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Know Your Global Crisis

What the AIDS industry might learn from the population story

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Introduction

Since the emergence of AIDS in the 1980s, it has been viewed by governments and the global development community alike as an unprecedented disease that puts our collective future at risk. In spite of the perception that the risk of AIDS is unparalled in human history, the understanding of AIDS as a global crisis and the requisite response has followed an established pattern. Barnett and Whiteside argue that pandemics are not unique in history, but since "the last global epidemic had been influenza in 1918-19, there was little 'institutional memory' of global epidemics" to inform the AIDS response (2006:29). Given this lack of historical memory about managing large-scale epidemics, the response to AIDS instead mirrored the response to the global problem immediately prior to AIDS, the population problem.

In placing AIDS within a larger history, we find that while the epidemic may be unprecedented; the historical pattern of the global response is not. Instead, AIDS fits within an established global problematization and response framework, even as it reshapes it. AIDS and population have both been seen as problems that are:

- Global in scope
- Threats to global stability
- Tempered by crisis intervention and short-term emergency solutions
- Countered by a unified, global solution
- Addressed through the collective expertise of a high-profile group of specialists from around the world.
- Overcome with global consensus and global agenda for action

Because of these similarities AIDS and population can be fruitfully juxtaposed to show the implications of global crises thinking on both. At the same time, we recognize that while AIDS and population share a global crisis problematization, they are different problems. In the case of population, many of the demographic assumptions underlying the notion of a population problem proved to be false as world population growth rates stabilized faster than expected. In contrast, the AIDS epidemic is a problem regardless of how it is framed. The epidemiological and demographic implications of AIDS will not be proved false, even in the eventuality of a cure and the perspective of historical hindsight.

There are two main goals for this paper. First, the paper aims to contextualize AIDS within the post-WWII international development industry to anticipate its likely trajectory. Secondly, this paper speculates on future directions for the AIDS response based on insights from historical narratives. Fitting AIDS within a larger historical terrain, including global health, problems and security, reveals it as part of an expansive development industry that has attempted to manage health, sexuality, morality and modernity on a global scale. We examine how AIDS fits within the context of 20th century global crises management, how global consensus is constructed to address global problems, and how the AIDS response builds on international development norms, mores and approaches to global problems. After carefully assessing the loss of momentum of the population movement post-Cairo, we offer some cautionary suggestions for the future of the AIDS response. Our suggestions include questioning of the notion of global problems, re-examining the potential of consensus,

rethinking the viability of a global program of action, and moving beyond the idea of the growth-model as a solution in and of itself.

From Population Crisis to Sexual and Reproductive Health

Population, or more accurately "overpopulation," manifested as a pressing, global problem after World War II. It was described as an imminent hazard in lurid, and now popularly familiar terms and images, such as the ignited "population bomb" on the verge of exploding war, poverty and hunger on the world. As population expert Kingsley Davis wrote in l945, "Viewed in long-run perspective, the growth of the earth's population has been like a long, thin powder fuse that burns slowly and haltingly until it finally reaches the charge and then explodes," (Davis 1945:1).

Creating the Concept of Overpopulation

According to experts—including those studying economics, politics, and population in U.S. institutions like Princeton University and the U.S. government—rapid population growth in the Third World threatened the well-being of world democracy, could upset the balance of international power, hampered world-wide economic development, and contributed to environmental destruction and food scarcity. This problematization of population was gendered and racialized: large numbers of brown women from the Third World were thought to have the potential to upset world security with their fertility.

Proposed population policy at the time was intimately bound with the post-war international development modernization project, a one-size-fits-all approach to remaking the economic, social and political structures of the Third World in the image of the First. An important part of this effort was to help the Third World modernize to keep it from aligning with the Second World of communist nations (Rostow 1960). According to demographic transition theory, population control was necessary to slow population growth rates and to propel economic development and modernization (Kirk 1944; Davis 1945; Szreter 1993). This assumption followed a long-standing trend of justifying spending on ambitious health programs, such as disease eradication, as a catalyst for social and economic development (Packard 1997).

It wasn't until the 1960s that these policy prescriptions coalesced into international action by the United States government, a chief promoter of population control around the world through the United States Agency for International Development (USAID) (Connelly 2008; Hartmann 1995). Population expert Donaldson notes that the early 1960s marked a new phase in U.S. involvement in population control efforts, "The federal bureaucracy joined those foundations and non-profit making groups that had been active in the field. In the process, fertility control was transformed from the preoccupation of a band of enthusiasts to the day-to-day business of the federal government" (Donaldson 1990:389). The U.S. government was only one actor in a conglomeration including international not-for-profit programs (like International Planned Parenthood), international governance bodies (like the United Nations Population Fund), national governmental programs and private foundations (like the Ford and Rockefeller Foundations) that have played a part in an extremely well-funded movement for

population control that peaked in the 1980s. This group of institutions and individuals has been dubbed the "population establishment" (Connelly 2008; Grimes 1998; Hartmann 1995).

