well. Here, Vanwesenbeeck's more ideational understanding of how global AIDS agendas are shaped might have more explanation value, keeping in mind that neoliberalism is more than just a financial strategy, and that ideas of moralism, medicalisation and the market are believed to influence each other as well as the more physical outcomes of these ideas and norms. For instance, and also recognised by Ingram (2013:444), how AIDS was framed as an exceptional emergency and a threat to national security might therefore not only have influenced the increased resources rolling in at the beginning of the millennia, but also why funds started to decrease as the effect of HIV-exceptionalism was questioned and the security complications of AIDS re-evaluated. As McInnes and Rushton (2011:131) argue, this process was not only based in so-called empirical evidence but also how the securitisation/de-securitisation of AIDS was constructed, presented and received.

In 2011, between the conferences in Vienna and Washington D.C., two significant events took place: the findings from the HPTN 052 trial on TASP, and the 2011 Political Declaration on HIV and AIDS. The HPTN 052 trial found that early treatment of HIV-positive people decreases sexual transmission of the virus with as much as 96 per cent (Granich *et al*., 2012:2). This sparked further belief and hailing of the TASP model (WHO, 2012:5-6). Around the same time the 2011 Political Declaration was adopted by the General Assembly in July. Reaffirming the 2001 Declaration of Commitment and the 2006 Political Declaration's commitment to accomplish "universal access to comprehensive treatment programmes, treatment, care and support" (UN General Assembly, 2011:2), it also came with a clearer message of eradicating AIDS once and for all.

This optimistic commitment was repeated at the XIX International AIDS Conference in Washington D.C. in 2012. The Washington D.C. Declaration is specifically aimed at ending AIDS (IAS *et al*., 2012), which is deemed possible with the many biomedical interventions now in place (The Lancet Infectious Diseases, 2012). Therefore, a topic at the conference was again calling for more funding in order to reach this goal and the engagement of the private sector and faith-based organisations was encouraged. The need to strengthen human rights and fight discrimination and stigma within the development, distribution and implementation of biomedical approaches was also frequently discussed (IAS, 2012:8-9). The goal of 'ending AIDS' is significant. It would indeed be optimal if the pandemic could be curbed. Yet the idea

of ending AIDS and the "AIDS-free generation" (PEPFAR, 2012:4) proposed by Hillary Clinton is not within sight with current strategies. The approach is first of all dependent on a new major scale-up in global funding, especially considering that previous targets for universal access are yet to be met (The Lancet, 2012), and secondly framed within a reliance on biomedical approaches and prevention technologies (Parker, 2013). Hence, despite a focus on human rights, the idea of high-road biomedical and vertical approaches seems to be the dominant one when the last International AIDS Conference was arranged in 2012.

3.4 Conclusion

This chapter has presented an historical overview of key events at and around the nine International AIDS Conferences arranged between 1996 and 2012. The main analysis of Vanwesenbeeck's (2011) model of high-road and low-road approaches only appears in Chapter 4, where it is explored whether her arguments holds in relation to the International AIDS Conferences, and how influential ideas of the market, morals and medicalisation are in shaping global AIDS agendas. The aim of this chapter has, therefore, been to shape the historical outline necessary for the further analysis. This has been done within frameworks that can highlight different sides of developments within multilateral AIDS responses and of Vanwesenbeeck's model itself. More specifically, these have been frameworks focused on neoliberalism's role in the pandemic, HIV-exceptionalism and securitisation, and the construction of medicalisation and its relationship to humans, culture and sex. Examining what has been discussed at the conferences and the surrounding events, there are clear signs of certain moralist approaches, top-down interventions, problematisations of AIDS, increased focus on evidence-based approaches, increased belief in biomedical solutions, and dependency of the neoliberal market, which indicate an ideational preference for high-road approaches. Hence, elements of Vanwesenbeeck's model can certainly be identified. However, the model shows signs of incoherence in some parts and it is not clear what has affected these various historical developments. Therefore, Vanwesenbeeck's argument of the ideational effects of the market, medicalisation and morals on global AIDS agendas is still to be fully discovered and discussed, especially in relation to the more materialistic effects of neoliberalism and rational reactions towards decreased amounts of resources. This is further explored in Chapter 4.

Chapter 4: Analysis of Vanwesenbeeck's model

4.1 Introduction

In light of the background theories of public policy problematisations and IR constructivism explored in Chapter 2, Vanwesenbeeck's model aims to interrogate how ideas and norms have affected how AIDS is globally problematised and responded to. As such, Vanwesenbeeck argues that there is a binary between biomedical and vertically distributed high-road approaches and the more contextual and sexually determined low-road approaches. This, she claims is because current ideas and norms of the market, morals and medicalisation are prioritising high-road approaches because of their de-sexual and de-contextual characteristics. The aim of this study is to investigate and test whether Vanwesenbeeck's (2011) model of high-road and low-road solutions can be identified in and illuminate the policy ideas, problem definitions and political binaries that play out in the discourse surrounding the biennial International AIDS Conferences between 1996 and 2012.

Chapter 3 provided an historical outline of the key events and tendencies regarding global AIDS policies during this time. It concluded that overall trends, such as increased emphasis on evidence-based research, presence of moralistic approaches, dependency of the neoliberal market and prominence of biomedical solutions indicate a prioritisation of high-road approaches since 1996. Chapter 3 thus suggests that features of Vanwesenbeeck's (2011) model can be recognised in multilateral AIDS governance since 1996. As already mentioned, Vanwesenbeeck's model suggests that ideas of medicalisation, moralism and the market have influenced this high-road prioritisation. However, as Chapter 3 indicates, there can also be other explanations for this development. For instance, measurable biomedical high-road solutions could also have gained prominence due to the changed economic landscape after the Global Financial Crisis and such approaches' alignment with rational principles of cost-efficiency and evaluation. In this case, high-road prioritisation could be a reaction to the material need to evaluate the efficacy of donor money after resources became scarcer, instead of a consequence of current ideas and norms of moralism, medicalisation and the market. This is one of the arguments that this chapter explores further for the purpose of analysing the utility of Vanwesenbeeck's model for explaining multilateral AIDS agendas.

This chapter aims to analyse Vanwesenbeeck's model of the binary between high-road and low-road approaches by discussing indicators of these approaches and exploring the explanation value of ideas of morals, medicalisation and the market. More specifically this involves an analysis of the prominence of moralistic policies and policymakers, the

understanding of evidence and knowledge, HIV-exceptionalism, the role of social justice and human rights, the complex protagonist of the neoliberal market, and the understanding of sexual and reproductive health. Identification of and engagement with Vanwesenbeeck's model, its limitations and alternative explanations for the development of multilateral AIDS responses are essential for this analysis.

4.2 The utility of Vanwesenbeeck's model

As Chapter 3 already indicates, elements of Vanwesenbeeck's (2011) model of high-road and low-road approaches can certainly be recognised in the events and developments surrounding the International AIDS Conferences between 1996 and 2012. What is not clear, however, is what kind of underlying factors have contributed to this development. Vanwesenbeeck argues that ideas and norms – a reverberation of constructivists' notion of 'norm cascades' (Finnemore & Sikkink, 1998) – of medicalisation, morals and the market are affecting high-road prioritisation. There can be, however, several other explanations or ideas behind an increasingly biomedical pandemic, such as financial consequences after the Global Financial Crisis, humanitarianism and the framing of AIDS as a security issue. The analysis in this chapter seeks to critically analyse the utility of Vanwesenbeeck's model by discussing high-road and low-road indicators and the effect of ideas of moralism, the market, medicalisation and the alternative ideas on these indicators. This discussion is complemented with insights from a personal semi-structured interview with Nathan Geffen, a key informant with long work experience from the Treatment Action Campaign (TAC) and the former AIDS Law Project (ALP) who attended many of the International AIDS Conferences under scrutiny in this study.

Table 4.1: Indicators of high-road and low-road approaches

	High-road approaches	Low-road approaches
Indicators	Moralistic values and policymakers	Sexual and reproductive health
	Evidence-based research, science and de-sexual approaches	Social and political science
	Market dependency	Social justice and human rights
	HIV-exceptionalism	Horizontal health approach

Table 4.1 provides an overview over the main indicators used to identify the presence of high-road and low-road approaches in the following analysis. It must be noted that not all of these indicators have their separate subheading, as they are discussed together with and compared to other indicators in the table. Importantly, this overview is also not an outline of everything

that this chapter discusses, as limitations and new suggestions to the model are also elaborated upon.

One of Vanwesenbeeck's (2011) suggestions for high-road prioritisation in global AIDS agendas is the prominence of moralistic norms and values and the influence such ideas pose on pushing de-sexualised responses to the pandemic. The following section explores this argument by exploring the prominence of these ideas, especially with regards to the US based PEPFAR programme under George W. Bush.

4.2.1 Prominence of moralistic values and policymakers

As Chapter 3 indicates, moralistic values – the conservative inter-subjective norms shaping some prominent actors' policies – have certainly been present in AIDS discourses after 1996. The Vatican, for instance, has kept a conservative stance when addressing the pandemic, preaching sexual abstinence and implying that the use of condoms and women's rights to sexual and reproductive health involves immoral behaviour that cannot be accepted (Adolphe, 2011). PEPFAR's initial policies under George W. Bush, known as PEPFAR I, had similar moralistic attitudes: the smaller bulk of the programme's finances that were addressing sexual transmission of HIV were ideationally and financially prioritising programmes focused on abstaining from sexual intercourse. Similar to the programme's predominantly biomedical focus these mentioned anti-sex characteristics are typical of high-road approaches. Other types of prevention of sexual transmission, for instance low-road approaches such as condom education and distribution, were saved for people engaging in so-called 'high-risk activities' (The Lancet, 2004:303; Office of the United States Global AIDS Coordinator, 2005:18-23). Akin to the very beginning of the pandemic the US government seemed uncomfortable with AIDS' sexual contents, expressing views of the many Christian conservatives in the US (Barnett & Parkhurst, 2005:590; Epstein, 2005). As stressed in previous chapters, such de-sexualising problematisations of AIDS are more aligned with biomedical and asexual high-road approaches than sexually contextualised low-road approaches. Considered that a large and significant programme such as PEPFAR I reflected these disapproving inter-subjective understandings of the sexual aspects of AIDS, it is not unreasonable of Vanwesenbeeck (2011) to suggest that morals have affected global AIDS agendas and governance.

At International AIDS Conferences, PEPFAR I – despite major successes in distributing ART – was met with protests and resistance for this conservative approach (Bliss, 2012:15; IAS, 2004:12; Rivers, 2004). Moralistic policymakers, and particularly PEPFAR I, have indeed been widely criticised for pushing an agenda that disregards scientific evidence, is unrealistic,

spreads misinformation, violates human rights and sexual and reproductive health and ignores structural challenges and restrictions on individual sexual agency (Barnett & Parkhurst, 2005:591; Cohen & Tate, 2005:67-70; Goldstein, 2011; The Lancet, 2004:303; Population Action International, 2007). Therefore, if one believes that the acceptance of ideas and norms are reflected in how they are taken for granted and thereby not criticised, the lack of acceptance of moralistic ideas and policies raises questions of how widespread moralistic norms actually are and whether Vanwesenbeeck (2011) overstates the ideational influence of moralism.

Nevertheless, although scholars tend to disagree on whether PEPFAR's initial policies were fruitful (Halperin *et al*., 2004:1913) or not (Cohen & Tate, 2005:1) they all seem to imply that the programme's involvement has been somewhat influential. For instance, the ones arguing that the sudden increase in Ugandan HIV infections "[i]s attributed to the [Ugandan] government's move away from condom promotion and distribution and substantial U.S. assistance for abstinence-only activities that has distorted Uganda's once-balanced approach" (Population Action International, 2007) are certainly indicating the impact of moralistic ideas on policy implementation albeit not agreeing with them.

