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The Competition within Global Health Governance: Normalising the HIV/AIDS Agenda

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Abstract

This paper sets out to study the shifting HIV/AIDS agenda in light of an occurring normalising process. By drawing on the Foucaudian concept of governmentality as the process of governance, the research will draw out power dynamics (be they disparities or (a)symmetries) to identify the emerging organising principle that defines the future HIV/AIDS programme. The first part of this dissertation is dedicated to understanding the debate around normalisation, highlighting the current state of affairs, and the theoretical framework behind it. The second part will study the existing capabilities within the domain and how powerful actors attempt to change the logical organisation of the HIV/AIDS intervention for their own ends by identifying three main facets of the normalising process. It will do so firstly, by examining the influence of pharmaceutical corporations but also governments seeking to reconfigure the pharmaceutical market by taking a closer look at research and development funding and the behaviour of pharmaceutical companies. Secondly, by using technologies of global governance, it will show that the HIV/AIDS response has shifted towards a more effective, efficient, and goal-oriented agenda. In a last step, the role of country-ownership strategies in shifting the structural logic will be highlighted. The paper finds that the HIV/AIDS agenda is normalising towards a marketisation displaying competitiveness as a driving force. In an environment of outcome-oriented frameworks, actors have been co-opted into a language of economisation with quantification, commensurability, and competitive capitalism at its heart.

Table of Contents

1. **Introduction**

Fifteen years ago, the international community was awed by General Secretary Kofi Annan's call for a multilateral funding body 'dedicated to the battle against HIV/AIDS and other infectious diseases' (Annan 2001), and sceptics were doubting whether more money for HIV/AIDS treatment would not simply be wasted (Buse 2011). Remarkably, ten years from then the global perception had changed and U.S. Secretary of State Hillary Clinton called for an 'AIDS-free generation' (Buse 2011). This year the Joint United Nations Programme for HIV/AIDS (UNAIDS) published its ambitious 'fast track' goals to eradicate HIV/AIDS by 2030 (UNAIDS 2014).

While not all of these goals have or will be reached, there are significant improvements to be noted in the global capability to fight HIV/AIDS. With more than 40% of the eligible world population receiving life-prolonging antiretroviral treatment (ART) in 2014 representing a 22-fold increase since 2000, a decrease of new infections of 35% between 2000 and 2014, and the number of AIDS-related deaths constantly shrinking, the global HIV/AIDS response thus far appears to be a success story (UNAIDS 2015b). Yet, despite these triumphs, the global response to HIV/AIDS remains partial and leaves vast opportunities for improvement unaddressed. The observed shift in the coordinated international response to HIV/AIDS, however, does not change the reality of the epidemic's character, of the disease that is ever-unfolding. While access to vital treatment is increasing, less than half of those in need find themselves on the receiving end and the first-tine ART resistance rate is growing. A report released by the UNAIDS-Lancet commission claims that 'without stepped-up efforts,

the world will risk the epidemic rebounding and face more HIV infections and deaths than five years ago' (Piot et al. 2015).

The response to HIV/AIDS thus remains a crucial topic on the global agenda. However, the way it has been handled has become subject to substantial criticism. The 'exceptionalism' that characterized the first response wave has increasingly been called into question. In this debate, proponents have argued that the challenge of HIV/AIDS requires such an exceptional response (cf. Smith et al. 2011; Whiteside & Smith 2009; Smith & Whiteside 2010) referring to a vertical approach to the epidemic, parallel to the existing health infrastructure.

Thanks to its exceptional status, the HIV/AIDS response benefitted for years from great media attention and respective funding. Now, this trend is reversing: Stagnating since 2010, the previously overwhelming financial and political attention is distracted and directed towards other pressing issues such as the global economic crisis. Additionally, previously negligible actors are growing stronger and demanding more influence on the global agenda (e.g. new emerging markets in BRICS countries), introducing an opportunity for either competition or collaboration. Finally, the criticism also has a normative component: It has been argued that the immense focus on HIV/AIDS has had a distorting effect upon global health and development priorities overall, demanding that the response should be normalised, and HIV/AIDS treated like any other disease (cf. Ooms et al. 2010). All these elements open up the so far vertical, exceptionalist style of intervention to substantial criticism and suggest the need of a re-organisation (cf. Bayer 1991; England 2007a; England 2008; Ooms et al. 2013).

The HIV/AIDS response is often viewed as being at the crossroads between a policy of exceptionalism and normalising forces If a shift away from the dominant approach to a normalised response seems desirable, how can such a transition be accomplished? And (how)

can it succeed? The changing global environment provides opportunities for, but also ample challenges to, advancing the future HIV/AIDS agenda. In order to foster a successful normalisation of international policy, it is crucial to understand what these challenges are. This paper will thus map out the changes that result from the shifting approach to identify which challenges the HIV/AIDS response is facing on its way to normalisation.

In order to tackle this question, firstly, it is crucial to understand the characteristics of the exceptionalist approach of the HIV/AIDS response (chapter 2). To understand the debate around normalising the HIV/AIDS agenda, one has to understand its exceptionalism with its conventional vertical approach as opposed to a horizontal organisation favoured by normalisation proponents (chapter 2.1). Secondly, by focussing on the public-private divide in its architecture, chapter 2.2 will highlight the competition embedded in the momentary HIV/AIDS architecture due to the plurality and diversity of its actors. By doing so, the contrast to the conventional HIV/AIDS relief will become apparent and help identify future tendencies of the normalising forces. Using this description as a starting point, the concept of Foucault's governmentality (chapter 3) will be applied to pinpoint the challenges of a transition from exceptionalism to normalisation. In this context, three major factors need to be taken into account: Firstly, the role of knowledge in governmentality needs to be explained. Chapter 4.1 will examine the influence of pharmaceutical corporations but also governments seeking to maintain or strengthen their respective positions, by taking a closer look at research and development (R&D) funding and the behaviour of pharmaceutical companies. Although Trade Related Aspects of Intellectual Property Rights (TRIPS) controversies surrounding access to ATR have been resolved for some time this issue is back to contestation as BRICS states' pharmaceutical production strategies are growing stronger, fuelled by increasing pressure to commit to TIPS-Plus agreements. Secondly, chapter 4.2 will examine the influence that changing indicators exert on the HIV/AIDS response. It will show that the response is shifting towards a more effective, efficient, and goal-oriented structural logic.

Finally, this dissertation will examine the role of individual actors, in this case countries, by debating the strategy of 'country ownership' as proposed by UNAIDS and the US President's Emergency Plan for AIDS Relief (PEPFAR) and its impact on power asymmetries and authority configurations (chapter 4.3). In the conclusion (chapter 5), it becomes apparent that this leads to the challenge of increased competition between the actors who fear for their role in a normalised HIV/AIDS response.