The Recommendation for Reducing Population

Population control programs were narrowly framed and primarily targeted women's fertility with long-term, provider-controlled contraception methods regardless of the adverse effects. Methods such as sterilization were promoted to the disadvantage of user-controlled barrier methods, like diaphragms and condoms. The sense of urgency driving the population establishment justified the use of coercive tactics, including financial incentives and violence. Infamous examples of population control efforts include China's one-child policy or India's sterilization camps in the 1970's Emergency (Warwick 1982; Hartmann 1995; Bandarage 1997). These extreme tactics have left a legacy of distrust in family planning among end-users and have tarnished current, long-term family planning efforts.

Although population control programs varied from country to country, they were often inspired by global norm-setting discussions and solution building. Population was the focus of regular United Nation meetings, including population conferences in 1954, 1964, 1974, and 1984 and an important issue at the environmental meeting at Rio de Janero in 1992, where women's issues also took the stage (Finkle & McIntosh 2002, McIntosh & Finkle 1995, Hodgson & Watkins 1997). The topics of the UN conferences demonstrate the changes in population control solutions—from technical, to development, to family planning solutions—however, while the most effective response to the overpopulation problem was openly debated, the concept of overpopulation itself did not shift.

The 1994 International Conference on Population and Development (known popularly as the "Cairo conference") was the pinnacle of these population meetings and a culmination for the population movement as a whole. ICPD was remarkable in several respects and is touted as representing a "quantum leap" forward in population policy (McIntosh and Finkle 2004; Nair et al. 2004). Its much-cited "consensus" endorsed and diffused a distinct paradigm shift in population thinking. In the conference's seminal document, the Program of Action, the alarmist language and programmatic responses of population reduction, targets and incentives, were replaced with language and suggested actions to promote women's empowerment and sexual and reproductive health and rights. The goal of reducing population growth rates remained, however, and was central to the meeting and consensus. Another novel aspect of the meeting, and a central reason for the shift in language and thinking, was that feminists entered the population control discussion and successfully shifted the terms of the debate.

Remaking the Population Paradigm

Advocates have hailed the Cairo consensus as marking a new era of sexual and reproductive rights programming over the fifteen years following the conference. Yet even those most supportive of the consensus have been disappointed by its uneven results to date. They attribute these failures to lack of resources for the Program of Action, including: 1) lack of funding and political capital given the shift to generalized sexual and reproductive health and

empowerment goals; 2) loss of crisis-driven rationale for programming with the broadening of the population control agenda; 3) backlash from religious and political conservatives around sexual and reproductive health schemes and the empowerment of women; 4) competing global crises, like HIV/AIDS; and 5) the need for new leadership to energize the movement (Blanc and Tsui 2005; Correa, Germaine and Petchetsky 2005; Sinding 2008).

Proponents of the Program of Action have identified the loss of crisis-mentality as the primary impediment to successful implementation. Family planning advocates have attempted to lend the sexual and reproductive health paradigm a sense of urgency akin to the population crisis, through new economic and security-oriented rationales for increased international family planning programming that recall the narrow population arguments of the past. Examples include the "demographic dividend" and "youth bulge" concepts. Despite these efforts at catalyzing crisis-mindsets in order to revive support and resources, population lost momentum and its status as a "global crisis" with the paradigm shift. One important indication of this is that sexual and reproductive health is not mentioned in the Millennium Development Goals. However, proponents and governments do agree that the Program of Action must be implemented in order to achieve the Millennium Development Goals. The 2009 Commission on Population and Development, hosted by the United Nations Population Division, confirmed the importance of the Program to that end. However, the omission suggests that the barriers to the implementation of the Cairo Program of Action have impacted the momentum, or at least the profile, of family planning on a global scale.

Rethinking the Cairo Consensus

While lack of support for implementing the Program of Action is a challenge, it should not be assumed that it is globally actionable no matter how many social, political and financial resources are expended toward that goal. Assessments of the Cairo Consensus often fall short of critically examining the Program of Action content and asking whether the "consensus" itself may pose hurdles to implementation and contribute to uneven results. It is our contention that it does for several reasons. First, the Program of Action did not sufficiently question the basis of the "population problem" (Hartmann 1995, Nair et al 2004, Richey 2008). Instead, it fashions a new, broader, rights-oriented response to overpopulation in place of the narrow family planning model. If, as Sauvy and so many others have contended, the problematization of population is false, than we need to direct our attention to finding a better problem rather than an equally false solution (Sauvy 1949). The architects of the Program of Action missed the opportunity to ask better questions related to sexual and reproductive health, gender and social justice and to de-link these issues from overpopulation thinking.