With this in mind, the crucial need and timing of PEPFAR I's initial $15 billion budget should not be underestimated, as it appeared at a time when scaling up of funds to AIDS was essential for the future global response to the pandemic. Thus, the impact of the programme's moralistic policies can be argued to rather be based in its financial authority as in the acceptance of its moralistic ideas. This distinction is not pointed out in Vanwesenbeeck's (2011) model. Certainly, an important criticism of PEPFAR I was that it "exert[ed] too much control over the design and emphasis of local HIV/AIDS programs" (Garrett, 2007:30) through its bilateral agreements. This indicates that the programme used its financial superiority to implement its own inter-subjective ideas where they perhaps had not been as readily accepted were it not for the need for financial support. Supporting this argument is how PEPFAR I also inserted its moralistic norms outside its own programme by making restrictions on what other organisations could purchase with PEPFAR funds. For instance, the Global Fund was not allowed to support family planning efforts – an essential part of low-road clustered sexual and reproductive health – with money from PEPFAR (Cleland & Ali, 2006:1792). Indeed, in 2004 an editorial in the respected journal The Lancet claimed that PEPFAR's financial position was an upper hand that made some prominent actors – including the Global Fund's Executive Director at the time, Richard Feachem – not reproach the programme's policies, believing that "the size of the US investment into AIDS render[ed]

President Bush immune from criticism" (The Lancet, 2004:304). That PEPFAR I's contributions have made the overall programme more legitimate is reflected in Nathan Geffen's comment from a personal interview, where he explains that although he has "been involved in […] criticisms [of PEPFAR] over the years [….] on balance PEPFAR has been predominantly something that saved lives" (Geffen, 2013).

With the example of PEPFAR I, it can seem as if widespread acceptance of moralistic ideas contribute less to high-road prioritisation than the material strength and legitimacy of moral policymakers. While this can highlight the impact moralistic policies have had in global responses to AIDS, supporting Vanwesenbeeck's (2011) argument of their influence, it still does not support Vanwesenbeeck's indication of widespread moral ideational 'forces', as the acceptance of moralistic ideas lies within certain policymakers and not the global AIDS community as a whole. Thus, the actual effect of moralistic ideas might not have been that significant had it not been for moralistic policymakers' financial muscles.

Simultaneously, the ideational scope of moralism must not be underestimated, as moralistic policymakers are not rational interest seekers operating in a vacuum unaffected by ideas and norms. Although the moralistic ideas these policymakers are expressing are inter-subjective rather than objective, this still suggests the presence of a moralistic ontology in some circles. Furthermore, despite criticism of moralistic ideas and norms, it is difficult to see how moralistic policies could have been implemented without any ideational legitimacy. This can be viewed in the light of Finnemore & Sikkink's (1998) idea of 'norm cascades' in international relations, where norms are accepted based on international pressure despite them not necessarily expressing domestic values. In this case, the ideational legitimacy of PEPFAR as a programme representing the US President should be considered an important factor in the acceptance of its moralistic ideas.

Furthermore, moralistic ideas and norms are still expressed in global discourses on AIDS. The Vatican, for instance, has pronounced a clear de-sexualised interest during meetings regarding future global AIDS responses, such as the high-level meeting resulting in the 2011 Political Declaration on HIV and AIDS (Goldstein, 2011). As a consequence of the UN system where various interests have to be taken into account, these meetings can easily turn into negotiations over values and religion, which again is reflected in the politically correct end result. Also, as Chapter 2 indicates, people living with HIV, and especially the communities particularly hard hit by the pandemic, have been alienated since AIDS was discovered in the 1980s. As such, stigmatisation and discrimination are to this day prominent issues posing

several challenges, which have been vigorously discussed at several International AIDS Conferences, especially from 2006 onwards. This can mean two things: first of all, there are still certain "value-based judgments" (IAS, 2007:33) stigmatising people living with HIV and the so-called 'high-risk groups' of infection, for instance by moralistically linking AIDS to acts of promiscuity and irresponsibility (IAS, 2007:33; Kort *et al*., 2008:25). In other words, moralistic ideas and norms are still prominent, as Vanwesenbeeck (2011) suggests. Second, and on the other hand, the fact that stigma and discrimination are met with resistance and action supports the abovementioned argument that the impact of moralistic norms are limited, as moralistic ideas are neither accepted nor taken for granted. Furthermore, the indication that human rights issues are discussed at the International AIDS Conferences suggests a presence of rights-based low-road approaches that are not reflected in Vanwesenbeeck's model. The role of this more recent rights-based focus is further explored in Sections 4.2.3 and 4.2.4. Yet still, as argued above, moralistic policymakers are part of shaping global AIDS policies.

It can thus be argued that moralistic policymakers' – such as PEPFAR under George W. Bush – executive ability is found somewhere in the nexus between materialism and ideas, where (desperately needed) financial authority is linked to somewhat acceptance of moralistic ideas through normative power and traditional legitimacy. IR constructivists' emphasis on this nexus of how ideas and materialism are reinforcing each other, as explored in Chapter 2, can elucidate and support Vanwesenbeeck's (2011) model here. Moralistic policies and material outcomes do not exist in a vacuum, thus, moralistic policymakers' financial influence must be understood in the light of the inter-subjective ideas encouraging them to enforce this influence. Similarly, the acceptance of moralistic policies in donor receiving countries must be based in somewhat acceptance of the ideas that they hold. This supports Vanwesenbeeck's model of the impact of morals on multilateral AIDS governance.

Interestingly, however, is how Vanwesenbeeck's (2011) model indicates that moralistic and medicalised ideas have affected high-road prioritisation simultaneously. Certainly, the de-contextualised and de-sexualised elements of medicalisation fit moralistic ideas well, as Vanwesenbeeck suggests. However, as indicated in Chapter 3, moralistic policies' link with evidence-based research is dubious at best (amfAR, 2007; Campbell & Shaw, 2008:691; El-Sadr & Hoos, 2008:553; IAS, 2007:15; Nguyen *et al*., 2011:292; PEPFARwatch, s.a.). Considering that evidence-based research is, as Chapter 2 also reports, an important element of medicalised ideas and suggested high-road prioritisation, moralistic norms and medicalised ideas do not necessarily complement each other as well as Vanwesenbeeck suggests. It is therefore paradoxical that ideas of moralism have gained prominence at the same time as the

need for evidence-based research has grown. As suggested in Chapter 3, this can highlight how certain positions of power and moralistic ideas play out in shaping policies and distributing funds. In terms of the nexus between ideas and materialism, moralistic beliefs and financial superiority might therefore not only have allowed moralistic actors to ignore criticism of their conservative policies, but also convincing results from evidence-based research suggesting the actual ineffectiveness of moralistic policies. Indeed, this idea that "even the best scientific evidence does not sway governments" (Nguyen *et al*., 2011:292) supports Vanwesenbeeck's argument regarding the influence of moralistic ideas. This is further elaborated upon in Section 4.2.4. However, this mismatch between moralistic and medicalised ideas can also indicate that moralistic ideas and norms have been less influential than Vanwesenbeeck gives them credit for, something that would be more explicated as medicalised ideas and evidence-based research have come to the fore.

In fact, evidence-based research has been used to counter moralistic policies, just like it has protected against harmful approaches in medicine and in countering inaccurate claims from AIDS denialists. The debate regarding needle exchange for injecting drug users is a good example here. While such harm reduction has been viewed as normatively or morally not acceptable by some policymakers, the much presented evidence-based research of the approach's effectiveness was so strong that "[t]he debate was [declared] over" (IAS, 2007:37) at the International AIDS Conference in Toronto in 2006. Accordingly, at the International AIDS Conference in Vienna in 2010 former US President Bill Clinton, an opponent of harm reduction efforts while in office, expressed that he had suddenly changed his mind (Schleifer, 2010). Similarly, already at the International AIDS Conference in Bangkok in 2004 "a 'new realism' [….] [was expressed] on the part of many countries to put evidence based prevention programmes in place despite their political, religious and moral sensitivity" (IAS, 2004:12). This indicates that medicalised ideas have gained prominence at the expense of moralistic norms. This development is not reflected in Vanwesenbeeck's (2011) model, which emphasise the concurrent existence of moralistic and medicalised ideas.

Accordingly, PEPFAR, which was reauthorized in 2008 under the Obama administration with a significantly higher $48 billion budget, went through some interesting changes. First of all, where PEPFAR I required that 33 per cent of the funds allocated at preventing sexual transmission had to be used on promoting abstinence, PEPFAR II removed this requirement. Second, the reauthorisation of PEPFAR focused more on gender disparities, the strengthening of local capacities and extended the amount of countries eligible for support. Thus, in many respects, PEPFAR II is more aligned with low-road approaches than its predecessor. PEPFAR

II's seemingly move away from moralistic ideas and policies is supported by key informant Nathan Geffen who stated in a personal interview that "there have been several important battles over the way PEPFAR has restricted funding, which I think we largely won" (Geffen, 2013). Interestingly, then, is it that PEPFAR II is also more medicalised than its predecessor, with more focus on prevention technologies and measurable targets (Kaiser Family Foundation, 2008:2-5).

These changing characters of PEPFAR II can both support and argue against Vanwesenbeeck's (2011) model. They can suggest that the new and more liberal changes in PEPFAR II are still adjusted to moralistic ideas. Table 3.1 indicates that these changes certainly came at a time when scientific developments provided alternative de-sexualised opportunities for policies that moralists and more liberally inclined actors eventually could agree upon. Indeed, in Obama's Global Health Initiative (GHI) for the years between 2009 and 2014 only "5% is reserved for family planning and reproductive health" (Vanwesenbeeck, 2011:292), suggesting that sexual health might still be an issue although some moral restrictions have been removed. This supports Vanwesenbeeck's model because it suggests that moralistic and medicalised ideas simultaneously impact multilateral AIDS responses. Together these ideas would agree upon more de-contextual and de-sexual high-road approaches. This is further explored in Section 4.2.4. On the other hand, the changes in PEPFAR II can also again suggest that moralistic ideas are not as strong as Vanwesenbeeck claims, because they are inconsistent, outdated and disapproved of by increasingly popular ideas of medicalisation. High-road prioritisation would, according to this view, be more affected by medicalised than moralistic ideas. As such, the explanation value of ideas and norms of medicalisation the development of multilateral AIDS responses is explored in the following section.

4.2.2 Evidence-based research, monetisation and scientific legitimacy

As the previous section and chapters stress, evidence-based research has been significant in order to counter harmful approaches in medicine and inaccurate claims about AIDS and has also been used to argue against unsustainable value conservative approaches. As Chapter 2 points out, evidence-based research is also linked to medicalised neoliberal principles of monitoring and evaluation to ensure cost-efficiency and legitimate use of donor money. Vanwesenbeeck's (2011) model suggests that high-road approaches are prioritised at the expense of low-road approaches because the de-contextualised characteristics of the former make those approaches easier to evaluate and demonstrate effectiveness. This section explores the prominence of evidence-based research and biomedical science as indicators of

medicalised ideas and their impact on global AIDS agendas and other epistemological understandings of knowledge.

