

## **15 years of ‘War on AIDS’: what impact has the global HIV/AIDS response had on the political economy of Africa?**

At the turn of the Millennium multiple leaders across sub-Saharan Africa declared a total war against HIV/AIDS.<sup>1</sup> For many, such declaration of war against HIV/AIDS was a turning point in the political response to the disease on the continent. With the exception of a handful of countries such as Uganda, few leaders or governments had taken an active role in publicly addressing the spread of the disease in their countries up to this point, with the majority of leaders remaining silent over high HIV prevalence rates, and some, perhaps most famously Thabo Mbeki in South Africa, denying the relationship between HIV and AIDS (Youde, 2007). The declaration of war against the disease at this point was perhaps in part because of wider recognition by African governments of the impact of the disease on the death and suffering of millions of Africans and the associated consequences for the economies and societies of sub-Saharan Africa. For some it was also a consequence of the United Nations Security Council declaring HIV/AIDS as a threat to peace and security in Africa (UNSC Resolution 1308) that made it an exceptional health issue (McInnes and Rushton, 2013: 122-3). However, it was also in part due to the increase in international attention and finance pledged towards combating HIV/AIDS. In 2000 ‘Combat HIV/AIDS, Malaria and other diseases’ became MDG6 of the eight United Nations Millennium Development Goals (MDGs) (UN 2000). The World Bank launched its Multi-Country AIDS Program; one of the first projects of its kind to require the formation of new government agencies to address the epidemic and for governments to commit 40% of the project to civil society organisations (World Bank 2007). In 2002 the international community came together to set up the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), a finance mechanism that was designed specifically to raise and disperse funds to support governments around the world, but particularly in Africa in the fight against HIV/AIDS. Multiple international, regional and local non-governmental and faith-based organisations mobilised to work with government and international institutions to assist with HIV prevention, treatment, care, and support of people living with the HIV/AIDS. Bilateral government aid commitments towards the disease grew, most notably with US President George W Bush pledging US\$15 billion in 2003 in support of his President’s Emergency Plan for AIDS Relief (PEPFAR). The result of which was a groundswell of activity towards combating HIV/AIDS across sub-Saharan Africa.

The last fifteen years were in many respects ‘the good times’ for HIV/AIDS in terms of the finance earmarked towards combating the disease and its elevation to high-level policy status both within African and international public policy arenas. However, as finance towards HIV/AIDS has now begun to decline and the international community shifts its focus towards the sustainable development goals and emergency health crises such as pandemic flu and Ebola, it is important to question not only the impact the fifteen year total war on HIV/AIDS has had on containing the spread and impact of the disease, but also the lasting impact it has had on the political economy of Africa. The purpose of this debate article is to reflect on this wider question. The article does so by first reviewing the positive narrative that has been built around the global HIV/AIDS response to suggest that the last fifteen years have been a success both in the achievements gained in efforts to contain and reduce the spread of the disease, and how multiple actors have mobilised and worked together to do so. The article then suggests such gains have been over-stated. Second, the article reflects on the wider impact of the global response on the political economy of Africa by looking at the impact of the war against HIV/AIDS on the health sector and wider governance structures of the state. The article concludes by arguing the war on HIV/AIDS has been notable in the funding and actors mobilised, the gains in treatment, and the normalisation of the disease in parts of Africa. However, such progress has also had external consequences for health sectors and the state across sub-Saharan Africa marked by the embedding of market practices of health delivery and a hollowing out of many African health sectors. The positive narrative associated with the HIV/AIDS response ignores the negative externalities of disease-specific interventions on the wider health system and the intrusive reform of the African state. While there have been some positive gains in the war on HIV/AIDS, such gains are undermined by questions over the longevity and sustainability of the response that have significant consequences for how African states organise future health systems and respond to health crises.