Second, the "solution" offered in the Program of Action is far more complicated and contradictory than the language of consensus might suggest. Descriptions of the Cairo consensus infer that governments, religious leaders, non-governmental organizations, foundations and feminists came together at the conference to find a mutually acceptable solution to the population problem. The Cairo consensus emerged as that solution despite differences on the contentious issues surrounding sexuality, sex, gender, contraception, abortion, international development and global power. The idea of a global, inclusive solution is misleading, however, and obscures the contradictions embedded in the Program of

Action. The notion of consensus might better describe the *processes* that created a sense of unification, rather than the actual Program of Action document. In other words, consensus in this sense does not describe international unity around political, hot-button issues and how to address them, but is a rhetorical label used to imply a sense of unification established by the conference proceedings.

The rhetoric of the consensus has had mixed impact. Despite some successes, there is evidence to suggest that the sexual and reproductive health paradigm has not superseded population control norms, goals, or target-setting program infrastructures in some locations. Sexual and reproductive health services are delivered through population control infrastructures and provide narrow population reduction messages and services. For instance, in her case study of reproductive health policies in Oaxaca, anthropologist Paola Sesia concluded that while there had been successful shifts in redirecting programming following the ICPD, overall "unresolved contradictions that can exist between distinct objectives and goals of specific programs. The family planning programs display the most obvious contradictions: The goal of curbing demographic growth, for example, is often diametrically opposed to the objective of allowing people the right to decide freely regarding their sexuality and reproduction" (Sesia 2007:47).

Finally, as many other commentators have well noted, the Cairo Program of Action supported the privatization of health care, including contraception distribution, and urged the removal of obstacles to private sector involvement in health care delivery (Hartmann 1995; Nair et al 2004; Petchetsky 1995). Given the decline in health services in many countries, these commentators argue that this support is misplaced and contrary to the goals of the consensus. As Petchetsky elaborates, "In other words, the Cairo document promotes the very privitisation, commodification, and deregulation of reproductive health services that, by its own admission, have led to diminished access and increasing mortality and morbidity for poor women, who constitute 'the most vulnerable groups' in both developing and developed countries" (1995:157).

These lessons of Cairo and the population story more broadly are particularly instructive to the AIDS response because they demonstrate the challenges of shifting from a disaster control approach to a long-term, sustainable problem and response. The population story suggests that the institutions and dedicated resources for managing the response on global, national, and regional scales and the concept of overpopulation are mutually dependent. In other words, the global population crisis engendered a global crisis response, and the longevity of this response is reliant upon maintaining a constant sense of crisis to sustain programmatic infrastructure and resource flows. In this way, the global crisis mindset and short-term action time-line become institutionalized and difficult to dislodge. The differences between the problematizations of AIDS and population do not change the likelihood that the AIDS response may face similar infrastructural challenges.

The Trouble with AIDS: When did AIDS become a problem, and for whom?

While historians emphasize the detection of HIV viruses found in blood samples from Equatorial Africa dating from as early as the 1950s (Iliffe 2006), the collection of symptoms that would come to be known as AIDS were not identified until the early 1980s. By 1981 "there was global recognition of the syndrome; clinicians and others now knew what to look for and that it could be given a name" (Barnett and Whiteside 2006:31). As the international medical community worked to understand this emerging disease and its epidemiology, the association of the new syndrome with gay men (and more specifically gay sex), black Africans and Haitians was not lost on the media or the public. If AIDS is an epidemic of signification, by the mid-1980s it had come to signify both a gay plague and black promiscuity, with injection drug users soon to join the unsavory crowd associated with the disease (Treichler 1987 and 1999).

In spite of its early origins as a disease affecting only the "4 Hs" (Haitians, hemophiliacs, heroin users, and homosexuals) by the late 1980s AIDS became an issue generating much coverage in the mainstream media. Protests at the third International AIDS Conference in 1987 attracted widespread attention, particularly because the police wore highly visible yellow latex gloves when handling activists for fear of contracting HIV (Kallings and McClure 2008). In 1988 AIDS arrived at every US doorstep in the form of "Understanding AIDS", a pamphlet sent to each American household by the US Surgeon General C. Everett Koop. The pamphlet began, "This brochure has been sent to you by the Government of the United States" and it urged every American family to take part in stopping "Public Health Enemy Number One" (Koop 1988:1). In order to convince the American public that AIDS was everyone's problem, the pamphlet asserted that, "Who you are has nothing to do with whether you are in danger of being infected with the AIDS virus" (Koop 1988:2).[1]

The predictions that AIDS would spread beyond marginalized groups and become a problem for people of all genders, colors, and sexual orientations has proven accurate in many settings. The African AIDS epidemic is predominantly heterosexual, and in many American cities the rates of infection are increasing most rapidly among heterosexual black women. In spite of its origin as a disease affecting some of the most marginalized populations in the world, today an estimated 33 million people are living with HIV worldwide.