2. **Characterisation of the HIV/AIDS response**

When epidemic HIV first emerged in the 1970s and '80s it was quickly recognized as a pandemic of an unprecedented and long lasting economic, social demographic, and political impact; it was unique in the way it spread and impacted the body as well as in its high lethality. Hence, the virus was met by a similarly unique health intervention. It had been declared too exceptional to be treated as 'normal' within the range of other communicable disease. This resulted in the intervention being referred to as holding a status of exceptionalism. In this sense, exceptionalism refers to the global response being disease-specific and receiving resources that exceed those of any previous global health interventions. Peter Piot (2005, p.4), former UNAIDS Executive Director, characterised the exceptionalist point of view stating that 'this pandemic is exceptional because there is no plateau in sight, exceptional because of the severity and longevity of its impact, and exceptional because of the special challenges it poses to effective public action'.

In order to identify the driving forces behind normalising the HIV/AIDS agenda, one has to understand the scope of its exceptionalism first and the implications of labelling a programme exceptional. Thus, the following section will present the theoretical debate between vertical (i.e. conventional programmes like the polio eradication) and horizontal (i.e. in response to non-communicable diseases) health care programmes. Subsequently, these

theoretical aspects will be linked to the practical HIV/AIDS response, tracing how the HIV/AIDS response has benefitted and suffered from its exceptionalist vertical organisation.

2.1. Vertical versus horizontal debate – the pendulum of health interventions

The impact of different health intervention systems has long been debated in health system research. Vertical interventions, where health care structures are based on one disease or a specific group of diseases, are propped up against horizontal health interventions, where health care is organised to encompass all diseases through general health care systems. In order to analyse the transformation of the HIV/AIDS agenda, this chapter will roughly outline the debate underlying vertical versus horizontal health care programmes and map out how the HIV/AIDS response has benefitted and suffered from its vertical organisation.

Vertical interventions possess the potential to be rapidly brought to scale to the standard of humanitarian interventions meeting the needs of particular health emergencies. These may include epidemics after natural disasters, unprecedented (exceptional) scales of epidemics (as in the case of HIV) and vaccine-preventable diseases such as polio and smallpox. This type of intervention is characterised by a strong top-down hierarchy with centralised management and short- or medium-term objectives. The clear-cut objectives and the quantifiability of vertical interventions allow for measurability of investment and thereby for an evaluation of the interventions' impact on population health, which makes these programmes especially attractive to donors (Cairncross et al. 1997). Due to these features, advocates of eradication programmes, such as the polio intervention, often favour vertical interventions, as was the case in the polio intervention.

While in the aftermath of the WHO's Alma Ata conference vertical interventions were 'hailed as the only way to produce success stories' (Cairncross et al. 1997, p.SIII21), they have increasingly come under crossfire: One of the strongest criticisms is that they divert

human and financial resources from general health care. Dybul, Piot, & Frenk (2012) argue that 'the focus on specific diseases has imposed and exposed fault lines in delivering services in places where many suffer from multiple health issues at the same time'. England sees this as especially problematic in the case of the HIV response: 'money for combating HIV/AIDS is the worst' (2007b, p.565). According to him (2007b), the international aid now surpasses some of the recipient countries' entire health budgets (e.g. Uganda) and undermines their efforts at strengthening their own health systems creating parallel structures. He criticises that 'as countries are strengthening their budgeting processes and linking planned expenditure to activities, donors are earmarking aid to their own priorities, led by lobby groups in rich countries and the acquiescence of compliant politicians' (England 2007b, p.565).

Another shortcoming of vertical intervention lies in their short-term scope: the vertical organisation is often not flexible enough for long-term interventions that require adaptation to evolving health objectives — 'for example, in countries undergoing rapid socioeconomic development with changing lifestyles, health risk taking, and care-seeking behavior' (Bärnighausen et al. 2011, p.2183). While vertical interventions might in some cases be very efficient as they allow programmes to focus on one particular (aspect of a) disease, they appear inadequate when it comes to strengthening public health systems (e.g. infrastructure, educating health care workers).

PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter Global Fund), and the Global Alliance for Vaccines and Immunisation (GAVI) are three of the most prominent vertical initiatives tackling disease-specific health issues[1] with apparent success in combatting HIV/AIDS both by increasing global access to ART (Global Fund and PEPFAR) and in expanding childhood vaccination coverage (GAVI) (Bärnighausen et al. 2011). In

[1] GAVI is not focused on any specific disease. It does have a vertical structure to target vaccine-preventable diseases, however.

response to the shortcomings of a vertical HIV/AIDS intervention and growing criticism, these large programmes have also begun to invest in a more horizontal approach. It is expected that integrating the HIV/AIDS agenda into a wider framework of global governance for health caters more adequately to the diverse needs of the affected people. In this context, enabling patients, incorporating health as a human right, and embedding the response within other health issues are some of the challenges highlighted by experts of this field (cf. Dybul et al. 2012; Piot et al. 2015; Grebe 2013). This trend finds expression in PEPFAR's aim to 'integrate and coordinate HIV/AIDS programs with broader global health and development programs to maximize impact on health systems' as part of its Health System Strengthening strategy reaffirmed in its latest report PEPFAR 3.0 (PEPFAR 2012). Albeit these attempts at increased horizontalisation, Bärnighausen et al. (2011) critically elaborate that

> 'the growing focus on horizontal interventions has the potential to substantially improve the efficiency and sustainability of health interventions in many settings. This potential is unlikely to be realized, however, through the addition of a common set of horizontal components to vertical programs or through the undifferentiated integration of vertical programs into countries' general health care systems' (Bärnighausen et al. 2011).

Conversely to the evaluation of vertical health programmes, horizontal interventions to advance health systems (building infrastructure, training health care workers, etc.) often defy direct quantifiability and evaluation as they are of a medium- or long-term scope and address multiple diseases at a time. Hence, the concurrent trends of implementing horizontal interventions while at the same time emphasising the need for evaluation are warring (Bärnighausen et al. 2011).

Recapitulating, the HIV/AIDS response has started out as possibly the largest vertical health programme in history with fundamental achievements during its earlier stages. Albeit, the realms of vertical and horizontal organisation are not always as clear-cut and polarised as the debate might suggest; even the eradication of smallpox, it has been argued, benefitted national health systems as it was implemented through them and coordinated with other programmes following a horizontal organising principle (Cairncross et al. 1997). Newell

argues that the broad characteristics distinguishing vertical and horizontal programmes are underlying opposing forces of power: 'whereas the horizontal intervention responds to patients' needs and demands, the vertical suits the requirements of the centralised state or international donor' (Cairncross et al. 1997, p.SIII21). Vertical programmes are thus far more attractive to donors as they can be quantified more easily than horizontal interventions having to cater to the needs of various health domains and across multiple sectors with a higher degree of flexibility. Due to a shifting discourse on the organisation of health care systems and the acknowledgment of the demanding interdisciplinary scope of the HI virus encompassing health care systems, the intervention is evolving towards a more horizontal approach. The next section will examine the impact of the exceptional status and the structural challenges resulting from such an extraordinary approach. This is done in terms of describing the plurality of public and private actors and funding in HIV/AIDS programmes as a domain of 'hyper-collective action' (Severino 2010).