### **The Positive Progress Narrative and Evoking HIV/AIDS**

The common narrative on the global response to HIV/AIDS is one of progress and positivity. Such progress is shown in two main ways: results and governance. The progress narrative associated with the response to HIV/AIDS in Africa is commonly associated with the results and gains in access to treatment and new infection rates. The Joint United Nations Programme on HIV/AIDS (UNAIDS) releases an annual report on the global HIV/AIDS response to coincide with World AIDS Day on the 1<sup>st</sup> December that acts as a progress report on the

epidemic, a source of data, and an advocacy tool for what will shape the HIV/AIDS agenda in the coming year. These reports are launched with press releases stressing the gains and results achieved in the fight against the disease, often citing a growth in numbers of people living with HIV/AIDS accessing care and treatment, while raising notes of caution with regard to complacency over such progress. The over-arching message is that the global response to HIV/AIDS, particularly in Africa, has generated positive change in combating the disease, but more of the same is needed to continue such progress.

The positivity surrounding such flagship reports is perhaps unsurprising: global institutions have to demonstrate to member states, partner states and the wider public that their activities and initiatives are working as a means of eliciting support and money; and the data monitoring global progress on HIV/AIDS does show some good global outcomes. New infections have declined by 50% between 2001 and 2012; 15 million people living with HIV/AIDS are now accessing treatment, 9.7 million of which live in low and middle income countries (UNAIDS 2013). However, whilst new infection rates in many African countries has declined, as of December 2012, only 7.6 million people living with HIV/AIDS in Africa were accessing treatment out of the 21.2 million deemed eligible (UNAIDS 2013b). It remains the case that 71% of people living with HIV/AIDS live in Africa (WHO 2014). Hence, while there has been some progress with regard to provision and uptake of treatment and a decline in new infection rates, particularly when looking at the global pandemic, progress in Africa has not been so great, with treatment still failing to reach over 50% of people living with HIV/AIDS. This is particularly disconcerting when considering that the majority of funds towards HIV/AIDS efforts go to treatment initiatives and treatment is increasingly cited as a means of prevention (UNAIDS 2012).

Measurable progress and results is a minor part of the progress and positive narrative; most of the positivity around the war on HIV/AIDS is associated with rhetoric of how a global HIV/AIDS community raised the profile of the disease and positioned it as a global emergency in need of a global response. This narrative is commonly asserted by UN agencies such as UNAIDS and the United Nations Development Programme (UNDP), non-governmental organisations, and leading individuals involved in global health and HIV/AIDS such as Peter Piot. HIV/AIDS is often evoked at times of global health crisis: for example the spread of Ebola in West Africa has been commonly compared to the spread of HIV/AIDS in Africa as a means

of provoking international condemnation and the need for action (see for example US Secretary of State John Kerry in Watt et al, 2014); when needing more effort in combating Ebola, the type of effort required is again likened to that seen in the global HIV/AIDS response. HIV/AIDS is evoked both as an example of how the global community can take action against a global, or increasingly African health crisis, and as a model of global governance to be replicated when addressing other concerns such as noncommunicable diseases on the continent. The supposedly multi-sectoral, multi-level way in which the global response to HIV/AIDS was organised - with civil society actors and people living with HIV/AIDS sitting on the Executive Board of institutions such as the Global Fund, money earmarked for community responses, celebrity-endorsed high profile advocacy campaigns against stigma or prevention of mother to child transmission, the Treatment Action Campaign of South Africa, cross-sector working in government and Presidential leadership – is often evoked as an effective model of global health governance (see for example Sidibe and Buse, 2013). Increasingly it is not the actual progress against HIV/AIDS that is presented as the positive narrative, but the efforts or governance of HIV/AIDS that becomes the main part of the positive progress story.

However there is much to suggest that such a positive narrative and the evocation of HIV/AIDS as a means of eliciting wider action towards a health issue overlooks several limitations associated with the global response. Global advocacy campaigns did make the international community and African leaders take action on HIV/AIDS. Most people living in sub-Saharan Africa are aware of HIV/AIDS. New institutions were created at the global level and in Africa. However treatment remains costly, people continue to become infected with HIV, stigma of people living with HIV/AIDS persists, and funding towards HIV/AIDS is now declining. In addition, the governance of HIV/AIDS has not been marked by collaboration and consensus but competition among international institutions, co-optation of key civil society organisations, and the creation of local HIV/AIDS markets where civil society organisations compete for resources (Harman 2010). Despite research highlighting the shortcomings of the recent global war on HIV/AIDS (see for example Seckinelgin 2010; Johnston 2013; Harman 2010) the need to develop a positive narrative around its governance is sustained as a means of justifying further investment and attention from the international community. The positive, progressive narrative associated with the global HIV/AIDS response is misleading and evoking HIV/AIDS is not the solution to the wider health problems of sub-Saharan Africa. As the section below demonstrates,

this is particularly the case when considering the impact of the global war on HIV/AIDS on the political economy of African health systems and the African state.