At the International AIDS Conference in Vancouver in 1996 the demonstration of the lifesaving combination of ART drugs made researchers interrogate the cost and cost-efficiency of distributing these medications. The original price of ART was so high that most people and even most governments would not be able to purchase them (Berger, 1996:719-720). This can be linked to the rise of the global justice movement challenging the pharmaceutical companies and their unreasonable prices, which is further explored in the following section. However, this scientific breakthrough can also be said to have monetised the pandemic in the sense that neoliberal norms of cost-efficiency became more pronounced. Efforts to monitor and evaluate AIDS responses became important, as these "allow programme managers to calculate how to allocate resources to achieve the best overall result" (UNAIDS, 2000:4). Contextual low-road approaches are challenging to quantify, monitor and evaluate. ART – a high-road approach according to Vanwesenbeeck's (2011) model – are on the other hand more aligned with these neoliberal and medicalised principles. Vanwesenbeeck's model argues that the increased prominence of ART and high-road solutions as such is thus based in how these approaches can more easily be measured according to standards reflecting already existing norms demanding a demonstration of efficiency.

However, as Chapter 3 indicates, despite the concerns that emerged after the Vancouver conference over a treatment vs. prevention binary, the 2004 International AIDS Conference in Bangkok's holistic agenda is a demonstration of how low-road approaches were still prominent long after the discovery of HAART. Indeed, the conference report indicates that the discovery of HAART opens up the opportunity to direct attention towards other pressing issues, such as social drivers of the pandemic (IAS, 2004:4). The Bangkok conference's political focus does not support Vanwesenbeeck's (2011) model of a de-prioritisation of low-road approaches or that the pandemic was steered by clinical forms of science. Nevertheless, Chapter 3's mentioning of how the Bangkok conference was criticised for being too political and how scientists escaped to other more biomedical conferences are interesting notions in this regard. Hence, although the conference organisers in Bangkok were confident about their holistic agenda, the conference might also represent the beginning of a crossroad where different problematisations of AIDS enhanced a binary between low-road and high-road approaches.

In a report Kippax and Holt (2009:3) made for the International AIDS Society they express that the "[a]ppreciation of the significant role that the social and political sciences have played in HIV prevention, treatment and care has declined as the focus on treatment and biomedical prevention technologies has grown stronger." Especially the development of prevention technologies is important here because, as Table 3.1 indicates, such approaches to prevention were presented for the first time at the International AIDS Conference in Toronto in 2006, simultaneously as high-road approaches became increasingly pronounced. The prominence of high-road approaches can thus be explained by increased biomedical solutions to traditionally non-biomedical fields. This suggests that the binary between political/social science and basic/clinical science visible in Bangkok deepened after the development of biomedical solutions to prevention. The fact that some scientists hoped this would bridge the divide supports Vanwesenbeeck's (2011) argument of medicalisation because it reflects a belief that 'everything' can be, and should be, explained through evidence-based research. The development of prevention technologies, thus, can be seen as a saviour from the traditional approaches towards prevention and their 'inefficiency', or lack of measurement of such at least. Thus, when Nathan Geffen expressed in a personal interview that "both [politics and science] are important and [….] good evidence provide the stuff you need to form political opinion" (Geffen, 2013) this can be argued to still be framed within medicalised problematisations of AIDS. This medicalisation of research and 'knowledge' is reflected in the norm that "you can't make confident good decisions without evidence" (Geffen, 2013).

Supporting this argument is how increased demands for evidence-based research only became explicitly pronounced during the 2000s, after prevention technologies had started to come to the fore. For instance, while the 2001 Declaration of Commitment on HIV/AIDS does not mention the word 'evidence' once in its 52-page document (UN General Assembly, 2001), the 2011 Political Declaration on HIV and AIDS shows a drastically changed rhetoric, as 'evidence' is referred to as much as twelve times in the declaration's 17 pages (UN General Assembly, 2011). Furthermore, where scientific evidence and evidence-based research is mentioned, it is with regards to prevention efforts and cost-efficiency. For instance, point 45 of the 2011 Political Declaration states "that programmes must become more *cost-effective* and *evidence-based* and deliver better *value for money*, and that [….] a lack of proper governance and *financial accountability* impede progress" (UN General Assembly, 2011:7, emphasis added).

Although it is reasonable for donors not to want their contributions to go to waste and evidence-based research is important for the further development of medical approaches to

the pandemic, these developments suggest a global AIDS response where quantitatively measurable approaches are preferred in order to evaluate their effect, ensure cost-efficiency and increase legitimacy through transparent accountability. This is important because while there are clear benefits with evidence-based research, an overly dependency on evidence-based approaches indicates an epistemological preference benefiting high-road approaches, which then also will have material proof to back up their plea for funding. The neoliberal norms to monitor and evaluate and ensure value for money thus supports Vanwesenbeeck's (2011) claim that medicalised ideas are enhancing high-road prioritisation.

Indeed, prevention technologies, such as 'treatment as prevention' (TASP), are still not acknowledging the mutual importance of both social and basic science. Prevention technologies frame solutions that traditionally were low-road approaches within a biomedical framework where evidence-based research is the appropriate way of accumulating knowledge. Furthermore, this epistemological framing of knowledge and efficiency suggests that the demand for evidence-based research has become so dominant that only approaches that can be measured by the metric 'gold standard' of RCTs can possibly be declared effective. Nathan Geffen's statement that "whatever works, works [….]. I'm not really aware of any behavioural prevention mechanisms that have been proven to work" (Geffen, 2013) in a personal interview reflects how "[t]he demand for immediate empirical evidence for success [has become] the norm" (Garrett, 2007:34), despite that many scholars find RCT results to be "misleading" (Nguyen *et al*., 2011:291). This indicates that Vanwesenbeeck (2011) has a point when claiming that norms of medicalisation have contributed to high-road prioritisation because medicalised norms of what 'evidence' and 'knowledge' are have disregarded social scientists' understanding of epistemology, methodology and how to address structural challenges within the AIDS pandemic.

Although the prominence and ideological importance of science and evidence-based research thus seems significant for epistemologically framing global AIDS agendas – an issue explored further in Section 4.2.4 regarding the medicalisation of sexual and reproductive health – other ideas can also be said to have contributed to an increasingly biomedical focus on AIDS. The following section explores the importance of global justice in the distribution of ART, which is not covered by Vanwesenbeeck's (2011) model.

4.2.3 Social justice and human rights

Chapter 3 indicates that after the discovery of HAART – the combination of ART drugs that can avert the development of HIV in the human body – and its announcement at the

International AIDS Conference in Vancouver in 1996, high-road and low-road approaches were simultaneously expressed in global AIDS responses, as the struggle to allocate funding for and universalise access to ART (a high-road approach) became a global justice issue (a low-road approach). Accordingly, the attitude towards AIDS changed from one of despair to "a question of resources" (Schechter, 1996:54). Particularly at the International AIDS Conferences in Vancouver, Geneva and Durban this was explicitly expressed, as even in the nascent phase of HAART it was clear that the access to these absurdly expensive medications would be determined by geographical position and wallet size (Berger, 1996:720; Walters, 1996:712-713).

Reflecting the Vancouver conference's theme of "One World, One Hope", some governments and activists became engaged in challenging what they believed were the contributing factors to such an unequal distribution of drugs within a pandemic that were already structurally discriminating vulnerable people and populations. Large activist groups, such as the AIDS Coalition to Unleash Power (Act Up), were significant for protesting against the pharmaceutical companies' monopoly already at the International AIDS Conference in Vancouver (Walters, 1996:713). As mentioned in Chapter 3, the fight for social justice and its successes can also be recognised in the establishment and engagement of the Treatment Action Campaign (TAC) in South Africa, the Indian and Brazilian governments' battle with pharmaceutical patent laws to ensure cheaper drugs for their citizens, and the curbing of the pharmaceutical industry's decision making power in the Accelerating Access Initiative (AAI) and the Doha Declaration. Another successful outcome of such mobilisation for social justice is illustrated by how the pharmaceutical companies' lawsuit of the South African Medicines and Related Substances Control Amendment Act (Republic of South Africa, 1997) was dropped in 2001 after immense public protests (Fourie, 2006:149). In many ways, these were direct attacks on the global neoliberal regime (Ingram, 2013), which in this case was amplified by the monopolised position of pharmaceutical companies. As Nathan Geffen expressed in a personal interview "it was critical to winning our battles that we took [human rights and social justice] into account, that those concepts were at the forefront of our struggle" (Geffen, 2013).

Thus, although the focus on the distribution of drugs worldwide have contributed to an increased focus on biomedical high-road approaches in global AIDS responses – supporting the claim of a medicalisation of sexuality explored in Section 4.2.4 – there are clear social justice and rights-based low-road aspects with this development. As Chapter 3 indicates, this is emphasised by Parker (2013) and his focus on the mid-1990s' structural explanations to

AIDS, as this humanitarian engagement and mobilisation of civil society and political involvement was essential for future responses and allocation of funds to the global AIDS pandemic. This more nuanced picture of the medicalisation of the pandemic through "scientific activism" (IAS, 2004:71) for global justice and universal human rights is not reflected in Vanwesenbeeck's (2011) model. The model suggests a binary between low-road and high-road approaches where the prioritisation of one is occurring at the expense of the other, which is not the case if one takes into consideration the global justice fight for universal access to drugs. This existence of a humanitarian grey zone between low-road and high-road approaches also suggests that ideas of moralism, medicalisation and the market cannot alone elucidate how global AIDS agendas have developed, as global justice and human rights rather work on ideas and principles of equality, humanitarianism and global solidarity. The increased focus on biomedical high-road approaches since 1996, then, can be argued to be a consequence of, and dependent on, the low-road initiative of a human rights-based approach to AIDS rather than being influenced by medicalised, moralistic or monetised ideas. Thus, Vanwesenbeeck's (2011) model has limitations when trying to explain this era in the history of AIDS. This argument of humanitarianism is, however, challenged by Ingram's (2013) understanding of the neoliberal market's re-legitimisation through humanitarian approaches to the AIDS pandemic. Ingram's argument, which supports Vanwesenbeeck's understanding of the power of the market, is further elaborated upon in Section 4.2.6. Furthermore, the securitisation of AIDS in the early 2000s can illuminate yet another explanation of the political engagement and scale-up of funds to the pandemic. This is discussed in Section 4.2.5.

As Section 4.2.1 indicates, human rights have been specifically addressed at the International AIDS Conferences, most particularly from 2006 onwards, and linked "to achiev[ing] universal access goals, including addressing workplace discrimination, travel restrictions, and the denial of women's property and inheritance rights" (Kort, 2008:5). Furthermore, at the 2012 International AIDS Conference in Washington D.C. "[t]here was consensus among conference participants that a real need exists to fight prejudice, stigma, discrimination, exclusion, and criminalization" (IAS, 2012:8). Thus, universal access to treatment has remained a human rights issue to this day, incorporating also the more contextual need for human rights in order to reach vulnerable people and populations.

The apparent need to still address issues such as discrimination and stigma at the conferences suggests, as Section 4.2.1 indicates, the continued presence of moralistic norms leading to such violation of human rights even as late as 25-30 years into the pandemic, which supports

Vanwesenbeeck's (2011) model. However, the fact that human rights are actually addressed at the International AIDS Conferences does not support the model's claim that human rights are marginalised (as a part of the low-road approach cluster) in global AIDS agendas. Indeed, as Table 3.1 suggests, the focus on such rights-based low-road approaches seems to even have expanded from focusing on global access to drugs – with the high-road approach consequence of a medicalised pandemic – to also include social and legal rights, effectively fighting stigma and discrimination of vulnerable people and enhancing the prominence of contextualised human rights-based low-road approaches.