AIDS goes global: shifting problematizations

The "population problem" focused on the purported single problem of population growth rates. Similarly, the problem of AIDS is assumed to be the virus. Our perception of whose bodies have the virus and how social and political contexts facilitate the entrance of the virus

[1] While it is factually true that the HIV virus does not distinguish between blacks or whites, and gays or straights, there is widespread consensus the risk of contracting HIV is not evenly distributed globally, nationally, or even regionally. Structural vulnerabilities along lines of race, class, gender, and geography have everything to do with who is at risk.

into individual bodies has changed over time, thereby shifting the meaning of AIDS as well. As AIDS epidemiology evolved, it focused its attention on particular bodies at various historical moments. Over the relatively brief history of the AIDS pandemic, a number of frameworks have emerged that have shaped what is thinkable about AIDS, and what actions need to be undertaken to combat it. They include the shift from AIDS as a gay problem to everyone's problem, the evolution of AIDS from a medical issue to a security threat and a development problem, the shift in emphasis on morality and behavior change to pharmaceutical solutions to AIDS, and the increasing emphasis on the funding imperative (to the current tune of US $25 billion) to stop the AIDS pandemic. These transitions have significant implications for global and national attempts to stem the pandemic.

One of the important legacies of AIDS is that it was first detected as an epidemic affecting gay men in the United States. The early stigma and association of the "gay disease" diverted attention from other infected populations until the late 1980s, and the epidemic spread among these other populations before they received much medical attention. Gay men were fully cognizant of their marginal status in the US. They understood AIDS as a community issue and quickly rallied around it. Organizations like Gay Men's Health Crisis formed to offer medical help, social support, and hospice care to patients that few mainstream medical providers would serve. The creation of groups like AIDS Coalition to Unleash Power (ACT UP) marked the gay community's transition from thinking of AIDS as a medical problem to embracing being HIV+ as a political identity and PLWA as a new kind of political constituency (Smith and Siplon 2006).

If gay men put AIDS into the public eye and successfully garnered political attention and medical resources for it, it was the growing awareness that HIV/AIDS could spread to the general population that catapulted AIDS into a national issue in the US and then into a global crisis. By the 1988 International AIDS Conference in Stockholm the vulnerability of both women and children were on the agenda. Southern Africa, with its heterosexual epidemic and the largest numbers of HIV+ people and AIDS deaths in the world, offered a view of the worst-case scenario. This looming horizon of global risk to HIV infection eventually succeeded in shifting the problematization of AIDS to from a plague of the marginal to a shared global problem.[2]

In the 1990s as AIDS cases continued to grow without a parallel increase in funding for international programs, UNAIDS aggressively promoted the notion of "innocent wives and babies at risk" to spur the world into action (Pisani 2008). Three years after the launch of UNAIDS in 1996, a renewed sense of the urgent danger posed by AIDS surfaced when the National Intelligence Council (NIC) declared AIDS a security threat in 1999.[3] Their pronouncement was endorsed by the US government, and the US Congress asked USAID to price out a global "Battle Plan" against AIDS (Pisani 2008:33). Soon after, US Vice President Al Gore successfully lobbied the UN Security Council to confirm AIDS as a threat to world security in 2000. The problematization of AIDS as a security threat to the United States and

[2] The theme of the international AIDS conference in 1992 was "A World United Against AIDS".
[3] The NIC is the official intelligence think tank affiliated with the US government and it reports directly the American Director of National Intelligence.

the entire global served as a catalyst to generate new sources of AIDS funding. The Global Fund to Fight AIDS, Tuberculosis, and Malaria, and President Bush's PEPFAR initiative were created in the wake of AIDS' rise to global security threat.

While asserting that AIDS is a threat to general populations, like the threat of overpopulation, is perhaps necessary for galvanizing a global response, some insiders argue that the actual vulnerability of general populations to HIV in many countries is overestimated, and that this strategy diverts funding and attention from those most at risk (Pisani 2008). This characterization of "innocent victims" generates support for AIDS relief among political conservatives in the US and Europe, but it has done little to increase political will to engage with LGBTQ[4], men who have sex with men (MSM), sex workers, or drug users. What seems to have emerged is a caste system of PLWA in which the innocent deserve support, treatment, and generous funding while less savory populations affected by AIDS remain marginal in the response.