2.2. HIV/AIDS as exception

The framing of the HIV/AIDS pandemic as exceptional has hugely impacted the organisational logic of the concerted response. An unprecedented level of proliferation has taken place concerning the diversity of actors as well as the proliferation of public-private-partnerships (PPPs) and the amount of funding and investment.

> 'HIV was considered so different, so "exceptional" in comparison to other communicable diseases that advocates and public health officials agreed that HIV policy should cater to the uniqueness of the epidemic rather than treat it like all other communicable diseases. Supposedly, the argument goes, public fear was so great, the political power of homosexual men so substantial, and concern over stigmatization so real, that public health authorities abandoned "traditional" approaches to communicable disease control in favour of a civil liberties approach' Lazzarini (2001, p.149).

Additionally to the characteristics attributed to the HIV/AIDS by Lazzarini (2001), the pandemic was framed in security terms. Although the nexus between HIV/AIDS prevalence and existing definitions of a security threat was based on little evidence, integrating the debate into a discourse of international security drew international attention to the epidemic (Smith & Whiteside 2010). With the UN Security Council declaring the HIV/AIDS pandemic the first health issue to pose an international security threat, gay rights activists capitalized on the momentum to frame HIV/AIDS within the human rights discourse. HIV/AIDS became the core of a social movement calling for medical as well as political actions. The emerging coalition, consisting of actors as diverse as gay rights activists from Europe and the U.S., women from poor villages in Africa, and sex workers from South Asia, under the visionary leadership of Kofi Annan, achieved the access for all to life-extending ART[2] to became a moral imperative (Grebe 2013). Consequently, after 2000, the right to treatment became orthodoxy in the global health community and the inaccessibility of HIV treatment qualified as a global humanitarian emergency respectively. Fears related to the treatment's cost, its negative impact on the resource allocation to other programmes and doubts about the ability of struggling health systems to effectively deliver treatment were silenced in the name of humanitarianism (Nguyen 2009). This perspective enforced the disease's exceptional status as it challenged the conventional public health approach by taking societal-based vulnerability into consideration, demanding protected privacy, and empowering the patient (Smith & Whiteside 2010). The elevation of the HIV/AIDS response to a status of exception called for a drastic restructuring and an unprecedented mobilisation of resources as highlighted in the next section. However, this also resulted in a proliferation of actors with competing interests and agendas obscuring coordination and cooperation.

[2] After its discovery in 1996, ART was rapidly made available in rich countries but considered to expensive and too complex in provision to be made accessible elsewhere.

The exceptionalist approach resulted in substantial changes in the health governance structure: International organizations, such as UNAIDS, the Global Fund, and PEPFAR were formed to specifically combat HIV/AIDS (Smith & Whiteside 2010). The global policy domain transformed from an international governmental approach to a plurality of non-governmental organisations (NGOs), private philanthropists, activist groups, pharmaceutical corporations, and other private sector entities embedding the HIV/AIDS agenda in a complex global network of 'hyper-collective action' (Severino 2010).

Accordingly, with the turn of the century, an outbreak of activity focused on global health issues, catalysing a 'golden age' of increased Development Assistance for Health (DAH). In response to these developments key health organisations with considerable resources were created (e.g. UNAIDS, PEPFAR, Global Fund), and private-public partnerships underwent the most considerable expansion (IHME 2012). After two decades of consistent growth, DAH peaked in 2010 with an unprecedented high in spending of $28.2 billion. With 70%, the largest share of DAH is contributed by governments but private sources such as NGOs, foundations, and industry have gained in importance: Since 1990, funding from private sources has increased from 8% to 15% of total DAH in 2010, with the most significant contributions coming from the Bill & Melinda Gates Foundation (BMGF) (IHME, 2012). From the five diseases causing the most deaths worldwide[3], HIV/AIDS receives the largest total amount of international financing, followed by maternal, newborn and child health (Moon & Omole 2013). To this point, the HIV/AIDS response has been a success story: The framing of the epidemic has elevated HIV/AIDS onto the global agenda drawing political attention to the topic and increasing international funding exponentially.

The exceptionalist global intervention for HIV/AIDS has brought about major achievements. However, these developments were accompanied by critical voices from the

[3] In 2000 the Group of 8 governments acknowledged the role of six diseases, including HIV/AIDS, TB, and Malaria, as main causes of death worldwide in 2000 rendering combatting them a priority.

beginning. As early as 1991, Bayer pledged, 'what is clear is that the effort to sustain a set of policies treating HIV infection as fundamentally different from all other public health threats will be increasingly difficult. Inevitably, HIV exceptionalism will be viewed as a relic of the epidemic's first years' (Bayer 1991). Critiques of HIV/AIDS exceptionalism claim that it is diverting financial assistance away from other diseases as it is receiving a disproportionate amount of funding. Sachs & Pronyk (2009, p.2111) elaborate on this perspective as 'we are not overspending on AIDS but underspending on the rest ... The choice is not between AIDS, health systems, and other Millennium Development Goals (MDGs)[4]. We can and must support them all'. Other scholars have followed this line of argument claiming that the 'principle on which it [HIV/AIDS response] is based should have been the norm for global health' (Ooms et al. 2010, p.6). Since 2007, sustained criticism has been growing even louder and has been more prominently reflected upon in the global discourse. Exceptionalism was called into question by England (2007a, p.344) accusing UNAIDS of having created 'the biggest vertical[5] programme in history' diverting attention from horizontal public health interventions and reinforcing dependencies of developing countries on donor countries rather than focusing on much needed strengthening of national health systems. Indeed HIV/AIDS receives approximately one-fifth of total health aid worldwide but causes lower mortality than stillbirths, infant death or diabetes taken together (Jack 2007). Ooms et al. (2010) suggest that with the security threat of HIV/AIDS diminishing, the 'right to health' argument might be the only advocate for continued exceptionalism left.

This changing tone was reflected by governments revising and redirecting their health budgets, which was mirrored in a stagnation of development assistance for health (DAH) from traditional donor countries. With the shock of the financial crisis unfolding, DAH has

[4] As this comment was published in 2009, Sachs & Pronyk still refer to the MDGs. They have been adapted and relaunched by the UN in 2015 as the Sustainable Development Goals (SDGs).

