HIV/AIDS REGIME PARTICIPANTS, THEIR NORMS AND BLOCKED COOPERATION IN RESPONSE TO HIV/AIDS

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ABSTRACT

Contrary to the probable expectation of neoliberal institutionalism, the deepening HIV/AIDS crisis and the shared understanding of AIDS as a security issue have not resulted in a coherent and effective international regime in response to AIDS. The research reported here suggests that a given pool of relevant actors (because of incompatibility of their ontological characteristics, i.e. organizational identities) opted for dissimilar bargaining leverages in the process of agreeing on the appropriate response to the AIDS pandemic and, as a result, produced a stalemate in norm diffusion. Convergence of norms is envisioned as a crucial factor fostering international cooperation against the pandemic. This factor created significant complications for cooperation, aggravated by the structural leader's lack of transparency and legitimacy. Empirically, the paper explores how the most important AIDS-related actors contribute to regime formation. The author builds on Young's specification to classify types of actors and then proceeds to analyze their identities in details. In conclusion, the author offers several recommendations how to build a new conceptual framework for norm diffusion.

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INTRODUCTION

The advent of the HIV/AIDS epidemic raised pivotal concerns about how to establish the new international regime to control HIV/AIDS. Today, serious disagreements persist if this regime came to existence or not. Given long period of AIDS spread, the gravity of the pandemic and obvious concern of many international actors about it, this regime could have been expected to emerge.

Indeed, according to Keohane, as any international regime is in general functional and operates on the Coase theorem, the externalities of HIV/AIDS should have been eliminated and spontaneous type of international regime might have been expected (Keohane 1986: 86). Within this framework, the level of communication (and therefore trust) to be increased over time and incompatibility of interests to be decreased (and thus convergence of interest to emerge). If this AIDS regime does not exist, why and what factors were conducive to the failure of regime formation?

Historically, several "clusters" of explanations why the international response to AIDS had not born any fruit emerged. First, to explain the cooperation failure in 1980s, analysts offered several ad hoc explanations: 1) the absence of medical consensus about AIDS, 2) the timing of the policy cycle, as any new issue requires a long time to be put on the agenda and considered as important and 3) isolationist sentiments in the US and increasing disinterest in the African affairs with the end of the Cold War. These explanations were incomplete as they rested on the public policy explanations and did not account for the international dimension of cooperation, as well as increasingly significant role of non-state actors in it.

Second, in 1990s more systematic studies of cooperation to combat AIDS came out. Gordneker, Coate, Jonsson and Soderholm (1995) used garbage can model to offer insights about decoupling of the reformulated problem (HIV/AIDS as human rights) and proposed solutions as well as undertaken practical measures. Besides, the failure of cooperation was aggravated by high fluidity within the pool of participants, low level of trust among different groups and unclear organizational priorities. Multiple groups have been pursuing the satisfaction of their narrow institutional, ideational or identity-informed preferences. As a result, they typically dropped out of any collaborative efforts after these narrow preferences have been more or less achieved. Building on Gordenker et al research, Jonssen and Soderholm (1994) indicated that AIDS issue-framing was abundant. Conflicting and overlapping AIDS issue-frames, propagated by dissimilar set of actors, never led to a cumulative understanding of the epidemic. Thus, the absence of shared understanding (language) precluded close cooperation and regime formation. Multiplicity of frames also obscured the nature of the appropriate international response to the pandemic.

Third, in early 2000s, many "practitioners" accused the conservative (republican) values being very pervasive on the international arena and in effect detrimental to the appropriate response to the pandemic. Conservative values were perceived as devoid from general medical consensus and decreasing the level of trust among those who combat against AIDS. The implication of this line of thinking is that the AIDS regime has hegemonic features and is by and large imposed by the powerful actors, including the US, the World Bank, the WTO and private pharmaceutical sector. In more general terms, O'Manique linked the deepening AIDS crisis to the pervasiveness of neoliberalism (2004), while Lee, Buse and Fustukian explained the cooperation problems as a result of divide in private—public sector policies and preferences (2002).