The notion of AIDS as a general threat and discourses about guilty versus innocent victims create several dilemmas for the AIDS response. As we have seen with both population and AIDS, the idea of generalized risk creates a sense of urgency, facilitates fundraising, and generates political will to address a problem. Yet an emphasis on generalized risk threatens to conceal the particular susceptibilities of marginalized groups, and to divert attention from strategic interventions that would address their needs. An effective AIDS response must examine the structural factors that underlie both concentrated and general epidemics, and mobilize political will to protect the innocent and the "guilty".

The rise of an AIDS industry: experts and resources

Unlike the excellent histories of the population control movement, including Connelly's exhaustive account, there have been few attempts to chronicle the growth of a global establishment to spearhead the response to AIDS. The AIDS industry emerged slowly in the 1980s, but it quickly gained momentum as AIDS rapidly eclipsed all other diseases, and ultimately all other development problems, as the focus of global concern. Whereas the support for population control coalesced gradually over several decades in the mid-20th century, within 13 years of the discovery of the HIV virus there was sufficient global alarm to warrant the creation of a UN multi-agency program whose sole purpose was combating AIDS. Less than ten years later, US President Bush announced the largest and most expensive plan in history to combat a disease that affected less than 2% of the American population. In hindsight, the rapid surge of global attention to AIDS, the conviction that it was a problem best addressed through the United Nations system, and the emergence of billion dollar global programs to deliver prevention and eventually treatment services is nothing short of stunning. Each of these outcomes reinforces the notion that AIDS is truly an "exceptional" disease.

One important dimension in the evolution of the AIDS establishment is the unique process of knowledge production that has characterized its history. Although global AIDS policy reflects the latest thinking of a core group of scientific and technical experts housed in institutions like

[4] LGBTQ stands for people who identify as lesbian, gay, bisexual, transgender, or questioning.

the US Centers for Disease Control (CDC), the US National Institutes of Health (NIH) and the UN, their thinking has proven remarkably malleable to the demands of activists and other non-experts. In the early 1980s biomedical researchers convened at annual AIDS conferences to discuss recent findings and to advise governments on sound public health policy. As the social complexities of AIDS transmission became evident, psychologists and other social scientists joined the medical scientists to their offer expertise. Anthropologists and other scholars produced increasingly sophisticated accounts of the social construction of gender, sexuality, and drug use in a variety of global settings. These studies often stressed how structural inequalities rendered certain populations acutely susceptible to contracting HIV (Parker 2001). But this research frequently did not lend itself easily to policy prescriptions or implementable strategies to combat the disease.

At the same time, AIDS activists grew increasingly restless in the absence of an effective vaccine, a cure, or adequate treatment for the disease. Unlike the population story, in which it took feminist activists several decades to influence global population policy decisively, from the earliest days of AIDS activists plunged into the fray, disrupting conferences and insisting on shaping the research agenda. These activists demanded attention for the disease, and they sought to create knowledge in tandem with scientists and to influence medical research, clinical trials, and FDA policy (Epstein 1996, Smith and Siplon 2006). In every phase of AIDS' evolution, activists have successfully pushed the boundary of the possible in the realms of research, prevention, and treatment.

While small groups of highly-motivated and dedicated individuals demanded funding and attention for AIDS (activists and AIDS researchers) early on, both would eventually be displaced by the large multi-lateral agencies who institutionalized procedures for setting policy, securing funding, and implementing the global response (Seckinelgin 2008). Following the population blueprint, once there was widespread conviction that AIDS was a threat to the entire world, a series of global institutions was created to mount and coordinate the fight against it. The first major institution created to deal with AIDS was the Global Program on AIDS launched by the WHO in 1987. The Global Program was supplanted by the creation of UNAIDS in 1996. Under the leadership of Peter Piot, UNAIDS was charged with coordinating the efforts of all of the UN agencies working on AIDS, and with centralizing all epidemiological data to provide a single set of official HIV/AIDS estimates (Pisani 2008: 14).

The next major phase in the evolution of the AIDS industry arrived with the new millennium. After the inclusion of HIV/AIDS in the Millennium Development Goals and the new understanding of AIDS as a threat to world stability, UN Secretary-General Kofi Annan called for a global "war chest" to fight AIDS in 2001. The new Global Fund to Fight AIDS, TB, and Malaria stressed a collaborative approach designed to improve global coordination of AIDS spending. In the Fund's own words, it is "an international financing institution that invests the world's money to save lives." As part of its alternative approach, the Global Fund invites countries to submit their own proposals, it stresses partnerships between governments and civil society, and it expects country teams to include HIV positive members (Bernstein and Sessions 2007; Pisani 2008:273). The Fund is now entertaining bids for its ninth round of funding.