[5] Vertical intervention understood as disease-specific intervention.

entered into a ‘no-growth’ phase with stagnant funds for Tuberculosis (TB), HIV/AIDS, and malaria programmes (IHME 2012), which has now flat-lined. An indicator of this trend of decreasing AIDS assistance is the annulation of the Global Fund’s eleventh round owing to funding shortfalls.

Adding to the regressing assistance to HIV/AIDS treatment, is the withering public attention: Despite some activists relentless efforts, media attention and the global political focus are shifting towards other problems such as the long-term risks of climate change or the recent economic crisis, especially in Europe. Whilst HIV/AIDS has been listed as one of the Millennium Development Goals, it is only mentioned within the wider health equality goal of the Sustainable Development Goals. With the new SDGs set to be decided by mid-2015 and global financing for development also in a period of transition, it remains to be seen whether HIV prevention R&D, and global health R&D as a whole, will receive a prominent place in the new international development agenda.

As with most changes in the global environment, these developments also provide opportunities to foster the future HIV and global health agenda (cf. Ingram 2013; Williams & Rushton 2009). While the global health architecture is confronted with a new set of challenges such as ensuring continued progress in R&D into new treatment and prevention, ART accessibility, and strengthening public healthcare systems, a reinforced call for increased funding is unlikely to solve these problems. With the status of exceptionalism being called into question, a changing discourse and the proliferation of global health governance actors, the HIV/ AIDS response might have outgrown its vertical approach. Scholars as well as practitioners are calling for a new vision for the HIV/ AIDS response: an integrated approach to the pandemic considering the various implications for affected individuals against the backdrop of global governance for health (Grebe 2013). In order for UNAIDS to succeed with their strategy to end the AIDS epidemic by 2030 published last year (2014), the global health

community must rethink the HIV/AIDS response as highlighted in recent academic publications (cf. England 2008; Grebe 2013; Ooms et al. 2013; Piot et al. 2015). The first generation of emergency response required this extraordinary mobilization of resources and dedicated agencies but global health governance has now moved past this stage and could be transforming from a vertical, conventional approach towards a horizontal organising principle.

To summarise, this dissertation has so far explained the origin of HIV/AIDS exceptionalism and its impact on the respective health architecture. Critical voices of the vertical organisation principle have grown louder and it seems that the pandemic has outgrown its initial organisational logic. Decreasing donor attention and a changing political environment pose challenges and are thus initiating a normalisation of the agenda. However, at the same time, competing interests will continue to pose one of the main challenges to the process.

The next chapter will apply Foucault's conception of 'governance from a distance' to the HIV/AIDS agenda in order to better understand the use of power in creating a normalising logic. By utilizing Foucault's 'technologies of power', this essay will attempt to carve out indicators rendering a shifting logic visible.

3. **Governmentality in global public health**

The concept of 'governmentality' and related terms such as 'liberalism', 'power', 'sovereignty', or 'knowledge' have been defined, criticised, and employed multifariously in a wide array of disciplines, leading to a certain degree of fuzziness, especially when used in an interdisciplinary context. As ample literature has been published offering in-depth analysis and critical reflection on governmentality (cf. Collier 2009; Joseph 2010b; Lemke 2002; Rose

et al. 2006), this thesis will only give a brief overview of the concept and related terms. This chapter will elucidate the concepts of i) governmentality, ii) knowledge and technology, and iii) power along Foucauldian[6] lines in relation to global public health, in order to outline the theoretical foundation of a shifting organising logic within the governance of the HIV/AIDS approach.

Foucault's lectures at the Collège de France on government rationality (governmentality) have traditionally conceptualised the topic within the frame of security studies, but have lately been applied to global health and securitisation (cf. Elbe 2009; Ingram 2011; Nguyen 2007; Joseph 2010a; Lemke 2002). During the 1970s, when Foucault first introduced the term governmentality, he was concerned with understanding the birth of liberalism as a political rationale in the course of investigating political power. Foucault's work suggests that governments were beginning to formulate an alternative rationality of government that was concerned less with maximizing sovereign and territorial power, but rather on managing a 'complex global assemblage' (Collier, 2006). Foucault understood governmentality as the shaping and regulating of the social, political, and economic realm of society from a distance and the study of techniques and practices of governing.

Rather than relying on the predominant association in political science of practices of government in line with institutions and territorial borders, governmentality refers to networks of governmental and non-state actors, and the alliances and contestations they seek out. Rose and Miller (2010, p.275) elaborate on this point:

> '…the question is no longer one of accounting for government in terms of 'the power of the State', but of ascertaining how, and to what extent, the state is articulated into the activity of government: what relations are established between political and other authorities; what funds, forces, persons, knowledge

[6] Foucault's governmentality has been well-established in health governance and there is no further need to debate its usefulness and shortcomings for analysing public health (cf. Ingram 2013; Elbe 2005; Nguyen 2007; Joseph 2010b).

> or legitimacy are utilised; and by means of what devices and techniques are these different tactics made operable.'

These governmental networks exercise political power through an abundance of 'shifting alliances between diverse authorities in projects to govern a multitude of facets of economic activity, social life and individual conduct' (Rose & Miller 2010, p.272). Thus, power has to be recognised in its multiple dimensions, from creating cooperative action as well as to exploit and dominate. In order to explain power relations in networks, Foucault applies the tools of *knowledge* and *technology*. Power resides with the architect of the metric and governors, in this context, 'are not simply passive recipients of defence or slaves to authorising forces' (Avant et al. 2010, p.21). By seizing tensions and opportunities governors are able to 'redefine problems, create ordering mechanisms for resolving contradictory mandates, or think differently about their authority' (Avant et al. 2010, p.21).

Forms of knowledge are the tools through which a space is rendered thinkable and governable such as management, human resources, accountancy or indicators with which to develop tactics to govern said space. Knowledge, according to Foucault, is interpreted as 'a domain of cognition, calculation, experimentation and evaluation' referring 'to the vast assemblage of persons, theories, projects, experiments and techniques that has become such a central component of government' (Rose & Miller 2010, p.273). By studying *technologies* of global government, such as indicators, this dissertation can unravel the intricate dependencies between the predominant rational and political authority.

While knowledge and indicators (technologies) are the tools of governmentality, there is a third factor, namely its goal: 'governance by empowerment … through the exercise of freedom' (Joseph 2010a, p.30). The network perspective of governmentality is linked with a liberal, a market rationale, where actors are responsible for their own actions and assumed to act freely. Governments incentivise individuals to act upon their free will and interests within

the market structure, respectively putting the individual in a position of responsibility and creating a form of 'self-entrepreneur '.