All these explanations convey some important elements of problems with AIDS regime formation, yet they concentrate on specific components of the potential regime and do not aim to answer the question of regime formation in general. Nor do they take into account current efforts to create such regime. This paper aims at

explaining why the international regime in response to AIDS was never created. In doing so, the author builds on Oran Young's insights of international regimes as human artifacts (Young 1982) and his typology how to characterize international leaders (or actors, more broadly) pertaining to development of international institutions (Young 1990).

My argument is twofold. In the early 21st century three ontologically dissimilar types of actors with different identities became mixed together. Donor states—principals—and their agent institutions, as well as activists, social movements, NGOs, private sector, and recipient states had to deal with each other. In essence, major actors used different bargaining principles and showed dissimilar—and often incompatible—patterns of organizational behavior, especially as related to the normative convergence. Simply put, these actors employed incompatible logics of action and, effectively, blocked normative convergence on what should constitute an appropriate response to HIV/AIDS.

The structural leader chose to impose the AIDS regime on its own terms, but other actors opted for either negotiation on their own conditions (entrepreneurs), or inaction (intellectuals) to create the AIDS regime. In general, the structural leader operated on the basis of norms, which have remained by-and-large opaque and not easily explicable for other builders of the AIDS regime. The AIDS regime could have been imposed only under the condition of perceived legitimacy and transparency. However, activists and entrepreneurs vehemently and passionately rejected the structural leaders' core normative commitments, thus denying legitimacy to the imposed regime. As a result, two core international institutions, around which the anti-AIDS collaboration could have been formed, were under fire of harsh (and yet sometimes unsubstantiated) criticism. One institution of structural leadership (PEPFAR) did not gain any legitimacy in the eyes of entrepreneurs, another (GFATM), albeit perceived as legitimate, remained almost dysfunctional. At the same time, they were not willing to see positive development beyond what was perceived as narrow conservative normative commitments.

Second, at the same time most participants started talking about AIDS in security terms, thus contributing to the convergence on the general meaning of the pandemic. However, contrary to the expectations of regime analysis, even being in the same "ballpark" did *not* lead to the formation of a regime. Reformulating Kratochwil and Ruggie (1986: 767), one can say that the presence of the inersubjective meaning is not a sufficient condition of the regime formation, contrary to what is typically underscored by regime analysis to characterize the international regime creation. Thus, convergence of meaning and shared HIV/AIDS issue-frame should be treated as less important analytical components.

As a corollary of these observations, regime literature by and large explores the formation of international regimes, looking at actors who are very similar ontologically (that is, states create regimes with other states, epistemic communities talk to their colleagues etc). Under this condition, creation of regime is easier. Thus, the next theoretical step in developing the international regimes literature should be building a framework to explain the nature of these interactions.

PARTICIPANTS AND THEIR BARGAINING PRINCIPLES FOR HIV/AIDS REGIME

In his classic treatise of political leadership and regime formation, Young (1991) delineated three types of leadership, including structural, intellectual and entrepreneurial. The distinctions in characteristics were based on

different bargaining strategies and dissimilar principles of organizational behavior. S*tructural* bargaining strategy was based on material leverage and social position, *intellectual* – on its knowledge-based claims, shared principled beliefs about this knowledge and emphasis on the novel and bettered issue definitions, and *entrepreneurial* – on its outstanding negotiation skills. These particular characteristics impact formation of an international regime: "Much of the real work of regime formation in international society occurs in the interplay of bargaining leverage, negotiating skill, and intellectual innovation" (Young 1991, 306).

Important caveat to Young's general line of argumentation should be that he is not necessarily talking about agents in the *leadership* positions. Rather, in the context of institutional bargaining, while attempting to reach "interlocking sets of rights and rules that are expected to govern their subsequent interaction," any participant can employ these three bargaining logics for the purposes of regime formation. Thus, it makes sense to omit Young's emphasis on leadership, but rather try to classify actors-participants according to his model.