Although the Global Fund has dispersed billions of dollars in AIDS funding, it still faces competition from bilateral programs, particularly US President Bush's PEPFAR program which was launched in 2003. Focusing on prevention, treatment, and care for those infected and affected by HIV/AIDS, close to US $19 billion dollars has been spent on PEPFAR programs since 2004. (In comparison, the US has pledged US $3.3 billion to the Global Fund since 2001). PEPFAR claims to have provided ARV treatment to over 2 million people to date, and has set a goal of treating another 3 million people in its second phase which began in 2008.

Not to be forgotten, the WHO still promotes itself as the agency that "takes the lead within the UN system on the global health sector response to AIDS." The WHO spearheaded the "3 by 5" initiative in 2003, aiming to enroll 3 million new patients into ARV therapy by 2005. This goal was met in 2007, largely because of the huge drop in prices for ARVs. In recent years the WHO has stressed a public health response to HIV/AIDS and five "strategic directions": enabling people to know their status, maximizing the health sector's contribution to prevention, scaling up access to treatment, strengthening and expanding health systems, and investing in strategic information to improve the response (WHO 2009).

Over the past thirty years, most of the classic development players have jockeyed to set the global AIDS agenda and to protect their turf vis-à-vis competing agencies. Changing understandings of "urgency", and the scale and nature of the AIDS problem, have propelled various actors into the fray at different historical moments. Alongside the official AIDS industry rooted in the sphere of international development, we have seen the growth of an activist establishment committed to pressuring governments and multi-lateral agencies to increase the size, scope, and scale of the AIDS response. ACT UP, the Global Network of People living with HIV/AIDS (GNP+), Health Global Access Project (Health GAP), Treatment Action Campaign (TAC), and The AIDS Support Organization (TASO) are just a few of the global advocacy and activist organizations that have effectively shifted the global discourse on AIDS and that continue to demand attending and funding for prevention, treatment, and social services.

Policy prescriptions: shifting solutions to the AIDS pandemic

The significance of evolving AIDS epidemiology and the shifting problematization of AIDS becomes evident when we examine how these social constructions of the pandemic lend themselves to particular kinds of interventions to combat the spread of HIV. From the 1980s through the mid-1990s the AIDS debate positioned those who would implement a classic public health response of "testing and constraining" against those who supported community education, protecting the civil rights of the HIV+ and PLWA, and working to end AIDS discrimination (Caceres and Race forthcoming). AIDS activists, including Jonathan Mann, first director of the World Health Organization's Special Program on AIDS from 1986-1990, were quick to use the language of human rights to condemn stigma, discrimination, and poor or inadequate medical treatment for people living with HIV and AIDS.

As the body of social science research on AIDS grew, there was a significant change in the emphasis of AIDS programs. Public health and health education strategies witnessed a transition from individual, behavior based responses stemming from medicine and psychology (Information, Education, and Communication (IEC), Behavior Change Communication (BCC), and Knowledge, Attitudes, and Practices (KAP) to more sophisticated approaches employing anthropological and sociological understandings of the social construction of sexuality, social capital, and the ways that political economy shapes the spread of AIDS (Campbell 2003, Parker 2001). By the late 1990s the notion of multi-faceted social and economic "vulnerability" to AIDS and the necessity of multi-sectoral initiatives dominated global policy discussions (Aggleton 2004, Caceres and Race forthcoming, UNAIDS 1998). But the notion of vulnerability doesn't lend itself easily to action, and the widespread consensus that vulnerability is at the heart of the spread of HIV has created a problematic impasse (Caceres and Race forthcoming).

The early failures of behavior change approaches, and the difficulty in implementing programs aimed at changing cultural scripts for gender relations and sexuality, have contributed to the enthusiasm for technical and biomedical solutions to AIDS, including the as yet elusive AIDS vaccine, ARVs, male circumcision, and microbicides. This eagerness for biomedical solutions was shared by AIDS activists, who from 2000 onwards successfully framed access to AIDS drugs as a human rights issue. Their globally-coordinated direct action strategies forced the pharmaceutical companies and the global AIDS industry to imagine the feasibility of delivering AIDS drugs to the poor throughout the Third World (Smith and Siplon 2006). PEPFAR and the WHO's 3 by 5 program, alongside earlier government initiatives in Brazil and Botswana, have transformed drug treatment for the poor from a radical counter-hegemonic demand into a routinized cog in the global AIDS machine.