While the focus here is on the individual, it lends itself to translation into the domain of global health, where there states replace individuals as primary units. Do existing international Organisations (IOs) follow the above presented idea of governmentality and assume a distant role to empower states or even populations as free actors to follow their interest in a liberal market?

4. HIV/AIDS in the contested space of global health governance

The development of global approaches to combat the HIV/AIDS pandemic is a classic point of contestation within global health governance (GHG). Previous works have highlighted the contestation of discourses within the HIV/AIDS domain associated with securitisation, human rights, economic or international development (cf. Elbe 2010). Some scholars have assumed the hegemony of neoliberalism which has in many instances set the agenda and the parameters of the debate in HIV/AIDS governance (cf. Ingram 2013; Williams & Rushton 2009). However, and in order to draw out the entanglement between the HIV/AIDS relief and normalisation in terms of governmentality, the following section will highlight the contestation within global health governance surrounding HIV/AIDS relief to establish the drivers of the emerging agenda of normalisation. As emphasised earlier by citing Susan Sell, the power lies with the governor – but who is the governor and who is the governed in this case? In order to address this issue the following three chapters will highlight the tools of knowledge and technology operating within governmentality. Looking at how

knowledge and technologies of global governance operate within the HIV/AIDS domain will point at the direction normalisation is taking.

4.1 The role of knowledge in normalising the HIV/AIDS agenda

Ample literature examines the rise and fall of funds directed towards HIV/AIDS R&D, innovation, prevention, and vertical programmes (cf. Fidler, 2010; Sridhar & Batniji, 2007) as well as the proliferation of private authority and non-state actors in the domain. GHG is on the one hand described as a domain characterised by fierce competition between actors for the limited amount of funding and resources and on the other hand as one between funders. Despite previous successes, there is a widespread perception that current attempts to turn back the tide of HIV/AIDS are failing (cf. Lee 2009) due to an absence of coordination in the global governance of HIV/AIDS. This does not merely result from a lack of coordination between the various agencies but also from their contesting worldviews and material interests (Williams & Rushton 2009).

For the purposes of developing this research framework, how then do we describe the process of contestation: how does it manifest itself? Williams and Rushton (2009) distinguish two forms contestation: the obvious and the tacit. The more 'obvious' forms revolve around relational power processes, which have both material and ideological dimensions. The less obvious, or tacit, forms of contestation are the result of structural power and, in some instances, resistance to it. The authors conclude that 'what matters here in terms of health and health policy outcomes is not so much who holds the power, but which particular worldview informs those actors' perceived interests' (Williams & Rushton 2009, p.15). One such

example is the U.S.'s position to TRIPS, which in turn was developed by U.S. Big Pharma and their interests (Sell 2007).

The multi-sectoral character of the HIV/AIDS intervention is generally put forward as one of the key reasons for the creation of the UNAIDS programme in 1996 which took over the role of co-ordinating the UN-wide response to HIV and AIDS from the WHO, a body which had previously been widely criticised for its narrow, biomedically focussed response to the epidemic (Woodling et al. 2012). The proliferation of public-private partnerships (PPPs) at the beginning of the century suggested a structural tool of reform and a trend toward decentralisation in the provision of health care. This has occurred both in the expansion of PPPs in the arena of research, health promotion, and education, as well as in the institutional structures of health governance (Glasgow 2005). Health reform has come to exhibit a very strong feature of liberal rationality – namely the application of market principles to the activities of the state. Through the alliances of industry and the UN or intergovernmental groupings, industry interests were incorporated into global governance structures. One of the most prominent examples is PEPFAR; First, whilst PEPFAR was clearly in part a recognition of US foreign policy it was also inaugurated to 'protect the commercial interests of Big Pharma, and enshrine these corporations' place in the global supply chain for the rolling-out of HIV/AIDS treatment' (Williams & Rushton 2009, p.24). PEPFAR was a major political response to the unparalleled social and governmental mobilisation and the growing international pressure but from the state's perspective it was also based on a 'perception that US commercial and patent interests were under threat' (Williams & Rushton 2009).

As highlighted in previous chapters, it is generally acknowledged that funds for the HIV/AIDS relief are stagnant if not decreasing. Furthermore, a recently published report by the HIV Vaccines & Microbicides Resource Tracking Working Group (hereafter 'the

Working Group') observes a decrease[7] in the pool of donors for biomedical HIV prevention R&D resulting in increasing sums being attributed to fewer major donors (2015). As in past years, the public sector made up the majority of total funding with 79% (US$ 990 million), out of which 69% came from the US. Combined, the US public sector and the BMGF account for 83% of all funding in HIV prevention R&D. Philanthropic support for HIV prevention R&D increased by US$ 9 million, up to US$ 200 million in 2014, reversing the trend of steady decline seen in the past few years. While the total amount of philanthropic funding increased in 2014, the number of philanthropic funders engaged in HIV prevention research has been steadily declining since 2010. In 2014, 16 philanthropic funders invested in HIV prevention research, down from 30 in 2010, increasing the risk that resource allocations by one or two primary donors would have a disproportionate impact on the whole field. A similar picture prevails for R&D in HIV *treatment*: Again, the largest donation came from the public sector supplying 70% of total HIV treatment R&D funding with 63% being provided by the US. However, a closer look at reported funders in 2011 reveals that the second largest investor after the US National Institutes of Health was the pharmaceutical *Gilead Sciences.* Investigations into pharmaceutical-sector investment in HIV treatment R&D commissioned by UNAIDS consider these to be of high significance. Furthermore, the report concluded that private-sector companies are extensively involved in research and production of diagnostic tools as well as with ART development (PhARMA 2014; TAG 2013). With the main donors in R&D for ART residing in the US and with more than 90% of revenues from the sale of antiretrovirals (ARVs) HIER FEHLT EIN VERB in high-income countries, there are limited incentives to focus research on developing countries' needs. Drahos and Braithwaite conclude:

[7] The Working Group has also ascertained a decrease in funds at the disposal of HIV Prevention R&D since 2012, which underlines the previously mentioned trend of the flat-lining of investments to the HIV/AIDS response.

> ‘patent-based R&D is not responsive to demand, but to ability to pay ... Much of what happens in the...health sectors of developed and developing countries will end up depending on the bidding or charity of biogopolists as they make strategic commercial decisions on how to use their intellectual property rights’ (Drahos & Braithwaite 2002, pp.167–168).

This highlights the vulnerabilities associated with relying mainly on the decisions and actions of private companies. However, and despite high intellectual property (IP) protection in the US, the non-generic pharmaceutical industry’s research and innovation has steadily declined. A report by Pharmaceutical Research and Manufacturers of America (PhRMA) revealed that America’s pharmaceutical research and biotechnology companies were testing 44 medicines to address HIV/AIDS and related conditions in 2014 opposed to 97 five years earlier. In order to fill this gap, President Obama has initiated the billion-dollar drug development centre, the National Institutes of Health (NIH) (PhARMA 2014).