This development does not coincide with the Vanwesenbeeck (2011) model's binary between high-road and low-road approaches because not only are some low-road approaches essential for the attention given to high-road approaches themselves, as the abovementioned historical development suggests, but they are also independently presented at the International AIDS Conferences in the form of efforts to curb stigma and discrimination. Although, as Table 3.1 indicates, high-road approaches started to become more prominent around the International AIDS Conference in Toronto in 2006, this development of high-road prioritisation is, according to this view, linked to and in company of rights-based low-road approaches. This is, in other words, another indication of how Vanwesenbeeck's model does not take grey zones between high-road and low-road approaches into consideration, which limits the model's explanation value in terms of which ideas might have contributed to high-road prioritisation.

However, instead of being an indication of a faulty claim of high-road prioritisation on Vanwesenbeeck's (2011) behalf, the presence of a human rights agenda simultaneously as the AIDS pandemic became remedicalised can also suggest that in practice low-road approaches are more split than they appear on paper. While human rights are an important part of low-road approaches the wide reaching scope of human rights themselves opens up the possibility that some aspects of human rights – the de-sexualised ones – might be preferred as they are more aligned with norms of moralism, medicalisation and the market than others. For instance, at the International AIDS Conference in Vienna in 2010, the conference theme was settled on human rights; however, the conference's rights based focus was aimed at injection drug use (Bliss, 2012:18). While the Vienna conference made great and important progress in spreading consensus and information regarding injecting drug users' human rights, this is an example of how human rights can be addressed while still adjusting to norms of quantification and moralism. From this point of view, it can be argued that only human rights that conform to medicalised and moralistic ideas are the ones addressed at the International AIDS

Conferences. Thus, although this disparity within low-road approaches is not mentioned in Vanwesenbeeck's model, which indeed is a limitation in terms of the model's simplicity, this argument is supporting the model's emphasis on the influence of moralistic and medicalised ideas.

The role of sexual and reproductive health and rights in global AIDS responses and discourses can thus stand as a crucial indicator for how multilateral AIDS governance and high-road prioritisation have developed and why. This is because approaches with a sexual and cultural focus – an important element of low-road approaches – are poorly aligned with the de-contextual and de-sexual preferences of both moralistic and medicalised ideas. The prominence of sexual and reproductive health is therefore an important indicator for the explanation value of Vanwesenbeeck's (2011) model and ideas of moralism and medicalisation. Sexual and reproductive health is therefore further explored in the following section.

4.2.4 Sexual and reproductive health…. and rights?

As previous chapters stress, a focus on sexual and reproductive health (SRH) is significant for a comprehensive global AIDS response. SRH is contextually focused on AIDS, recognising the pandemic's sexual nature and links with discrimination, power and violence. In an SRH framework empowerment of women and their right to decide over their own bodies is seen as a significant factor in addressing AIDS and improving overall global health. This contextual emphasis is aligned with Parker's (2013) understanding of the structural explanations to AIDS that gained prominence around the mid-1990s. Indeed, when UNAIDS was established in 1996 the UN Population Fund (UNFPA) – an institution focused on sexual and reproductive health working towards the acclaimed Programme of Action from the 1994 International Conference on Population and Development (ICPD) – was a natural cosponsor of the new AIDS institution. After the review of the ICPD in 1999 clear targets were set between the two institutions in order to coordinate efforts on AIDS and sexual and reproductive health (SRH) (Knight, 2008:82). Furthermore, as Chapter 3 indicates, the International AIDS Conference in Bangkok in 2004 acknowledged both the importance of condoms – an essential tool in securing family planning and sexual and reproductive health – and women's empowerment in confronting the AIDS pandemic. In 2005 access to reproductive health was included in the Millennium Development Goals (MDGs), stressing the importance of SRH in order to meet the rest of the MDG targets (Greer, *et al*., 2009:674). Also the 2006 Political Declaration on HIV/AIDS expresses the importance of gender equality and sexual and reproductive health (UN General Assembly, 2006:5). All these factors indicate that sexual and reproductive health

has been acknowledged in global AIDS agendas, not supporting Vanwesenbeeck's (2011) claim that SRH has been marginalised by moralistic and medicalised ideas.

As mentioned in Chapter 3, however, sexual and reproductive health and rights (SRHR) are claimed to be deprioritised compared to the attention given to AIDS alone. Since the biomedical HAART breakthrough in 1996 the concern of an emerging treatment vs. prevention (of sexual transmission) binary, benefitting the former at the expense of the latter, was expressed at several International AIDS Conferences. As Chapter 3 indicates, this concern was articulated as early as the International AIDS Conference in Geneva in 1998, and amplified as funding for AIDS responses started to increase. Prevention of sexual transmission of HIV is connected to the overall agenda of sexual and reproductive health, and the marginalisation thereof can thus indicate that SRH has indeed been overshadowed by the global initiatives focused on treatment. Indeed, the money distributed to SRH drastically decreased around the same time as funding for biomedical AIDS responses increased and peaked (Greer *et al*., 2009:674; Greene *et al*., 2012:90; Vanwesenbeeck, 2011:291).

The previous section argues the link between low-road and high-road approaches in the global justice aim for access to treatment; a link that is not recognised in the Vanwesenbeeck (2011) model's claim that medicalisation, morals and the market are the ideas contributing to biomedical high-road prioritisation. Similar to this argument, the treatment vs. prevention binary and marginalisation of SRH compared to AIDS can also be claimed to be affected by the sense of urgency around the human right to access AIDS treatment. Thus, Vanwesenbeeck's ideas of moralism, medicalisation and the market can also be said to have limitations for explaining the marginalisation of SRH in global AIDS agendas. Section 4.2.5 explores yet another idea beyond humanitarianism that also could have contributed to the prioritisation of high-road approaches' short-term and vertical solutions to AIDS, and that is not taken into consideration in Vanwesenbeeck's model. However, as the former section points out, an increasingly de-sexualised high-road initiative in global AIDS responses can still be valuably elucidated by the Vanwesenbeeck model's focus on moralistic and medicalised ideas. This is because these ideas' alignment with de-contextualised and moralistically refined high-road approaches might elucidate why biomedical solutions are preferred as viable options to low-road approaches in order to meet donors' requirement of cost-efficiency while simultaneously avoiding culturally sensitive issues.

Supporting Vanwesenbeeck's (2011) argument are the scholars pointing out the perplexing decision to leave sexual and reproductive health out of the original MDG targets, despite the

widely recognised Cairo Agenda's emphasis to work towards universal access to reproductive health by 2015 (Fathalla *et al*., 2006:2098). The exclusion of SRH and the Cairo Agenda from international and domestic programmes in general, and the MDGs in particular, are claimed by some to be due to moralistic norms and conservative values. These moralistic inclinations have, according to this view, made some policymakers – such as PEPFAR I, the Vatican and some conservative nations in the developing world – actively campaign against SRH and family planning in multilateral agendas regarding AIDS and health. The reproductive right to abortion, for instance, seems to be one of the more sensitive issues making moralistically inclined policymakers back away from anything regarding sexual and reproductive health (Buse *et al*., 2006:2101; Crossette, 2005:72, 76; Greer *et al*., 2009:674). From this point of view, PEPFAR I's requirement that the majority of its funds had to be spent on biomedical treatment efforts (Kaiser Family Foundation, 2008:2) can be argued to be based in moralistic norms and the consequent inclination to de-sexualise the AIDS agenda by avoiding low-road approaches focused on sexual and reproductive health. Within sexually conservative cultures, biomedical high-road approaches must be a safe haven where a sexually transmittable infection can actually be addressed without addressing 'the sex'. Thus, moralistic norms could have contributed to the mentioned treatment vs. prevention binary rather than, or in addition to, the humanitarian need to ensure universal access to drugs. This supports Vanwesenbeeck's emphasis on the impact of moralistic norms.

Also interesting for the explanation value of Vanwesenbeeck's (2011) model is the role of measurable targets in the development of the MDGs. Apparently the drafters of the MDGs, although acknowledging the importance of reproductive health, "wanted goals that were quantifiable [….] [and were under the understanding] that reproductive health could not be quantified in any way" (Crossette, 2005:76). This reflects the claim from Section 4.2.2 that a norm of medicalisation affects the global AIDS agenda, and supports Vanwesenbeeck's argument that medicalised ideas contribute to high-road prioritisation because of the challenge to quantitatively measure, evaluate and raise funds for sexual and contextual low-road approaches.

Structural solutions, such as the ones based in sexual and reproductive health, to the AIDS pandemic have indeed been viewed as challenging to define, target, change and evaluate (Gupta *et al*., 2008:764, 770-771; Parker, 2013). As such, structural solutions to prevent transmission of HIV – addressing structural and sexual violence – have been marginalised due to lack of funding (Piot *et al*., 2008:845). While this supports Vanwesenbeeck's (2011) idea of medicalisation, as explored in Section 4.2.2, it also elucidates how AIDS responses are

dependent on the choices of the donors, which is further elaborated upon in Section 4.2.6. Regardless of these challenges, SRH and structural emphases were, as mentioned above, still recognised around 2005-2006, with the inclusion of SRH in the MDGs and the acknowledgement in the 2006 Political Declaration. Therefore, with regards to Vanwesenbeeck's model, the evolvements around and after the International AIDS Conference in Toronto in 2006 are interesting, especially because, as Table 3.1 indicates, de-sexual high-road approaches started to become increasingly dominant around this time.

As indicated in Chapter 3, while the International AIDS Conference in Toronto in 2006 shared the Bangkok conference's gender sensitive approach, recognising the link between gender discrimination and HIV transmission, it was also the conference first emphasising biomedical prevention efforts and TASP. The conference's encouragement for further development of biomedical approaches, such as microbicides, was addressed within the framework that such discoveries can help people in vulnerable situations and thereby also the structure that they are in. Also in Toronto the promising results of TASP made some scholars consider the treatment vs. prevention binary as bridged due to the biomedical prevention benefits with expanded treatment efforts. The coining of the term 'combination prevention' at the International AIDS Conference in Mexico City two years later also promised more straightforward solutions to initial complex structural challenges. Combination prevention is aimed at applying a variety of approaches – structural as well as behavioural and biomedical – and adjust these to different settings in order to reach vulnerable people and address the further approach needed to lower the chances of HIV transmission (IAS, 2010:17; Kort *et al*., 2008:5; Parker, 2013). Combination prevention was believed to address the importance of structure and make up for the otherwise marginalised efforts to prevent sexual transmission of HIV (Merson *et al*., 2008:485). Prevention technologies, TASP and combination prevention were thus important discoveries for multilateral AIDS responses because – among other things – they were set at eliminating the challenges that up until then were associated with structural approaches.

Indeed, at first glance, this is a holistic development suggesting less prominence of medicalised and moralistic ideas than Vanwesenbeeck (2011) claims. Combination prevention could represent what Vanwesenbeeck calls for: a 'combination' of biomedical high-road and contextual low-road approaches. However, TASP, prevention technologies, combination prevention and even the more recent call to end the AIDS pandemic presented at the International AIDS Conference in Washington D.C. in 2012 (IAS, 2012:48) and by organisations such as UNAIDS and PEPFAR can be argued to be based in a "biomedical

triumphalism" (Nguyen *et al*., 2011:291), as they essentially are dependent on ART distribution or other clinical solutions to the pandemic (Giami & Perrey, 2012:357; Montaner, 2008:2; Stein, 2011). HIV prevention within these approaches is thus framed and even dependent on the existence of biomedical high-road approaches. Importantly, sexual and reproductive health is rarely mentioned as a part of combination prevention and the seemingly structural elements of combination prevention remains de-contextualised from overall health initiatives, such as securing maternal health. Sexual and reproductive health is thereby supposedly dealt with by biomedical interventions without actually being addressed. This "medicalization of sexuality" (Giami & Perrey, 2012:357) can be argued to be based in a wish to make initial contextual and structural elements easier to control and measure, which suggests the appearance of a biomedical ontology oblivious to what more contextual approaches focused on sexual and reproductive health are about. Making targets more straightforward so that they are easier to reach and demonstrate might look good for donors, but as long as they do not deal with essential underlying challenges nothing will change. Vanwesenbeeck's argument that medicalised ideas are enhancing high-road prioritisation can illuminate this development, because taken-for-granted norms and epistemological understandings of what makes AIDS responses effective reflect a problematisation of AIDS that underscores the appropriateness of biomedical and/or quantifiable high-road solutions. This need to fix AIDS the biomedical way turns a blind eye towards the challenges biomedical high-road approaches, including combination prevention, cannot solve alone.