In spite of continued calls for "structural interventions" (Gupta et al. 2008), the emergence of HAART therapy in 1996 much emphasis in the AIDS response has been on scaling up voluntary testing and access to treatment. The global discourse has shifted from one of hope and excitement about the life-saving potential of these treatments to continual demands to deliver on the promise of AIDS drugs. The success of the global treatment movement has meant that in many places, including countries like Brazil that offer universal treatment, we are witnessing the "pharmaceuticalization of AIDS" (Biehl 2007). Biehl uses the concept of pharmaceuticalization to describe a situation in which health policy is no longer about prevention or medical care, but merely about the provision of drugs.[5]

Pharmaceuticalization is problematic both for the long-term costs of therapy and because it diverts attention from risky environments and social contexts (as distinct from risky behavior) that fuel the pandemic. As Caceres and Race argue, by the mid-2000s there was widespread recognition that sustainable universal access to drugs would be impossible without better prevention. The failure of "magic bullets" has now shifted the emphasis to combined biomedical-social approaches that include comprehensive sex education, improving access to prevention by strengthening human rights, and employing the full the biomedical toolkit of

[5] Importantly, the pharmaceuticalization process stems as much from the demands of patients for access to drugs and the activist discourse of drug access as a human rights issue as it does from the narrow focus of global and national AIDS programs (Biehl 2007).

developing vaccines and microbicides, controlling STIs, and promoting male circumcision (Coates et al. 2008 cited in Caceres and Race forthcoming).

The global state of AIDS: current approaches and future challenges

Under the leadership of the WHO and then UNAIDS, there has been a conviction that the AIDS pandemic requires centralized, global coordination of national and local interventions. UNAIDS continues to hold the mantle of global AIDS management, and this thirteen year old institution has just experienced its first transition in leadership as Peter Piot retired and Michel Sidibe became the new Executive Director. While UNAIDS maintains its place as the headquarters of global coordination of the AIDS response, activists and advocacy organizations continue to assert themselves as instrumental actors in crafting AIDS policy. Under Sidibe's leadership partnerships with civil society are emphasized, and in this collaborative spirit, UNAIDS has initiated on-line dialogues between community groups, international NGOs, activists, and scholars. These dialogues
look for prevention programming answers from marginalized groups and those most directly affected by AIDS.

While the pharmaceuticalization of AIDS is one important outcome of the success of global AIDS activism, there has been a sobering recognition that treatment and prevention are not oppositional strategies but must be used in tandem. A current dilemma for the AIDS response is how to generate the same sense of urgency for prevention that created the momentum for universal access to treatment. In the words of Peter Piot “there is no constituency for prevention”, and this lack of popular demand for prevention has facilitated over-emphasis on drugs as the ultimate solution to the pandemic. Yet the language of urgency often comes at a cost. In many countries the legacy of using scare tactics for prevention and AIDS’ early depiction as a horrifying, incurable disease continues to undermine efforts to provide comprehensive sex education, to promote testing and to reduce stigma and discrimination.

The embracing of ARVs as a magic bullet for AIDS parallels the enthusiasm of the population establishment for long-acting and provider-controlled contraceptive technologies. In each case we see the familiar development pattern of assuming that complex social, political, and economic problems can be overcome with technological solutions. Some of the same challenges that undermined the Cairo Program of Action threaten to diminish the impact of technology in the AIDS response: weak health infrastructure, uneven political commitment, lack of strategic financing, and above all failure to engage with the structural factors affecting people’s lives that made them vulnerable to HIV (or high fertility) in the first place. These factors also directly influence one’s ability to use HAART or contraception effectively.

An important trend in the evolution of the AIDS response (and one related directly to the demand for universal access to AIDS drugs) is the increasing conviction that AIDS is a billion dollar problem that requires a long-term financial commitment from the governments of the North. UNAIDS estimates that we need to spend US $25 billion in low and middle income countries to reach “country-defined targets for universal access to HIV prevention, treatment care and support by 2010.” This figure is $11.5 million more than is currently available (UNAIDS 2009b). Regardless of uneven political commitment to combating AIDS, the globe

is awash in AIDS dollars. By 2003 development assistance to combat the global AIDS pandemic represented 1.8% of total assistance, and it had increased annually at a rate of 36.7% since 1993 (MacKellar 2005:296).

AIDS has followed the growth model in which success is measured by an ability to increase the size, scale, and geographic reach of prevention and treatment interventions by investing growing amounts of money for an assumed increase in returns. Significantly, if HIV/AIDS dollars are removed from the calculations of development assistance over the decade 1993-2003 we see that health spending as a portion of development assistance has actually decreased (MacKellar 2005:297). The increased attention to AIDS has come at the expense of basic health infrastructure and other health spending that might have a more immediate impact on the burden of disease in developing countries. Even more importantly, early evidence suggests that countries with historically under-resourced health systems face significant challenges to "scaling up" and spending vast sums of AIDS money effectively (Bernstein and Sessions 2007).