Sell analyses the provision of medication in light of TRIPS agreement concluding that ‘ongoing contestation is the central process of the politics of intellectual property’ (Sell 2011, p.29). Despite the 2001 WTO Declaration on the TRIPS Agreement and Public Health (the Doha Declaration), the implementation has been slow and TRIPS was just the start to subsequent IP rights negotiations. In her work on IP rights she examined the case of HIV/AIDS in the background of global power relations. She observes a ‘strong trend toward transforming life-saving drugs into private commodities for sale at premium prices through higher levels of intellectual property protection has made them less available to those who need them most (Sell 2007, p.41). In recent years, critical voices have proliferated and states like Brazil, India, and South Africa have taken a leading example of addressing their public health emergencies. TRIPs have offered countries much flexibility to adapt their IP policies to allow public health policy goals. Albeit, ‘public international law such as TRIPS is embedded in a broader context of asymmetrical power relationships between developed and developing

countries, and between producers and consumers of the fruits of intellectual property' (Sell, 2007, 58).

Sell observes a vertical trend in IP norm-setting where powerful actors, like the US or even private actors, try to persuade governments to 'adopt and implement wildly inappropriate and potentially damaging policies that only benefit the rights holders, and to discourage behavior that seeks to exercise flexibilities in IP policy that help both the poor and consumers in general' (Sell 2011, p.20). In order to enforce stronger IP regulations, advocates negotiate while avoiding the multilateral arena in the hope of locking in changes that opposing countries (such as the BRICS) might over time feel compelled to adopt. 'This behavior clearly poses dangers to public health. Expanded intellectual property rights, economic concentration and strong-arm tactics against vulnerable populations add up to a dangerous situation' (Sell 2011, p.24). The suppression of low- and middle-income countries through TRIPS(-Plus) by powerful actors such as pharmaceutical companies and governmental organisations indicates a shift in the structure. As a number of ART patents will expire in the coming years and enable further generic production, competition in R&D between wealthy and middle-income countries will increase. All the above are indicators for a shifting environment: rising resistance to TRIPS(-Plus), advocacy for emerging new models for innovation in medicine (e.g. UNITAID's[8]), a proliferation of stronger south industries with high-level skills in innovation, manufacturing, and marketing, and expiring patents. Additionally, this agglomeration of changing factors will lead to peer-trade-competition between middle-income countries and Western countries.

[8] UNITAID established a patent pool for HIV/AIDS medicines in 2008 as an innovative model to help overcome the three main reasons for a limited access to ARVs in developing countries: 'increasing treatment needs, rising drug costs linked to the broader reach of ARV patents, and decreasing financial resources' (UNITAID 2009).

While multinational drug companies seek out Chinese and Indian researchers to capitalize on the Eastern laboratories' efficiency in testing for drug candidates and new drug development, Eastern researchers enjoy the immediate benefits of profit shares and IP rights with new medical breakthroughs and the development of a local industry waiting in the long run (Dionisio 2010).

Yet, recent events have shed light on the delicate nature of this competition: In China, the scandal surrounding British GlaxoSmithKline (GSK) and the corruption crackdowns that seem to disproportionately emphasize the wrongdoings of global pharmaceutical companies should not just be interpreted as part of the growing governmental reform of the Chinese public health system but as part of the 'one in a lifetime expansion' of its healthcare system and its becoming less hospitable to multinationals. China is protecting its domestic pharmaceutical market - estimated to develop into one of the largest markets for generics worldwide in the coming years – and its state-owned enterprises (SOE), giving preferential treatment to SOE over multinational pharmaceutical companies. In addition, the incentives set by the Chinese government to encourage technology transfer within the public health sector will shift the competitive landscape both within the country and in many of the emerging economies worldwide once Chinese competitors demand their bit of the market share (Shobert 2014).

Another indicator of a growing competitiveness and marketisation of global HIV/AIDS governance is a proliferation of market mergers to spur competition. Additionally, as non-generic companies are worried about losing weight, deals between originator companies have already been struck or are in progress as far as joint manufacturing of ARVs is concerned. Examples of such mergers are GSK and Pfizer merging their HIV/AIDS business into the new company ViiV Healthcare and the Bristol-Myers Squibb & Gilead Sciences' venture for a non-generic ARV combination drug.

This is no to say that the public context of health and health care is devolving irrevocably into the private. Several broad studies of welfare reform generally, and health reform more specifically, suggest that the welfare state in Western societies is not in the process of being dismantled. Rather, this process expresses an attempt of altering institutional configurations in accordance with a particular logic emphasizing competitiveness and efficiency. Glasgow points out that,

> 'In none of these countries have policymakers sought to abandon planning and regulation. Rather, the aim has been to combine some market incentives with a framework of rules to guide competition and the capacity to intervene to tackle market failure. The reforms that are taking place are in this way leading to the development of regulated or managed markets' (Glasgow 2005, p.191).

After having highlighted the power disparities between private and state actors as well as between hitherto more powerful nations and less developed nations, the notion of competition seems to outweigh the idea of the HIV/AIDS agenda as an arena of collaboration. The great influence of pharmaceutical companies on R&D and the increasing neglect of the US market for less lucrative diseases, highlight the need of a diverse donor base. Conversely, the pharmaceutical market is trending towards hegemony; Powerful actors attempt to economically coerce countries whose growing (generic) pharmaceutical R&D markets pose potential threats in the coming decade through IP rights negotiations to retain their authority – a phenomenon that Sell (2011) termed 'going granular'. The merging of markets and innovation models to incentivise competition are forerunners of an increasing commercialisation of medication and market dynamics. Additionally, patents still hinder third-party follow-on innovation, creating high barriers to market participation. This configuration translates into a greater influence of economic power over policy-making 'that has hitherto been seen as the realm of the public sphere' (Buse et al. 2002). The increasing commercialisation of medicine leads to a contortion of the global research agenda in favour of rich countries' markets (e.g. in favour of lifestyle drugs) neglecting the diseases of the poor.

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

4.2 Indicators as technology in global health governance

The normative power of standards and indicators has become a key tool in the transition of global governance attributed to its disciplinary power, making economies and producers commensurable (cf. Collier & Ong 2007). According to the Foucaudian framework, indicators are a *technology* of global governance affecting the 'topology of global governance (who are the governors and the governed, and in what ways), the processes of standard setting and decision-making, and affecting ways in which contestation of governance occurs, with a potential effect also on the demand for and the supply of regulation in particular modalities' (Davis et al. 2012, 100). The development of indicators will ultimately result in the definition of specific goals, the setting of targets, and the embedment of obligations to achieve these goals. Thus, indicators create standards against which societies, populations or governments can be measured. They are an expression of a rationalist functional and are widely institutionalised in the development domain (e.g. Human Development Index). However, this

section will show that this also applies to global health governance when framed from a functionalist perspective.