On the other hand, Vanwesenbeeck (2011:294-295) herself is optimistic about recent developments regarding sexual and reproductive health. Indeed, contributions to the UNFPA have increased from $783 million in 2009, to $870 million in 2010 and $981 million in 2012 (UNFPA, 2011:29; UNFPA, 2013:44). Although this amount is still small compared to the $7,9 billion disbursed specifically to the AIDS pandemic in 2012 (Kates *et al*., 2012:2) it is interesting that this increase in funds for UNFPA has occurred simultaneously as funds for AIDS has decreased – which has seemingly been because of the Global Financial Crisis. This is explored further in Section 4.2.6. It is not yet clear, however, how much of the funds for UNFPA will be coordinated with responses to AIDS. In a UNAIDS report from 2011 it was reported that of all the resources allocated to AIDS, 53 per cent were still focused on treatment and care, 22 per cent went to prevention efforts (including biomedical prevention technologies) and only 1.2 per cent was reserved for "social protection and social services" (UNAIDS, 2011:154). In terms of global AIDS responses, thus, SRH still seems to be

deprioritised compared to biomedical interventions, which supports Vanwesenbeeck's model, but not her optimism.

As Section 4.2.3 indicates, while human rights in terms of "structural inequalit[ies] based on race, class, gender, age and sexual orientation" (Kort *et al*., 2008:25) are addressed at International AIDS Conferences, the direct addressing of sexual and reproductive health (SRH) can be argued to be merely "a rhetorical necessity" (Giami & Perrey, 2012:357). Indeed, although SRH is a human right, it seems as if its presence still has to be justified (see Greene *et al*., 2012:iv-v). Furthermore, the few times SRH is actually addressed in the conference report following the International AIDS Conference in Washington D.C., no strategy is communicated on how to effectively deal with the lack of access to it, despite the issue being characterised as essential. Thus, despite the focus on human rights, discrimination and stigma at recent International AIDS Conferences, sex still seems to be an issue that is brushed under the carpet. This is supported by the fact that PEPFAR II, despite having less direct moralistic requirements than PEPFAR I, necessitates that the US Congress must be made aware "if less than half of prevention funds in any host country go to abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction" (Kaiser Family Foundation, 2008:4). Hence, PEPFAR II still pressures the importance of moralistic approaches at the expense of approaches aimed at safe sex and condom distribution, which is amplified by the latter being restricted with an age limit (PEPFARwatch, s.a.). PEPFAR II has also kept its predecessor's restrictions against supporting organisations working with family planning and/or do not explicitly state that they are against prostitution (Kaiser Family Foundation, 2008:4).

Perhaps the biomedical developments within prevention technologies since 2006, then, has allowed for low-road approaches dealing with human rights to enter AIDS agendas and discourses because the actual addressing of other contextual factors, such as the 'sex thing', can now more easily be avoided by being handed over to biomedical solutions, such as TASP, male circumcision and microbicides. Thus, SRH can be dealt with without actually discussing sensitive political and cultural issues. In other words, by framing structure within biomedical terms, SRH can be separated from human rights because biomedical solutions are seemingly already about to address the problem. This supports Vanwesenbeeck's (2011) claim that morals are affecting multilateral AIDS agendas, and that medicalised and moralistic ideas have indeed developed simultaneously around the common ground of de-contextual and de-sexual high-road approaches, as one of the arguments in Section 4.2.1 suggests. However, it also supports the point, as suggested in Section 4.2.3, that Vanwesenbeeck's (2011)

demonstration of low-road approaches is too simplistic. Since some low-road approaches are floating in a grey zone between high-road and low-road approaches, low-road approaches can be argued to be more split in reality than on paper.

In terms of the development of sexual and reproductive health, not everyone agrees with the idea that the 1994 ICPD's broader SRH development agenda necessarily contributed to long-term benefits for the distribution of all SRH goals. Cleland *et al*. (2006:1811, 1823) argues that the ICPD undermined the importance of family planning by disconnecting it from overall economic development, framing the issue as less urgent. While these scholars paradoxically disregard the importance of linking family planning with gender equality and sexual and reproductive rights, their argument can illustrate two important insights. First of all, urgency is key for prioritisation in global politics. This is further explored in the following section. Second, economic development is considered urgent. The role of the neoliberal market is discussed in Section 4.2.6.

4.2.5 HIV-exceptionalism

HIV-exceptionalism is the idea that since AIDS, due to its widespread political, social and economic implications, has consequences beyond health and medicine it is a disease that requires an exceptional response. In the earlier phases of the pandemic, HIV-exceptionalism was closely linked to the frightening and fatal consequences of HIV, the distinctive needs of vulnerable communities and the struggle for social justice for people living with HIV (Smith & Whiteside, 2010:1-3). After the HAART breakthrough in 1996, the possibility of treating AIDS made HIV less threatening and "AIDS exceptionalism came to refer to the disease-specific global response" (Smith & Whiteside, 2010:1) amplified by "fevered aid" (Smith & Whiteside, 2010:1) for the pandemic.

Vanwesenbeeck's (2011) model suggests that HIV-exceptionalism is a characteristic of high-road approaches, affected by moralistic de-sexual preferences as well as medicalised and monetised principles to vertically target and measure solutions for ensuring cost-effectiveness (Garrett, 2007:34). As the previous section suggests, monetised targets, de-sexualised morals and medicalised vertical distribution can all have explanation value for understanding the development of a global AIDS response where AIDS specific services are the objectives of prioritisation, as compared to overall health systems. Importantly, as Chapter 3 indicates, the link between short-term measurable targets and donor prioritisation is profound (Garrett, 2007:15), which suggests how medicalised needs to monitor and evaluate approaches can contribute to the prioritisation of quantifiable high-road approaches. Thus, although

Vanwesenbeeck's model does not take into consideration the global justice and human rights elements that have contributed to a more de-contextual and biomedical global approach to the pandemic, as previous sections suggest, HIV-exceptionalism as an indicator of high-road prioritisation can in some respects be explained by the Vanwesenbeeck model's emphasis on the de-contextual preferences of the market, moralistic and medicalised ideas.

For instance, at the International AIDS Conference in Mexico City in 2008, the claimed implications of vertical HIV-exceptionalism on the rest of the health system discussed at the conference in Toronto two years earlier was declared "a 'false debate'" (Kort, 2008:5) by scientists who argued that vertically distributed AIDS specific services would rather improve health systems. However, as indicated in Chapter 3, the idea that AIDS specific services are strengthening general health systems is based on the understanding that health care and health infrastructure is the same thing; while in many respects these are separate. The positive findings presented at the International AIDS Conference in Mexico referred to a strengthening of health infrastructure dependent on donors' AIDS specific vertical distribution of biomedical high-road approaches. The findings did not take into consideration a general health focus on local capacity building and horizontally distributed health care. Thus, while health infrastructure might be improved by AIDS specific services, the consequent de-contextualising of the pandemic still ignores the link between AIDS and general health and wellbeing (Garrett, 2007:32-33) which is one of Vanwesenbeeck's (2011) arguments against high-road prioritisation and HIV-exceptionalism.

These different perceptions of what a strengthened health system contains are valuably elucidated by Vanwesenbeeck's (2011) model because the idea that health infrastructure is the same as health care reveals a biomedical ontological understanding where vertically distributed AIDS specific services is the norm and low-road approaches are deprioritised. Just as the previous section argues that the de-contextual and de-sexual preferences of medicalised, monetised and moralistic ideas have affected SRH marginalisation, these ideas can have contributed to HIV-exceptionalism. In the example of the health systems debate at the International AIDS Conferences in Toronto and Mexico City, medicalised ideas can be argued to be particularly evident, as the arguments pro HIV-exceptionalism at the Mexico City conference were relying on the findings from evidence-based research and ignoring the many African leaders that reported coordination problems between AIDS specific services and the overall health system (Kort, 2008:5).

However, Vanwesenbeeck's (2011) model does not indicate any alternative explanations for HIV-exceptionalism. The model implies that HIV-exceptionalism and AIDS specific services are a consequence of overall de-contextualisation and de-sexualisation of AIDS responses following the scale-up for AIDS, rooted in medicalised, monetised and moralistic ideas. As indicated in Chapter 3, other scholars have argued that HIV-exceptionalism is not necessarily only a symptom of scale-up and particularly medicalised ideas, but also something essential for the scale-up to occur in the first place. This can be linked to neoliberal re-legitimisation, which is discussed in Section 4.2.6. Moreover, HIV-exceptionalism can also be linked to how AIDS was framed as an emergency and security threat, which is explored in the remaining part of this section.

As indicated in Chapter 3, AIDS was deliberately framed as something exceptional before the scale-up for funds materialised. Significantly, at the UN Security Council (UNSC) meeting in 2000, and in the subsequent Resolution 1308, AIDS was framed as a threat to national security. UNAIDS was a part of this framing process (Behrman, 2004:175-176; Ingram, 2013:440; McInnes & Rushton, 2011:122; Smith & Whiteside, 2010:3). This is interesting for several reasons. First of all, it illuminates alternative explanations to high-road prioritisation, because the responses to an emergency would be that of a fire fighter: short-term drastic solutions to deal with the most apparent and urgent factors. Thus, HIV-exceptionalism, short-term solutions, vertical distribution and the urgent need for evidence-based research and access to ART – all indicators of high-road approaches – could be direct urgent responses to the idea of AIDS as a national security threat, rather than ideas of moralism, medicalisation and the market, as Vanwesenbeeck (2011) argues, or humanitarianism, as this study stresses. This supports the insight from Cleland *et al.*'s (2006:1811, 1823) argument in Section 4.2.4 on how family planning has been deprioritised after being taken off the 'high politics' economy agenda and thereby deemed less urgent. Since urgent cases are prioritised in global politics, an AIDS emergency can also explain the de-prioritisation of the 'less urgent' sexual and reproductive health. This is not reflected in Vanwesenbeeck's model.

Second, the framing of AIDS strengthens the constructivist argument that ideas and materialism are reinforcing each other. The idea of AIDS as a security threat, as compared to solid material evidence (McInnes & Rushton, 2011:125; Smith & Whiteside, 2010:4), was enough for policymakers to start pouring money in to the pandemic. This securitised idea was enhanced by Western, and particularly the US', focus on security, especially after the terrorist attacks 11 September 2001. The idea that "the 'high politics' of health issues that is, their security aspects rather than 'low politics' in which health issues are seen as a reflection of

human dignity" (Fourie, 2013:3) needs to be emphasised in order to trigger a response is depressing from a global health perspective. However, this view calls for a re-evaluation of the importance of ideational framing in material responses in global politics.

These points imply that something is lacking from Vanwesenbeeck's (2011) model. An idea or norm of 'sensationalism' to describe the role of multilateral actors in framing emergencies in order to allocate attention and funds, and the security and/or sensational preferences of policymakers that use this sort of framing to legitimise their engagement, could perhaps be valuable for the model's interrogation of high-road prioritisation.