### **HIV/AIDS and the health sector**

The war on HIV/AIDS in sub-Saharan Africa has had three notable impacts on the political economy of the health sector in the sub-continent: it has skewed health policy and planning around HIV/AIDS, particularly in aid-dependent countries; it has introduced a new layer of international consultants and accountants to the management of health programmes; and it has led to a preoccupation of vertical, disease-based interventions to the detriment of wider health system strengthening. Combined, such processes have embedded the use of the market as the guiding principle on which health policy is decided upon and created a new non-health specialist management-accountancy class within the health sector. The introduction of the market to health sector policy and planning in sub-Saharan Africa is not new and can be traced to the flawed structural reforms of the health sector in the 1980s. However, as shall be discussed below, the finance and models on which HIV/AIDS projects were based since 2000 have accelerated this process.

Financing for HIV/AIDS through international aid programmes has ‘flat-lined’ to an average of US\$7.6-7.8 billion (Kates et al 2013); 47% of which goes to HIV/AIDS programmes in sub-Saharan Africa. The majority of this money comes not from multilateral financing mechanisms such as the Global Fund, but from the US government’s PEPFAR project. In addition to aid assistance, African governments such as Kenya, Togo, Zambia, Sierra Leone, Chad and Guinea have increased domestic spending towards HIV/AIDS (AVERT, 2014). South Africa tends to be the exception to the majority of African countries with high rates of HIV/AIDS prevalence in that it funds most of its own response with domestic funds and is thus less aid dependent (AVERT, 2014). Measurement of Development Assistance for Health (DAH) is fraught with complication, however as a general measure as of 2010, it can be said to be around US\$28 billion (Ottersen et al, 2014), the majority of which is allocated to low and middle income countries. Data on DAH includes development assistance to HIV/AIDS projects, hence HIV/AIDS spending makes up over a quarter of all global aid towards health, most of which is spent in Africa.

The scale of such financing towards HIV/AIDS has a notable impact on the political economy of health sector planning and financing, particularly in aid dependent low and middle income African countries. The amount of money towards HIV/AIDS and the high-level political status afforded to it has created distortions in African health sectors (Biesma et al, 2009), where policy and planning is organised around HIV/AIDS rather than the wider needs and concerns of a specific country's health sector. Money earmarked for HIV/AIDS does not go into a wider spending pot for public health spending by African state systems but comes with specific conditionalities or targets and performance criteria. For example, in the majority of aid-dependent African countries with high prevalence rates, multilateral funding for HIV/AIDS is agreed upon and disbursed through the Ministry of Finance and stand-alone National AIDS Councils or co-ordinating functions such as the Global Fund' Country Co-ordinating Mechanisms. Some bilateral funding for HIV/AIDS may be channelled through the Ministry of Health but this tends to be the exception than the rule (Harman, 2010). The last fifteen years have been marked by a rise in vertical health spending, where development assistance is allocated to specific diseases (predominantly HIV/AIDS, malaria, tuberculosis, maternal and new-born child health) rather than horizontal efforts such as health system strengthening. This has several important consequences. As HIV/AIDS receives more international assistance than any other health issue in Africa, it dominates health sector targets. Such financial commitment generates significant political will towards proving the impact of such finance in reversing the trend of the epidemic. Thus significant parts of the health sector – health ministries, local government authorities, Presidential officers, health practitioners – are specifically organised around fulfilling international criteria attached to aid and reaching MDG6 above other health concerns that may be important to a specific country but lack the finance to back initiatives or the political exposure to make them a worthwhile endeavour. Hence the first consequence is distortion in the planning and priorities of African health sectors around HIV/AIDS to the detriment of other health concerns (see for example Biesma et al 2009 and Pfeiffer et al 2010). This is particularly pertinent to the under-investment in health systems across the continent.