Discussing the role of indicators in global governance, Fisher (2012, p.2) notes that

> 'Those evaluations can in turn form a basis for various actors' decisions on how to create or distribute resources, and how to try to alter the behavior of others or their own behavior. Where a single actor (or set of actors) outside the state have governing power in relation to the state, the governing actors may use indicators in the exercise of this power, for example in taking decisions on whether the state merits particular resources and on whether measures aimed at inducing or achieving compliance with the relevant standard are warranted.'

This rational is expressed in the *UNAIDS Introduction to Indicators* guidelines (n.d.) claiming that

> 'at the global level, harmonized indicator sets … provide international agencies and organizations with much-needed strategic information, which influences their planning and allocation of resources. Indicators provide critical information on performance, achievement and accountability, which is the cornerstone of effective monitoring and evaluation. In addition, the data from indicators provide the strategic insights that are essential for the effective management of the AIDS epidemic and response'.

Hence, indicators emerge as a powerful tool to shift the logic of the HIV/AIDS agenda as they have the potential to set targets and therefore evaluate states' performance. The financial, political, and social attention surrounding the HIV/AIDS pandemic and especially the vertical approach with its result-based financing mechanisms spurred demand for more substantial statistics and evaluation processes. The monitoring of the pandemic was codified in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS with the operationalization of the UNGASS indicators (now Global AIDS Response Progress Reporting Indicators). Despite these recognised efforts, HIV/AIDS indicators fall short of producing crucial data due to the developing countries' limited capacity in producing data and tracking progress. This shortcoming relates back to one of the main contradictory tendencies in shifting from a conventional to a horizontal approach,

namely the broad spectrum[9] of data required to evaluate and monitor HIV/AIDS. Further, the landscape of HIV/AIDS-related indicators mirrors the landscape of its response: there is a multitude of indicators from various actors. They are contested in so far as there is no consent on which indicators are actually key to evaluating and monitoring HIV/AIDS and to respective policy decisions. An architecture ensuring standardised data collection is missing which in turn hampers the efficient and effective generation and use of information.[10] The *Global AIDS Response Progress Reporting Indicators* is one of the most widely used sets of indicators and forms the basis of UNAIDS' annual progress report. However, their influence remains limited: thus far, encouragement for funding has been based on a commodity approach that granted the coexistence of numerous strategies irrespective of their relative effects rather than enhancing indicator-based decision-making (Schwartländer et al. 2011).

Nonetheless, donors are increasingly calling for quantifiable indicators. As Padian et al. (2011, p.199) argue on the *USAID's Implementation Science Investment Framework*:

> 'In the second phase of PEPFAR, characterized by an increased emphasis on sustainability, programs must demonstrate value and impact to be prioritized within complex and resource-constrained environments. In this context, there is a greater demand to causally attribute outcomes to programs. Better attribution can be used to inform midcourse corrections in the scale-up of new interventions (e.g. male circumcision) or to re-evaluate investments in programs for which impact is less clear.'

This demonstrates the need for greater visibility, calculability and attributability of all aspects of the response. In general, global public health policy is driven towards a focus on technical expertise so that 'problem, cause and effect can be quantified and compared with others' (Ingram 2013, p.448). Another indication for increasing demand is the growing

[9] According to a study into HIV/AIDS indicator frameworks this holds especially true for the social factors shaping HIV/AIDS risk and vulnerability despite the acclaimed recognition of a need to integrate social drivers into HIV/AIDS relief (Mannell et al. 2014).

[10] This paper recognises the endeavour of the 'HIV Indicator Registry' (hereafter Indicator Registry), which was launched in 2008 through a multiagency effort by the WHO, UNICEF, the Global Fund, PEPFAR, and the UNAIDS Secretariat. It is an attempt to centrally display indicators according to thematic similarities and harmonise where possible. Even though this attempt seemed promising, it has been criticised as insufficient by experts of these organisations themselves (cf. Chan et al. 2010). While this is a fitting example for the importance attributed to indicators, it is beyond the scope of this study to examine it individually.

influence of the Institute for Health Metrics and Evaluation (IHME), a recently launched initiative associated with the University of Washington and largely funded by the BMGF. Its vision is to 'improve the health of the world's populations' (IHME n.d.) through the application of scientific knowledge. A vision that is in line with the increasing donor preference for quantifiable and replicable (successful) outcomes, but also the need for rationalisation on the grounds of efficiency. Governments, private actors, and specialized agencies have been co-opted into the language of 'economism'. Hence, in the Foucauldian sense, global HIV/AIDS governance has largely become a technical exercise in monitoring, statistics, and the efficient delivery of biomedical solutions (Elbe 2005).

Besides governments and governmental actors being calculating subjects under governmentality, they also become quantifiable objects by being turned into 'flexible and manipulable market subjects' (Isleyen 2014). Exposed to the market instrument of indexing, they are ranked in order of their performance. This trend finds expression in the BMGF's heavy investment in the IHME. Additionally, these examples show that an economic rationale has started to pervade the HIV/AIDS response, revitalising market forces.

This chapter has established that indicators operate as a technology of global health governance. They are an expression of a shifting HIV/AIDS approach towards an outcome-oriented, effectiveness-based rationale. To conclude this analysis, the last empirical section will concern itself with the question of global governmentality as raised earlier. The demonstrated interest to entrench the HIV/AIDS response within local systems yields a last piece of evidence indicating a shifting rationale and leading to the final operator of governmentality: the 'self-entrepreneur'.

4.3 Country ownership as governing a state from a distance?

Governmentality emphasises the establishment of 'governance from a distance' through the responsibilisation of the individual. However, is this shift also apparent on a global level in an arena of uneven and combined character? In 2013, PEPFAR rendered 'moving from an emergency response toward a more sustainable and country-owned response to the HIV epidemic' a priority, launching a 'Roadmap of shared responsibility' as part of its (2012) launched blueprint. UNAIDS (2015a) highlighted the 'critical role of communities in reaching global targets to end the epidemic' in a recently published report and has pronounced its view on country ownership as being 'means to an end for achieving effectiveness, efficiency and sustainability of national AIDS responses' (2011, p.5).