Peter Piot, previous Executive Director of UNAIDS, understood the importance of getting AIDS discussed in the UNSC in order to increase much needed attention for the pandemic (Berhman, 2004:175; Cleland *et al*., 2006:1823). As a security issue, AIDS is exceptional and separated from its overall context for targeted emergency measurements. While targeted and urgent short-term responses to the AIDS pandemic can be understood from a medicalised point of view for the importance of monitoring and demonstrating effective use of donor money, they are also important attention seekers for engaging donor contributions in the first place. Although Vanwesenbeeck's (2011) ideas of the market, medicalisation and moralism, in addition to humanitarianism, can explain some parts of high-road prioritisation, these ideas cannot elucidate why "donations are propelled by mass emotional responses" (Garrett, 2007:21). In the latter case, issues are prioritised based on how much attention they can get – how sensational they are and urgent they are portrayed – and not whether they are the largest killer. In this sense, HIV-exceptionalism and high-road prioritisation can be elucidated by how AIDS was seen as sensational although "the top three killers in most poor countries are maternal death around childbirth and pediatric respiratory and intestinal infections leading to death from pulmonary failure or diarrhea" (Garrett, 2007:23).

The point here is not that AIDS as a pandemic does not have serious, even exceptional, widespread consequences that deserve high-profiled political attention. Indeed "after three decades [the pandemic] is still unfolding" (Smith & Whiteside, 2010:6). Furthermore, as Nathan Geffen (2013) pointed out in a personal interview, "[if] there weren't seven or eight million people on treatment across the world I think you'd find that many, many more people would die of HIV than any other diseases". The point, thus, is rather that there are certain ideas shaping global AIDS agendas based on how AIDS has been problematised. In order to ensure a comprehensive response, these ideas and processes ought to be understood. Vanwesenbeeck's (2011) model can elucidate some of these processes, but not all. In addition

to an insight of the humanitarian aspects of scale-up for global AIDS responses, an idea entailing how de-contextual high-road approaches has been necessary parts of ensuring this scale-up in the first place is also an important aspect lacking from Vanwesenbeeck's model.

Another limitation to Vanwesenbeeck's (2011) model is how it does not mention the depletion of the market during the Global Financial Crisis while simultaneously emphasising the influence of the market and the medicalised ideas at the ground for demands of cost-efficiency, productivity, accountability and legitimacy. Interestingly, the remedicalisation of the pandemic recognised in Table 3.1 came around the time as funds started to decrease. Another explanation for high-road prioritisation and remedicalisation of the AIDS pandemic can therefore be found in a material need to ensure productive allocation of a tight budget rather than medicalised norms. This is further explored in the following section.

4.2.6 The complex role of the neoliberal market

In the current neoliberal world market dynamics play a significant role, also when it comes to global health. For instance, in bilateral funds for the AIDS pandemic, North-America and Western Europe alone distributed $5.5 billion to regions such as Latin America, Northern Africa and the Middle East, sub-Saharan Africa, Russia and Asia in 2008 (UNAIDS, 2010b:10), suggesting a large flow and allocation of resources. Regarding the pharmaceutical industry "global pharmaceutical sales reached $602 billion" (Biehl, 2007:1097) in 2005. As Chapter 3 indicates, people living with HIV are dependent on ART drugs to survive and market actors, the pharmaceutical industry in particular, have been criticised for their cynical or greedy approach to the AIDS pandemic. As such, Vanwesenbeeck's (2011) model claims that market forces have been significant in encouraging high-road prioritisation, as these biomedical approaches opens up for more money-making opportunities than low-road approaches.

A significant limitation to Vanwesenbeeck's (2011) model, as Section 4.2.3 indicates, is its failure to elucidate the grey zone between low-road and high-road approaches, exemplified by how the low-road based global justice campaign was essential for securing access to high-road ART drugs. Furthermore, the model's emphasis on the influence of moralistic, monetised and medicalised ideas ignores the humanitarian idea behind this scale-up. Countering the argument from Section 4.2.3 that this humanitarianism has disempowered the neoliberal market by curbing the pharmaceutical industry, however, is Ingram's (2013:440-441) claim that this fight for global justice effectively re-legitimised the market by engaging market principles and dynamics in order to improve global health. The quest for universal

access to ART could therefore be accepted by market enthusiasts on the premise that market dynamics and actors, such as multilateral and philanthropic organisations and corporations, would be used in responding to the crisis.

This can be illustrated by Biehl (2007:1084, 1095-1096), who argues that in the background of Brazil's decision to challenge the pharmaceutical industry by making ART a public good was an army of market principles deeming supply and demand. While Brazil is almost completely independent of international investments in terms of the AIDS pandemic, its biomedical problematisation of AIDS has made the country overly dependent on ARTs in order to address their domestic situation (UNAIDS, 2011:154). To sustain this, coalitions between government, civil society and the pharmaceutical industry had to eventually be made in order to ensure access to the drugs that could not be cheaply generically produced in accordance with the WTO TRIPS agreement. Such coalitions become especially important in order to ensure back up medication for the citizens that get resistant to their generically produced ART drugs (Biehl, 2007:1100). Thus, where Vanwesenbeeck (2011) argues that the market is avoiding human rights-based approaches because of the lack of financial opportunities, Ingram's (2013) argument can elucidate the opposite. This suggests that Vanwesenbeeck's model has a point in terms of the impact of the market. Furthermore, it can also explain why human rights have entered the official programme at the International AIDS Conferences simultaneously as the pandemic has become increasingly remedicalised, as humanitarian spread of biomedical solutions serves the market.

While the humanitarian efforts behind the distribution of drugs for the AIDS pandemic must not be underestimated, the strong links between access to ART, human rights and the pharmaceutical industry can illustrate the ability of the neoliberal market to adapt and reinvent itself (Biehl, 2007:1099-1100). This can "indicate[…] the possibilities that may exist for working creatively with neoliberalism [….] to expand welfare" (Ingram, 2013:442), however, it can also illustrate an increased dependency on the market. Thus, in support of Vanwesenbeeck's (2011) claim that market forces are shaping global AIDS agendas and contributing to high-road prioritisation is the idea that the neoliberal market, with the pharmaceutical industry in front, has cooped the 'universal access' paradigm from overall humanitarian principles. From this point of view, Vanwesenbeeck's emphasis on the greedy market can elucidate the increasingly biomedical solutions to the pandemic. Especially the TASP paradigm deemed necessary to 'end AIDS' and the biomedical elements of combination prevention aimed at sorting out even structural challenges are based in biomedical ideas the market would benefit from as an increasing amount of people start using

these drugs. Since the market prefers targeted, measurable, 'quick-fixes' and profitable high-road approaches, increased dependency ignores the non-pharmaceutical low-road responses to the pandemic. While more people on treatment might reduce the chances of passing on the HI-virus, as is the idea behind TASP, it will also increase the number of people getting resistant to ART, which again increases demands for new medications. This downward spiral of supply and demand in the AIDS pandemic supports both Vanwesenbeeck's argument of how the market and biomedicine enhance each other towards high-road prioritisation, and the claim that a purely high-road approach to AIDS is unsustainable.

Simultaneously, it might be more the hope entailed to ending the pandemic that drives market dynamics and high-road prioritisation than greedy actors of themselves. In the aftermath of numerous behavioural and structural approaches with limited effect according to evidence-based research – reflecting the trust in medicalised ideas – biomedical approaches present an idea of controllable and seemingly effective solutions to the pandemic (Giami & Perrey, 2012:357). In this case, it is less the direct 'evilness' of market actors and more the web of ideas and belief that the pandemic is best fought through market dynamics, that drive high-road prioritisation. Vanwesenbeeck (2011) might therefore exaggerate the greediness of market actors, or at least their impact on AIDS agendas, and not elaborate enough on the ideational factors of the market and the ideas of freedom and hope it entails.

Nevertheless, perhaps the most significant demonstration of how the market affects global AIDS responses is how the pandemic is still dependent on donor contributions. Even the International AIDS Conferences, as Chapter 3 indicates, are supported by and dependent on the financial contributions of the pharmaceutical industry. In a pandemic that affect the most vulnerable people in this world hardest, both individually and internationally, donor preferences towards AIDS specific, biomedical and vertically distributed high-road approaches can be argued to increase global inequalities by making countries in the developing world dependent on developed countries – despite whatever humanitarian reasoning behind this. The influence of market dynamics and the pandemic's dependence on funds become visible when the money for the vertical tap of funds stop flowing in and no local capacity has been built (Garrett, 2007:30, 38). Thus, the impact the flatlining and decreasing funds had on the AIDS pandemic after the Global Financial Crisis is a clear demonstration of donor and market dependency.

Interestingly, for a model that acknowledges both the growth of medicalised ideas' focus on cost-efficiency and the AIDS pandemic's dependency on the market, Vanwesenbeeck's

(2011) model does not take into account the Global Financial Crisis although its impact on the pandemic is widely recognised (Ahmed *et al*., 2009:9; Fourie, 2013:3; IAS, 2010:8; UN General Assembly, 2011:3; WHO *et al*., 2011:7-8). With regards to donor dependency and priorities, Nathan Geffen rationalises the Global Financial Crisis' impact on global AIDS responses with the belief that "[r]ich people are a lot more likely to give their money to poor people when things are going well" (Geffen, 2013). Furthermore, the Global Financial Crisis is significant for the analysis of Vanwesenbeeck's model because, although it supports Vanwesenbeeck's argument by demonstrating the influence of the market, it provides yet another explanation apart from moralistic, medicalised and market-driven ideas for why global AIDS agendas have become increasingly remedicalised and focused on high-road approaches. Indeed, with less money to distribute for AIDS approaches, Ingram (2013:447) suggests that neoliberal principles focused on cost-efficiency and 'value for money' came to the fore, consequently increasing the demand for approaches that can be legitimated through evidence-based research, which, as this study has articulated, are usually high-road approaches.

Furthermore, the impact of the Global Financial Crisis on global AIDS responses and high-road prioritisation suggests that there might be a purely rational and material explanation for the prioritisation of high-road approaches at the expense of low-road approaches. This undermines the entirety of Vanwesenbeeck's (2011) model, as it stresses the importance of how ideas and materialism reinforce each other. However, the Global Financial Crisis cannot explain why increased focus on science, medicalised approaches and evidence-based research became increasingly pronounced as the early 2000s went by or why, as Table 3.1 indicates, a binary between high-road and low-road approaches emerged around the time of the International AIDS Conference in Toronto in 2006. During this time, resources for the AIDS pandemic were abundant and still growing, which undermines Ingram's (2013) argument that neoliberal principles of 'scarcity' impacted global AIDS agendas. In fact, as Chapter 3 indicates, medicalised ideas of 'value for money', cost-efficiency and biomedical approaches were increasingly pronounced as the scale-up for funds became abundant. This supports Vanwesenbeeck's (2011) model because it suggests that high-road prioritisation did not happen as a reaction to scarce material resources, but rather to medicalised ideas and norms. Again the framing of AIDS, or sensationalism, comes up as a lacking factor in Vanwesenbeeck's model.