The second consequence is that finance earmarked to HIV/AIDS has given rise to specialist units and care and treatment centres to the neglect of more general health services in Africa. For example, the last fifteen years have seen a growth of new care and treatment centres and maternity and new-born child units at the regional and district level in many African countries.

Whilst welcome, the introduction of these units have not occurred at the same time as an increase in regional and district health centres that address a range of other health concerns that affect the health of the African population.

The third consequence is that in recognition of such trends, health authorities align wider health objectives to HIV/AIDS targets rather than HIV/AIDS targets to health objectives (see for example Barnes et al, 2015). Understanding that over the last ten years one of the only ways to get financing is to align a health issue (or even educational, gender, labour or agricultural issues for that matter) to HIV/AIDS as a means of diverting sources to where you want them to go there has led to a rise of HIV/AIDS add-ons such as Pink Ribbon Red Ribbon (AIDS + Cervical and Breast Cancer) Campaign, or HIV/AIDS and neglected tropical disease. HIV/AIDS thus affects the political economy of the health sector with regard to how HIV/AIDS finance organises the way in which African health authorities have developed health policy and planning so that health policy is oriented around the disease and where the money is rather than the wider needs of the health service or a particular country's population where HIV/AIDS is one among many health concerns.

It is not only the amount of money towards HIV/AIDS that has had a distorting impact on the political economy of African health systems, but it is how disbursement of the funds have been organised. Contemporary financing mechanisms for HIV/AIDS do not include the conditionalities of old, but instead refer to performance targets, indicators and results. Targets are mostly associated with the MDGs and measures of how progress in reaching these targets is linked to indicators such as uptake of antiretroviral treatment, or the number of people undergoing voluntary counselling and testing. The performance or results element comes in when key targets are met and actors are thus seen to be performing. The introduction of such targets and indicators has been a significant part of how both the Global Fund and PEPFAR disburse funds. The purpose of targets and indicators is to show measurable results and progress in the war on HIV/AIDS, to show that development assistance money works, and to provide transparency and accountability over how aid money is spent. For some the introduction of performance targets and indicators has been a welcome development in the health sector (Eichler, 2006). However the introduction of such targets and indicators has created confusion and an additional layer of bureaucracy with regard to how such indicators are managed and adjudicated. Different donors have different indicators and targets that are sometimes drawn from a country's Health Management Information System (HMIS) set of indicators and targets

for the health sector but often are not or include additional indicators. This leads to overlap and the health authorities having to manage competing sets of indicators depending on the donor (Barnes et al 2015).

One of the most striking trends of the war on HIV/AIDS in Africa is that it has been a war administered by global accountancy firms. Finance for HIV/AIDS in Africa from the Global Fund is not managed by the government but principally the accountancy firm PriceWaterhouseCoopers.<sup>2</sup> PriceWaterhouseCoopers acts as the local fund agent for the Global Fund, which means it is responsible for overseeing the institution's operations in Africa, verifying performance by the recipients of Global Fund money, and acting as the Fund's in-country representative. As local fund agent, such accountancy firms participate in government and donor partnership meetings and policy planning processes. Notably they act as an interlocutor between government health authorities and donors (Barnes et al, 2015). The role and presence of such accountancy firms has specific repercussions for the political economy of the health sector. The priorities of the health sector around HIV/AIDS becomes that which can be measured and that which demonstrates the best performance according to accountancy models of performance rather than public health models of performance. Here the emphasis is not on how public health can be delivered to all regardless of quantity of people reached or cost, but how health interventions can demonstrate a return on investment either by scale of the intervention or its ability to produce a result on a spreadsheet. Combined the use of performance targets and indicators and accountants to adjudicate on what constitutes performance introduces new economic actors into the health sector in Africa and embeds new public management models of performance and return in investment. These changes in the health sector introduced as part of the wider machinery of the war on HIV/AIDS in Africa are an extension of the market-based approach to health that emphasises return on financial aid investment and rewards measurable impact to the detriment of that which cannot be measured.