Hence, the outstanding question is, whether international actors (e.g. IOs) can actually impose country ownership through governmentality given the nature of the economy, the state, civil society, and prevailing social conditions of the development partner and encourage countries to take on ownership and develop their own HIV/AIDS eradication strategies. Fostering country ownership, it is argued, contributes to improving local health systems and decreases dependencies of developing nations from (mostly) Western donors. The positive spill-over effects from integrating the HIV/AIDS intervention on the local level are also expected to strengthen a sustainable response (cf. Bärnighausen et al. 2011).

By doing so, IOs are shifting the focus to local project ownership and an equal partnership. This implies a change in the role of IOs towards the provision of technical assistance, strengthening capacity building and fostering greater participation in the development process. From a classical understanding of governmentality, these programmes can be interpreted as tools to cultivate the 'self-entrepreneur', which is embedding an outsourced responsibility. They feed into the discourse of the cultivation of a responsible,

self-governing subject via techniques of empowerment, self-surveillance, and towards the goal of a healthy and productive life (Glasgow 2005). Calling on countries to 'to plan, manage, and monitor the implementation of the AIDS strategy effectively' speaks to the calculable and instrumental terms of the relationships between donor countries and recipients. Further, the UNAIDS (2011, p.19) country-ownership report elaborates:

> 'To achieve the goals of improved effectiveness, efficiency and sustainability of development aid, the agreements call for: country ownership; better alignment of donor support with country-developed strategies; donor harmonization; increased emphasis on results-based management'

The partners at play will have to shift their focus towards more result-oriented agendas in the future. The country ownership framework addresses mutual accountability between development partners and recipients suggesting a reciprocal approach. While this output-oriented strategy appears to prioritize the wealth, health and well-being of the population at heart, critics claim it to be about monitoring state compliance at its core (Joseph 2010a). In Joseph's analysis of global governmentality exemplified by the World Bank's 'Poverty Reduction Strategy', he concludes 'that the targeting of populations is really only a small part of a bigger strategy' (Joseph 2010a, p.47). Going beyond the rhetoric, one will have to anticipate the idea that these strategies imposed by powerful actors are attempting to institutionally embed the discipline of capitalist competitiveness exposing societies to the mechanisms of competition.

The country ownership framework may well be a rhetoric used to cater to donor demands. Nevertheless, it is through this partnering process that governmentality is deployed most powerfully. Country-ownership strategies claim to have the well-being of populations at heart and whether or not this is the case is irrelevant when the aim is to regulate state behaviour. The rhetoric of country ownership takes shape in an apprehension for populations but with the real targets being states. In the end, the implications of country ownership strategies for global governmentality can be explained reformulating Foucault's own claim –

‘that global governmentality, in this context, becomes a complex ensemble of institutions, procedures, analyses, and tactics that has the state as its target, and a political economy of poor populations as its main form of knowledge’ (Joseph 2010a, p.48). From this perspective, powerful actors are using asymmetrical power relations to their advantage with the effect of reinforcing market dynamics as the predominant organising principle.

While the country-ownership model might augur a shift towards enabling a responsible population and advocating a more sustainable HIV/AIDS governance, studying this model through global governmentality has led to a different conclusion. ‘Governing from a distance’ in this case does not translate into governments governing populations. Rather, it is an expression of how powerful states are trying to reinforce authority asymmetries.

5. **Conclusion**

The HIV/AIDS intervention has come a long way and has been able to make great progress. Yet, due to critical voices growing louder and a changing global environment, the HIV/AIDS agenda is at a crossroads. This dissertation mapped out the normalising process the HIV/AIDS response is currently undergoing by answering which challenges it is facing on its way to normalisation.

Through the application of the Foucaudian concept of governmentality, this paper identified indicators of the normalising process and traced the emerging rationale. Mapping out the increasing diversity of actors of private authority as well as states, NGOs, foundations, and philanthropists with different vested interests, this dissertation has shown the dominance of powerful private actors and their approach to the proliferation of new pharmaceutical markets. These players, especially U.S. Big Pharma, are increasingly trying to preserve their

monopoly through TIPS-plus and market mergers. However, emerging markets such as the Chinese generic market are challenging their monopoly. Due to the increasing marketization of medicine and a rising competition between powerful pharmaceutical companies this domain is exposed to the growing demands of market forces. On the other hand, we see governments interfering with these dynamics by protecting their own markets (e.g. China[11]) or by counteracting them, as is the case of the NIH. This is an aspect that needs further analysis to disentangle the relations between government and Big Pharma's interests. How much authority is exercised by each actor? Who is the dominant actor and driven by which underlying interests? While there is an absence of regulation in the domain of HIV/AIDS, this does not translate into an absence of governance. Rather, the gap is not necessarily an indication that governance is not happening but that it serves the interest of powerful governing forces (e.g. industry).

Secondly, this paper has used indicators as a technology of global governance and addressed their normative power in setting standards. The variety of indicators for HIV/AIDS monitoring is as diverse as the plurality of actors and little consent exists on key indicators making it difficult to quantify the global HIV/AIDS response. Nevertheless, donors have lately taken more interest in making data and indicators accessible and integrating them into funding decision processes (e.g. PEPFAR, BMGF). Recognising recent attempts to standardise data production and indicators by the 'big IOs' involved in the HIV/AIDS relief is insufficient (e.g. the HIV Indicator Registry). Again, private actors have taken it upon themselves to foster this aspect of the HIV/AIDS agenda and emphasised the need for greater quantifiability to support rationalisation based on effectiveness and efficiency.

Lastly, having stressed the importance of governmentality to observe the transformation of the HIV/AIDS agenda, this dissertation has shown how, through global

[11] In the case of China, a large part of the pharmaceutical companies are state-owned, which renders this example even more politicized.

governmentality, powerful actors have attempted to export their underlying liberal doctrine. This can be described not as governing a population from a distance but rather the state by trying to impose a capitalist competitiveness.

Overall, this dissertation has shed light on an emerging structuring logic of liberal characteristic: The HIV/AIDS agenda is normalising towards marketisation with competitiveness as a driving force and surveilled by outcome-oriented actors. Actors have been co-opted into a language of economisation where quantifiablitiy, commensurability, and 'competitive capitalism' set the tone. The more powerful ones are attempting to subvert previously less powerful ones, however, especially Chinese markets and intergovernmental actions (of BRICS states) will favour the 'old' agenda. To overcome these challenges liberal market competitiveness is necessary, especially concerning the production of R&D in HIV/AIDS treatment. On the other hand, the system cannot be trusted to produce desired outcomes if left entirely to market dynamics as illustrated by the case of pharmaceutical companies neglecting less profitable disease. Here, the alliance of previously less authoritative actors could greatly contribute to resolving these challenges. To answer this question fully, more research into the economic scope is obligatory, particularly in view of the evolving markets in the Global South, with boosting South-South cooperation and China and Brazil bringing stimulating local markets.

6. **Bibliography**

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