The securitisation of AIDS explored in the previous section can also serve as an argument against the impact of the Global Financial Crisis on high-road prioritisation. This is because

the de-securitisation of AIDS – occurring after it became more "clear that AIDS and other diseases are not the *cause* of global insecurity and state failure" (Fourie, 2013:3, original emphasis) – happened just before the Global Financial Crisis and funds for AIDS responses decreased. Just as the Global Financial Crisis, the de-securitisation of AIDS – consequently reversing HIV-exceptionalism – might have contributed to less funds for the pandemic as the matter was declared less urgent (Ingram, 2013:446-447; McInnes & Rushton, 2011:118). While the Global Financial Crisis is believed to have had a major impact on decreased funds for the pandemic, if AIDS was still perceived as a security threat worthy of 'high-politics' attention, the funds for the pandemic might not have decreased as much as they did. Supporting this argument is how funding for UNFPA increased at the same time as funding for AIDS decreased, as Section 4.2.4 indicates. This is important because, although Vanwesenbeeck (2011) does not mention the framing of AIDS in her model, it illustrates the importance of ideas in global AIDS governance, which in the end is part of the important contribution Vanwesenbeeck is making.

Curious is it then that Vanwesenbeeck (2011) herself does not explicitly elaborate on the ideational and ideological link between the market and medicalisation. While the capitalist market has existed for a long time, it has since the 1980s been particularly affected by neoliberal financial principles. Medicalisation's emphasis on cost-efficiency, 'value for money', monitoring and evaluations is also, as Chapter 2 indicated, based on a neoliberal ideology restructuring governments around the same time. This is significant because the ideational link between these, the link Vanwesenbeeck forgets to emphasise, is actually supporting her argument. The increasingly medicalised AIDS pandemic despite abundant resources can therefore be illuminated by a neoliberal belief in how market money is best allocated – cost-efficiently – and can also explain why these neoliberal principles became more explicit as funds decreased. Ingram's (2013) principles of 'scarcity' after the Global Financial Crisis are thus still relevant because they are, according to this view, based on norms already present that became increasingly visible as funding stopped. This is, again, an illustration of the nexus between materialism and ideas.

4.2.7 The Vanwesenbeeck model's explanation value

As this chapter has aimed to demonstrate, Vanwesenbeeck's (2011) model has explanation value beyond illuminating the prioritisation of high-road approaches at the expense of low-road approaches. The model's emphasis on ideas and norms of morals, medicalisation and the market can highlight certain developments around the International AIDS Conferences between 1996 and 2012, albeit not all.

The model's focus on ideas of the market, moralism and medicalisation certainly has explanation value for why high-road approaches have become increasingly prominent. Moralistic ideas and policymakers have been, and are still, evident. This study argues that because of the financial supremacy some moralistic policymakers have, combined with these policymakers' legitimacy – as reflected in the constructivist notion of 'norm cascades' – and the ideas believed to affect these policymakers themselves and the inhabitants of receiving donor countries, the impact of moralistic norms must be found in the nexus between materialism and ideas. This supports the Vanwesenbeeck (2011) model's insight for how ideas and materialism reinforce each other and the model's claim that moralistic norms have contributed to high-road prioritisation. Furthermore, the continued significance of moralistic ideas become especially pronounced in PEPFAR II's continued sex negative or asexual policies and how sexual and reproductive health as part of a broader human rights agenda at more recent International AIDS Conferences has been avoided. While the latter points out a limitation to Vanwesenbeeck's (2011) model, that is that this incoherence within low-road approaches is not expressed, the fact that sexual and reproductive health is ignored can be explained by continued presence of moralistic ideas.

Medicalised ideas, although incoherent with moralism in terms of evidence-based research, can also be identified in increased demand for evidence-based research and promotion of biomedical approaches believed to 'solve' very complex social and structural issues. Thus, although there is a mismatch between the increased prominence of moralistic ideas and evidence-based research – because the former is often not supported in the latter – the focus on prevention technologies since 2006 can signify a good compromise between moralistic and medicalised ideas, as they avoid culturally sensitive and/or moralistic discussions as well as contextual and unquantifiable approaches. Such measurable approaches are well aligned with the increased demand for evidence-based research and medicalised principles of cost-efficiency and evaluation. The development of prevention technologies, TASP and combination prevention and their supposed ability to address non-biomedical contexts and structure also suggest the presence of a biomedical ontology where a positivist inclined epistemology is preferred, or even taken for granted, for accumulating knowledge, at the expense of social and political sciences' understandings of epistemology and methodology. This supports Vanwesenbeeck's (2011) claim of the prominence of medicalised ideas, as well as these ideas' co-existence with moralistic norms.

The development of such biomedical prevention technologies also benefits the market, because of the increased pharmaceutical distribution and the downward spiral of dependency

this entail. The complex role of the market in the AIDS pandemic – both at the heart of global justice struggles to distribute lifesaving medications and as contributor to donor dependency – supports Vanwesenbeeck's (2011) emphasis on the influence of the market on global AIDS agendas and high-road prioritisation, although this impact might be less materialistically inclined than Vanwesenbeeck recognises. Indeed, Vanwesenbeeck's suggestion that ideas of the market, moralism and medicalisation have enhanced high-road prioritisation is reasonable because in the complicated nexus between these ideas, high-road approaches are perhaps the only thing that can actually be agreed upon.

Thus, the high-road/low-road model elucidates much of the problematisations AIDS has gone through in recent years. However, while a model is a necessary simplification of reality, there are contestations within low-road approaches that indicate that Vanwesenbeeck's (2011) binary between high-road and low-road approaches is too pronounced. First of all, Vanwesenbeeck fails to see the significance of the global justice movement on the focus on and distribution of biomedical solutions and thereby also humanitarian ideas for high-road prioritisation. This humanitarian idea indicates a grey zone between high-road and low-road approaches that is not expressed in Vanwesenbeeck's model, and which can give a more nuanced picture of how the pandemic has become more biomedical. In this sense, Vanwesenbeeck's binary is too pronounced.

Second, Vanwesenbeeck does not recognise other ideas than moralism, medicalisation and the market for HIV-exceptionalism. Where the model implies that HIV-exceptionalism is a result of these ideas and the scale-up of funds for the AIDS pandemic, many scholars argue that HIV-exceptionalism and the framing of AIDS as a national security emergency – removing it from its overall context – were necessary for the scale-up to happen in the first place. HIV-exceptionalism is therefore not only an indicator of high-road approaches, but also a contributor to high-road prioritisation on the whole. This study argues, thus, that an idea or norm of sensationalism could with benefit be added to Vanwesenbeeck's model, as this would help illuminate the significance of framing issues as urgent in global policymaking and the emotional drive this provokes at the hands of the donors.

Lastly, Vanwesenbeeck (2011) does not recognise the ideological link between the market and medicalisation, which are both based on neoliberal norms and principles. This becomes particularly explicit when she fails to incorporate the impact the Global Financial Crisis had on funding for AIDS. Although the Global Financial Crisis cannot explain high-road prioritisation and the increased prominence of medicalised ideas of cost-efficiency before its

occurrence, it can elucidate why high-road approaches and neoliberal principles became more pronounced as funds decreased, as high-road prioritisation would merely be a natural reaction to already existing neoliberal ideas and norms. Thus, had Vanwesenbeeck recognised the ideational link between the market and medicalisation, an implementation of the Global Financial Crisis would have made her argument stronger, as it all the more clearer demonstrate the ideational importance of neoliberalism – as compared to purely material responses – and thereby also both medicalised and market-driven ideas.

4.3 Conclusion

Chapter 3 argues that Vanwesenbeeck's (2011) distinction between high-road and low-road approaches can be recognised in the events and discourses surrounding the biennial International AIDS Conferences between 1996 and 2012, albeit with some incoherencies, limitations and unclear underlying ideas. Thus, the aim of this chapter has been to analyse Vanwesenbeeck's model to explore whether the model can valuably explain and simplify the complex situation and development of recent and current multilateral AIDS agendas. Vanwesenbeeck claims that biomedical high-road solutions are currently prioritised at the expense of more contextual and sexual low-road solutions due to moral, medicalised and monetised preferences of donors and policymakers. These ideas have some clear limitations for explaining global AIDS policies and the prioritisation of high-road approaches, such as how they ignore the significance of humanitarianism in the distribution of lifesaving medications and thus also the existence of a grey zone between low-road and high-road approaches. Furthermore, the ideological link between the market and medicalisation is not directly emphasised, neither is the impact of the Global Financial Crisis, and, finally what appears to be a norm of sensationalism in global policymaking. Nevertheless, this study argues that Vanwesenbeeck's model, despite its limitations, can both be recognised and valuably illuminate the events and political discourses around the International AIDS Conferences between 1996 and 2012. This is because ideas of morals, medicalisation and the market still seem to have prominence and affect multilateral AIDS agendas, albeit perhaps not as strong as Vanwesenbeeck initially claims. Moralistic ideas and norms are still visible in global AIDS agendas. Ideas of medicalisation are evident in the emphasis on evidence-based research and cost-efficiency, which appeared before the Global Financial Crisis hit. Finally, the AIDS pandemic is dependent on the market, which in many senses is necessary yet also destructive. In many ways, de-sexualised, measurable, biomedical and profitable high-road approaches are the only solutions that can be agreed upon in the idea space between these norms. This is expressed in Vanwesenbeeck's model. The following chapter summarises the

main points of this study, answers the research questions, and provides suggestions for future research on the topic.

Chapter 5: Conclusions, and Future Agendas

5.1 Introduction

Global, multilateral, medical and societal actors and responses to the AIDS pandemic have been plentiful since AIDS was first identified in 1981. These multiple engagements have been essential for working towards an effective global AIDS response, as the pandemic represents complex political, social and biomedical concerns. Simultaneously, however, these various responses can also represent binaries of contested constructs shaped by how AIDS has been problematised and inter-subjectively understood. Vanwesenbeeck (2011) constructed a model that interrogates how problematisations of AIDS have affected global AIDS agendas as well as multilateral AIDS governance. The Vanwesenbeeck model suggests that although multilateral AIDS policies ought to be holistic for a comprehensive response, they have become increasingly focused on de-sexualised, biomedical and vertically distributed 'high-road' approaches at the expense of the more contextual, sexual, human rights-based and developmentally focused 'low-road' approaches. This high-road prioritisation, Vanwesenbeeck proposes, results from ideas and norms reflective of the market, moralism and medicalisation.

It was the aim of this study to test the analytical utility of the Vanwesenbeeck model's binary of problem definitions and response mechanisms to see if it could simplify the complexity and narrow the scope of effective and sustainable policy responses by valuably elucidating the relationship between ideas, global AIDS agendas and multilateral AIDS governance. For this purpose, this study investigated the following research question:

Can Vanwesenbeeck's (2011) model of high-road and low-road solutions be identified in and illuminate the policy ideas, problem definitions and political binaries that play out in the discourse surrounding the biennial International AIDS Conferences between 1996 and 2012?

Sub-questions complementing this primary research question included the following:

- What are the strengths and limitations of Vanwesenbeeck's (2011) model?
- What have been the general trends and developments in global AIDS policy/political responses as presented by policymakers, donors, civil society and multilateral organisations during, before and after the biennial International AIDS Conferences?
- Has the Global Financial Crisis affected the global AIDS response, and if so, in what way(s)?

This chapter concludes this study by summarising the main points from each chapter, answering the research questions and suggesting future research on the topic.

5.2 Summary of the study

Apart from presenting the research aim, question and supportive sub-questions as referred to above, *Chapter 1* provided a general introduction to the study with an overview of the background and main discussions on the topic, the presentation of the problem statement, a demonstration of the theoretical background and model of scrutiny, the methodology of choice, as well as the limitations of the study.