### **HIV/AIDS and the African state**

The impact of HIV/AIDS interventions on the political economy of the health sector has wider ramifications for those states in Africa with high incidence rates. The war on HIV/AIDS introduced new agencies and processes at the national and local level of government and embedded multi-sectoral working at the highest level of office. New agencies such as National



AIDS Councils and decentralised district and community AIDS councils became the institutional core of national HIV/AIDS strategies and responses in Africa over the last fifteen years. In a few cases such as Uganda, these councils predated the MDGs and the scaled up global war on HIV/AIDS of the new millennium; however most councils became reinvigorated or introduced across sub-Saharan Africa as a result of the World Bank's Multi-country AIDS Program that partly funded the establishment, salaries and institutional support of these agencies. The Global Fund contributed to such agencies by housing its country co-ordinating mechanisms (CCMs) in the national HIV/AIDS councils in countries such as Tanzania. HIV/AIDS councils operate outside of the Ministry of Health and tend to fall under the umbrella of the Office of the President or Prime Minister. The establishment of these bodies has clear implications for the African state. The most apparent is the fragmentation of the health sector in African states where specific health issues such as HIV/AIDS, and now increasingly maternal and newborn child health, become removed from the health sector as a means of affording such issues special political status. Removing an issue from the health sector to the Office of the President or Prime Minister can be interpreted as both a statement of political will and a suggestion that the health sector is somehow failing or inadequate. The result of which is a divide between the health sector and HIV/AIDS programmes, an embedding of health silos across the machinery of government, and the exacerbation of competition and mistrust across ministerial portfolios and between civil servants between health ministries, HIV/AIDS councils, and the finance ministries that manage international aid. Such practices embed preconceived notions of big man leadership on the continent; where issues are only addressed or afforded political will when they are elevated to the Office of the President or Prime Minister. The elevation of HIV/AIDS from the health sector to the office of the president or prime minister was often not led by the leaders themselves but by the donors that established the national AIDS councils as part of their funding criteria (Harman 2009; Harman 2010).

The establishment of new agencies to take the lead in the war on HIV/AIDS and the accompaniment of certain standards has wider impacts on the processes of the state and government practice. A clear example of this is the criteria that civil society actors are brought in to multiple levels of the state in responding to HIV/AIDS. Such criteria are justified by the notion that HIV/AIDS is an exceptional health issue (Lisk 2010) requiring a multi-sectoral response. On the one hand such criteria of international funding are an acknowledgment of the significant role civil society actors have had on the global response to the epidemic. On the other

hand, such requirements can be used as tools to make the government more open and plural to non-state-based activities. Such interventions are not just about changing how states approach the issue of HIV/AIDS but are changing state practices as to how policy is made and implemented by opening government processes up to non-state actor participation and influence. In this sense, HIV/AIDS interventions are as much about reforming state processes and participation in government structures to be more pluralist as it is about creating a national response to HIV/AIDS (Harman 2009; Harman 2010). In responding to HIV/AIDS, international donors such as the World Bank and Global Fund have created models for states to replicate that require a restructuring of how the African state works to be inclusive and open to non-state actors and influences. Such models have created a market in which civil society organisations compete for government and donor contracts and positions in decision-making structures. For some authors such as Seckinelgin (2008) the global war of HIV/AIDS has led to an institutionalisation of the agency of non-governmental organisations which presents a disjuncture between the presumed roles of such actors – e.g. feeding in to the policy arena, delivering on international policy preferences –and what they do in practice. HIV/AIDS has provided justification for international programmes that engage in wider processes of state-society and government reform in Africa. Such reforms would not be so easily countenanced under a programme of good governance, but are somehow permissible or overlooked because of the specialist status afforded to the disease by both international donors that are keen to promote good governance and the international non-governmental organisations and state agencies that normally decry such practices.

## **Conclusion**

The war against HIV/AIDS launched by civil society, international institutions and key states at the start of the millennium has claimed some victories in Africa. More people living with the disease in the continent have access to anti-retroviral treatment, people are aware of AIDS and how to prevent HIV transmission, and government leaders from across the continent have taken an active and public role in acknowledging the scale of HIV/AIDS and the need to take efforts to address it. The response to the epidemic has led to an increase in the number of actors at the global, regional, national and local levels from the public, private, health and non-health sectors dedicated to responding to the disease. The result of which is for many to claim that the war waged on HIV/AIDS is a successful example of how the global community and African societies can come together to tackle health problems and turn a health crisis into a manageable,

chronic disease. However this article has argued that such a positive progressive framing of the war on HIV/AIDS overlooks the wider impact the global response has had on the health sector and state in African countries.