This growth model takes on a life of its own and begs the question, is AIDS really a problem that is solved by spending billions? The emphasis on keeping the funds rolling seems to have superseded strategic ideas about how to use that money. Recognizing the dilemmas created by billions of dollars in AIDS assistance, UNAIDS committed itself in 2007 to "spending money more effectively". In spite of this pledge to "spend better", the increasing amounts of money available for AIDS programming are taken as reassurance that AIDS hasn't been dropped from the global agenda. Just as the population establishment feared that the advent of AIDS would undermine political will and funding for family planning, AIDS now faces climate change as the new rival that threatens to become the most pressing global crisis.

Conclusion

In this paper we suggest that the population story is a useful foil for examining the implicit assumptions in the AIDS response to date. AIDS, like population control, is history and should be placed in a historical context with other global health issues. AIDS must be adequately historicized rather than positioned outside of history. Even in the course of its very brief existence we have evidence of shifting AIDS problematizations and their implications. These historically contingent configurations must be examined in a larger context to show repeating patterns over time, to reveal significant changes, and to demonstrate that our naturalized assumptions about AIDS are in fact historical products. The story we tell about AIDS will determine how we see its present and possible futures.

We have employed the concept of problematization to highlight the ways that global problems, like the global crises of population and AIDS, are social constructions. Not only are they social constructions, but they are particular interpretations that delineate what is and is not possible in regard to their solutions. We contend that the AIDS response is at a critical juncture that requires a rethinking of the multiple ways the pandemic has been problematized. In particular, we suggest the following:

1) Question the notions of global crisis and global problems—The language of "global crisis" facilitates short-term planning which tends to follow a global blueprint emphasizing narrow, vertical programming. Early experiences with coercive sterilization programs and quarantines for the HIV positive have created obstacles for routinization and normalization of contraception and HIV/AIDS prevention and treatment as long-term problems. Attempts to merge fragmented crises into a single global crisis draw our attention to maintaining the global problem network and blueprint solutions, and can distract us from realizing the specificity of AIDS in any given location and fruitfully comparing those specificities. Knowing your local epidemic necessarily disrupts the notion of a global problem; the two are in constant tension with one another.

2) Approach the promise of consensus with caution—As the solutions to population and AIDS shifted from crisis mindsets to long-term approaches, partnerships and consensus have emerged as the promise for an effective global response. Yet the complexities of power, position and politics are easily erased in the language of partnership and collaboration. As Halfon reminds us, the convergence of people occupying the same policy spaces and using the same rhetoric does not necessarily contribute to shared conclusions and coordinated action (Halfon 2006:785).

The AIDS establishment is currently employing novel approaches to expand the socio-technical space of partnership to include online communities, cyber-dialogues, and open channels of communication between everyday PLWA and the global policy elite. While these kinds of spaces offer an important venue for challenging limitations in current approaches to AIDS, we suggest that the concept of partnership needs to be historicized and clearly articulated, lest it become another hollow development term like sustainability or participation.

3) Question the need for a global agenda—We contend that a global agenda to fight AIDS (similar to the Cairo Program of Action) is misguided. The push for consensus risks masking the multiplicity of AIDS epidemics in the name of fighting a single global pandemic, thereby diverting attention from the need for context-specific, regional and local responses to AIDS. We suggest approaching the idea of a global agenda cautiously, lest the concerted effort necessary to foster widespread agreement detract from efforts to combat AIDS in specific locales. We also suggest interrogating the assumption that sharing space and a mutual agenda, even one printed on paper, will lead to programmatic solutions.

4) Growth and scaling up are not a solution—There is sufficient reason (beyond the lessons we might learn from the current economic collapse) to be wary of the current enthusiasm for growth-models without questioning the implications of rapid growth with little reflection. As we look for long-term solutions to AIDS we should assess our assumptions that more money, scaling up, and the use of new technology will result in better programs. It is likely that the growth mindset is just as unsustainable as a crisis one.

In moving forward from the short-term crisis mindset, it is important to address past shortcomings as we envision current and future responses to AIDS. Innovation without acknowledgement of past practices and mistakes, as we have seen in the cases of both population and AIDS, runs the risk of building new solutions on a weak foundation. If tackling AIDS is indeed a question of adequate attention to numerous local and regional epidemics, than we must consider the possibility that growing a global solution to the AIDS pandemic is a fool's errand.

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