Chapter 2 went on further to explore Vanwesenbeeck's model and to explicate its contributions and limitations. The chapter started with a theoretical contextualisation of the model within theories of public policy problematisations and IR constructivism. These theories emphasise how inter-subjective ontological and epistemological assumptions and problematisations of issues shape what is perceived as 'appropriate' policies, and thereby also epistemological preferences. Used as theoretical background, these theories can elucidate significant aspects with the Vanwesenbeeck model's understanding of the nexus between ideas and materialism and the suggested effect of the market, moralism and medicalisation on norm entrepreneurs' ontological assumptions. As such, Vanwesenbeeck argues that high-road approaches are prioritised in global AIDS agendas and responses because their biomedical, quantifiable, de-sexual and clinical characteristics are more aligned with ideas and norms of moralism, the market and medicalisation, as compared to low-road approaches' focus on human rights, sexual and reproductive rights, communities and development. Chapter 2 suggests some limitations of the Vanwesenbeeck model: the possible oversimplification of the model's binary, as well as its ignorance of the Global Financial Crisis' effect on the global AIDS response.

Chapter 3 provided an historical outline of the key events and discourses surrounding the International AIDS Conferences between 1996 and 2012. In doing so, different frameworks – such as neoliberalism's complex role, HIV-exceptionalism and biomedical constructions of sex and culture – were explored for elucidating several perspectives and portrayals of how multilateral AIDS governance and global AIDS agendas have developed since 1996. The chapter pointed out three recognisable tendencies during the relevant timeframe of the study, most specifically the 'building of institutions', 'increased funding' and the 'remedicalisation and eventual funding cuts'. It concluded that features of Vanwesenbeeck's model could indeed be identified through increased focus on evidence-based research, the presence of

moralistic approaches, and the legitimisation of biomedicine and top-down interventions – all indicators of high-road approaches. However, the underlying contributions for this high-road prioritisation were not clear, as the chapter found that there can be other factors affecting global AIDS agendas and policies than the moralistic, market-driven and medicalised ideas and norms suggested by Vanwesenbeeck.

Consequently, *Chapter 4* investigated various indicators of high-road and low-road approaches – such as epistemological understandings of evidence and knowledge, sexual and reproductive health, human rights and HIV-exceptionalism – for testing the explanation value of Vanwesenbeeck's model. Particularly under scrutiny were Vanwesenbeeck's ideas of medicalisation, the market and moralism, as compared to alternative explanations for high-road prioritisation. The chapter concludes that Vanwesenbeeck's model can be both identified in and valuably elucidate the developments and political discourses and outcomes surrounding the International AIDS Conferences between 1996 and 2012. However, it fails to take into consideration the impact of the Global Financial Crisis, humanitarian engagement and the securitisation of AIDS on the development of high-road prioritisation in multilateral AIDS governance, which affects the model's analytical utility.

5.3 The study's findings with regards to the research question and sub-questions

As the preceding section implies the short answer to whether Vanwesenbeeck's model of high-road and low-road solutions can be identified in and illuminate the policy ideas, problem definitions and political binaries that play out in the discourse surrounding the biennial International AIDS Conferences between 1996 and 2012 is: yes, it can. However, although the model can be both identified in and elucidate these elements, it has significant shortcomings that limit the model's analytical utility. Hence, Vanwesenbeeck's model can valuably simplify some of the developments and discourses surrounding the International AIDS Conferences but not all, as it leaves out important information. The complementary sub-questions assisted in the findings for the development of this conclusion.

One of the complementary sub-questions concerns what the general trends and developments have been in global AIDS policy/political responses as presented by policymakers, donors, civil society and multilateral organisations during, before and after the biennial International AIDS Conferences. This question allowed for an in-depth exploration of the case study of the International AIDS Conferences within the specific timeframe, which was necessary for the further analysis and testing of Vanwesenbeeck's model. In response to this question key developments and tendencies were identified and it became evident that between 1996 and

2012 the global and multilateral responses to the pandemic changed drastically. Access to HAART early became a global justice issue, signifying the fight against, as well as the dependency on, the neoliberal market and pharmaceutical companies. Institutions were built and political commitment and funding for the pandemic increased. After 2006 and the introduction of prevention technologies and 'treatment as prevention' (TASP) the pandemic became increasingly dependent on biomedical solutions, a trend that continued as funds for AIDS flatlined and decreased in the aftermath of the Global Financial Crisis (2008-2011).

This sub-question assisted in exploring whether high-road and low-road approaches could be identified in the case study. Although low-road approaches were, as Table 3.1 suggests, prominent up until 2006, the increased focus on approaches aligned with evidence-based research, the presence of moralistic norms and policymakers, dependency of the neoliberal market and prominence of biomedical and vertically distributed solutions suggests a trend of high-road prioritisation, just as Vanwesenbeeck's model suggests.

This historically inclined sub-question is linked to the sub-question that addresses the strengths and limitations of Vanwesenbeeck's model. Ultimately, the identification of the model's contributions and limitations has been useful for clarifying the model's analytical utility. Vanwesenbeeck's ideas and norms of the market, medicalisation and moralism all have explanation value, albeit limited, for the development of high-road prioritisation. As Chapter 4 demonstrated, medicalised ideas and norms can be recognised in increased demands for monitoring and evaluation, evidence-based research and how knowledge has increasingly been defined according to scientific or biomedical epistemological preferences, at the expense of political and social sciences' understandings of epistemology and methodology. Medicalised and moralistic ideas' preference to avoid culturally challenging debates and unquantifiable and sexual solutions can elucidate why sexual and reproductive health and structural approaches were marginalised after viable alternatives in form of biomedical prevention efforts were first presented at International AIDS Conferences in 2006 and 2008. Furthermore, the belief that biomedical solutions can address structurally complex issues also suggests the prominence of a biomedical ontology where certain epistemological concerns are taken for granted.

Furthermore, Vanwesenbeeck's emphasis on moralistic ideas is reasonable as such norms are still present in the pandemic in the form of the abovementioned marginalisation of sexual and reproductive health, but also via the continued stigmatisation and discrimination of people living with HIV. In light of constructivists' emphasis on the relationship between material

existence and ideas, and on the significance of legitimacy and 'norm cascades', this study suggests that moralistic ideas and policymakers' effect on global AIDS agendas can be found in a nexus of financial authority, normative power and legitimacy. Although medicalised evidence-based research do not support many moralistic ideas, and have even been used to counter moralism, the simultaneous existence of both of these ideas – exemplified by PEPFAR II's medicalised, de-sexual and still moralistic programme and the separation of sexual and reproductive health from overall human rights at recent International AIDS Conferences – suggests the continued prominence of moralistic norms. The de-sexual and de-contextual characteristics of high-road approaches are indeed something moralistic and medicalised ideas can agree upon, which Vanwesenbeeck's model manages to elucidate.

Vanwesenbeeck's focus on the market also has explanatory value for high-road prioritisation. While the distribution of ART has saved lives and is an essential element in global health, these medications are also dependent on market dynamics and donors' preferences and can thus be said to have contributed to a re-legitimisation of the neoliberal market for accessing essential health services. This link between the market and biomedicine is amplified as global AIDS governance becomes increasingly dependent on biomedical solutions to the pandemic. The de-prioritisation of low-road approaches can therefore be explained by the market's preference of profitable, targetable and readily quantifiable high-road solutions.

However, Vanwesenbeeck's model has several limitations, as it fails to elucidate other explanations for high-road prioritisation. First of all, it ignores the link between human rights, activism and the access to lifesaving HAART drugs. This humanitarian idea – as compared to market-driven, medicalised or moralistic ideas – suggests a grey zone between low-road and high-road approaches, where the latter is dependent on the former in order to materialise. Thus, although Vanwesenbeeck's model can highlight the link between human rights and the market, the binary between high-road and low-road approaches is too pronounced and neglects the important impact that global justice and activism have had in the course of the pandemic and even on high-road prioritisation. Secondly, Vanwesenbeeck's model sees HIV-exceptionalism as a consequence of market-driven, medicalised and moralistic ideas as well as the scale-up of funds for the pandemic, and does not recognise other ideas affecting HIV-exceptionalism and high-road prioritisation. The model, therefore, ignores how HIV-exceptionalism and the framing of AIDS as an urgent security issue were essential elements for the scale-up of funds to happen in the first place. An idea of sensationalism, reflecting the significance of framing and the impact of donors' emotional preferences, could therefore

valuably be added to Vanwesenbeeck's model, especially as this would strengthen Vanwesenbeeck's own argument of the influence of ideas.

Another limitation to Vanwesenbeeck's model is how it does not explore whether, and if so in what way(s), the Global Financial Crisis affected the global AIDS response, which is also the third and last sub-question of this study. This question has assisted this study in focusing on a possible material and rational explanation for high-road prioritisation, as limited access to funds could have enhanced the need for measurable and evidence-based compatible high-road approaches for ensuring efficient use of already strained donor money instead of ideas and norms of medicalisation, the market and moralism. The Global Financial Crisis is recognised as a crucial factor for decreased funds for AIDS after 2008, and it is therefore significant that Vanwesenbeeck has not included this event in her model. However, such an undermining of ideas cannot explain the growing prominence of biomedical and quantifiable high-road approaches before the Global Financial Crisis hit and even as resources became increasingly abundant. The importance of securitisation/sensationalism is again demonstrated by these ideas' impact on the scale-up of funds, as well as the scale down when AIDS were considered less urgent before or at the same time as the Global Financial Crisis.

Nevertheless, this study argues that the Global Financial Crisis has affected global AIDS responses and should therefore be considered in Vanwesenbeeck's model. The exclusion of the Global Financial Crisis from the model is particularly interesting when taking the ideational relationship between the neoliberal market and neoliberal medicalised ideas into consideration. While Vanwesenbeeck does not elaborate on this link, this ideological relationship of neoliberal principles supports the model in the sense that medicalisation and high-road prioritisation could be rooted in neoliberal beliefs of cost-efficient management of increasingly abundant funds. This is important because the recognition of this link can also explain neoliberalism's impact on high-road prioritisation and remedicalisation as resources became more finite, as the amplified focus on these ideas thus would be based in already prominent and existing norms.

The research sub-questions have thus assisted in exploring the main research question and reach the conclusion that Vanwesenbeeck's model can be identified, valuably elucidate and explain certain key developments, political binaries and policy discourses surrounding the International AIDS Conferences between 1996 and 2012. This conclusion is based on the findings that suggest that high-road approaches indeed seem to be prioritised at the expense of low-road approaches, especially from 2006 onwards. Furthermore, Vanwesenbeeck's claim

that this development has been affected by medicalised, market-driven and moralistic ideas is reasonable. However, despite these contributions, the model's analytical utility is undermined by its neglect of humanitarian and sensational ideas, the Global Financial Crisis and neoliberalism as ideology.

5.4 Recommendations for future research

As Chapter 1 points out, this study is limited to a restricted timeframe and case study. Although the 1996-2012 timeframe is aligned with Vanwesenbeeck's model, a test of the model on a different case study would make for an interesting study, would contribute to the existing literature, and would be a good way to triangulate the findings from this study. An interesting case study could for instance be the policy documents from and discourses surrounding the establishment and evolution of UNAIDS since 1996.

Furthermore, the constructivist notion of 'norm cascades' can valuably elucidate several processes within multilateral and bilateral AIDS agendas and responses. With regards to donor dependency, vertically distributed responses and programmes such as PEPFAR, a study of the 'norm cascade' focus on legitimacy could give ideational depth to otherwise often exclusively materialist explanations of financial dependency and the market.

Lastly, the theories of public policy problematisations and IR constructivism, as elaborated in Chapter 2, and their emphasis on inter-subjective understandings and problematisations of 'problems' can be useful theories for an in-depth study where the aim is to understand the processes behind HIV-exceptionalism, securitisation/de-securitisation and sensationalism of AIDS, as well as the consequent impact on important issues such as sexual and reproductive health.

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