The war on HIV/AIDS has led to health sectors being organised around HIV/AIDS, an obsession with performance measurement and results to the detriment of wider public health concerns and investment in health systems, and the introduction of new models of management that have dispersed the authority of the health sector. HIV/AIDS has fundamentally altered the political economy of health in Africa in three key ways. First it has expanded the role of the market in the delivery of health indicators and results. It has established a market in the health sector made up of donor and government contracts to be competed for and won by a range of public sector actors - the Ministry of Health, the Ministry of Finance, the Office of the President/Prime Minister – and private sector actors drawn from civil society, management consultancies, and accountancy firms. This has removed health concerns, policy and delivery away from central planning within the health sector and generated a system of health planning that is dependent on international targets. Second, the health sector in Africa has been hollowed out. This has occurred through the plurality of actors associated with the HIV/AIDS market and through the introduction of new institutions and models for governing health concerns by international donors that are created outside of the health sector. The establishment of these institutions gives rise to the assumption that African health ministries cannot manage health emergencies such as HIV/AIDS and that for a health issue to be afforded high-level political status it has to be linked to the highest office of government and managed by accountants. Such assumptions are reinforcing: the more health ministries are seen as unable to act, the less they are financed, the more their mandate is dispersed and thus compromised. Finally, the market for HIV/AIDS has been donor-led and in most countries donor-dependent. The gains made in uptake of anti-retroviral treatment, with few exceptions, are principally because of the US government's PEPFAR project. Hence the longevity of progress and the ability of African states to fit the bill of such treatment programmes when international donors inevitably withdraw will yet again make HIV/AIDS a contemporary political hazard for African governments and societies.

The consequence of these factors is that after fifteen years of war against the disease, HIV/AIDS has changed how the health sector works in Africa but not necessarily for the good, and those gains that have been achieved could be easily reversed. This will have significant

implications for the African state in delivering health and treatment, care and support for people living with HIV/AIDS. A decline in international assistance for HIV/AIDS may present an opportunity for African states to think about how they want to fund and organise their health systems. This would be a welcome opportunity to reflect and learn the lessons from past vertical financing strategies, see what worked in HIV/AIDS funding, what the challenges were, and how this can be used for health system investment. However this scenario takes little account of the influence of international donors, non-governmental organisations, accountancy firms, and health policy experts and their accompanied finance that often sway the priorities of African health policy and practice. The challenge of the African state in financing HIV/AIDS care and treatment will be to manage the expectations and interests of international actors, and identify new sources of income to finance both HIV/AIDS interventions and the wider health sector infrastructure. Alternative sources of income could be derived from new types of donor such as the African Development Bank, or would require the state to think about sources of state revenue involving new forms (or reform of old forms) of taxation, particularly of the growing middle class. However these alternatives come with their own set of problems: new donors follow old forms of conditional-based lending, and new forms of taxation require upfront costs for the state, and a need to show delivery for what the rising middle class are paying for. The legacy of HIV/AIDS financing on the African state and the decline in international commitments present both an internal challenge to the African state in regard to how it delivers health to its citizens and who pays for it and an external challenge as to how the state manages its relationship with a growing number of public and private international actors interested in health. Given these challenges, the battle to reverse the disease in Africa is beginning all over again for Africans.

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<sup>1</sup> Multiple African government agencies such as National HIV/AIDS Councils and Presidents have used the rhetoric of a war on or against HIV/AIDS. Kenya has been the most overt with a Total War Against HIV/AIDS project financed by the World Bank. In addition the rhetoric of war, battle and fight is often used by the Joint United Nations Programme on HIV/AIDS (UNAIDS).

<sup>2</sup> Of the 60 Global Fund projects in Africa (which also includes Palestine, Jordan, Iraq and Syria in the grouping of North Africa and the Middle East), 40 are managed by PriceWaterhouseCoopers. The rest are managed by KPMG, Swiss TPH, and UNOPS. For a full list of Local Fund Agents, please see <http://www.theglobalfund.org/en/lfa/>