This caveat is especially important because of an overwhelming presence of multiple uncoordinated actors has been the characteristic feature of the recent transnational cooperation in response to HIV/AIDS. Put differently, there is no stable set of predominant decision-makers—leaders—for AIDS governance. Since late 1980s, the candidates for leadership roles in the new regime against AIDS varied greatly, rotated quickly and came from different sources. It is reasonable to suggest that there was never a single unquestionable leader in response to HIV/AIDS. Even those actors who claimed the position of the exceptional leadership (such as Mann's Global Programme on AIDS, GPA) in 1992 ceased to exit, giving place to the structure with complex mandate, unclear status among the AIDS-related organizations and incoherent strategies for international cooperation (UNAIDS in 1996).

As Young suggested, structural leaders/actors are "translating the possession of material resources into bargaining leverage cast in terms appropriate to the issues at stake in specific instances of institutional bargaining… it is natural for such leaders to espouse institutional arrangements that seem well suited to the interests of the states they represent" (Young 1991, 288). Today the possession of material resources which can be appropriated in response to AIDS is almost exclusively concentrated in the hands of a few donor states. Among donor states, the US established the "appropriate" rules for donorship (that is, the balance and level of financial contributions from the OECD), as well as procedural, organizational rules for the newly created AIDS-centered international organizations. The structural leadership is exercised through *the U.S. President's Emergency Plan for AIDS Relief* (PEPFAR, the Plan) and *the Global Fund to Fight AIDS, TB and Malaria* (GFATM, the Fund). The latter is often perceived as an autonomous international actor, but the desired level of independence is yet to be obtained. Relations between the US and GFATM can be best explained in terms of principal-agent problem, where an international organization is trying to become independent from the state-creator and build its own agenda for action. The principal is pulling all the strings to prevent this independence form happening.

President Bush's Emergency Plan and his support for GFATM is of paramount importance. These are the most recent massive programs (instilled in 2001 and 2003), and as such, might implement a new understanding of the evolving nature of the pandemic as depicted by the intellectual actors/leaders. They were originally designed to have the most impact to curb the pandemic, by overcoming the WHO or UNAIDS's "traditional" organizational constraints to international cooperation. In terms of financial commitments, countries covered, and the number of

local nongovernmental actors involved—these two are the biggest programs against AIDS to date. They also are programs supposed to have a robust impact on the future.

Entrepreneurial actors/leaders to create an international regime “relying on negotiating skill to frame issues in ways that foster integrative bargaining and to put together deals that would otherwise elude participants endeavoring to form international regimes through institutional bargaining” (Young 1991, 293). Entrepreneurial leaders possess a capacity for uncovering commonalities and putting together package deals. Despite in Young’s model this sounds like a proven analytical statement, it is more of a normative prescription what “entrepreneurs” should do in order to be instrumental in a regime formation. These insights by and large are supported by the recent constructivist research on international cooperation, which underscores the role of dialogical disputation to reach an international commitment (Duffy et al 1998) and the role of discourse convergence (Fierke 2002).

In reality, many active AIDS-related entrepreneurs, NGOs and social movements, on the contrary, preferred a very aggressive and offensive type of bargaining with donors, including shaming, accusation in hidden agendas (Talbott 2003). Quite often, the debate is carried away from the tangible and manageable AIDS-related issues and dragged into the major discussion of the appropriateness of the existing funding norms, as well as debt reduction and religious implication for AIDS curbing. Activists’ political behavior is very capricious and dependent not upon strategic concerns, but rather upon sentiments. They act essentially as obstructers of global collaboration and reinforce negative attitudes of donors and the private sector towards activists and NGOs. This is not an integrative, but rather an obstructive bargaining.

The most voluble critics of the donors’ policies include Médecins sans Frontières (MSF), Consumer Project on Technology (CPT), the South Center, the Friend World Committee for Consultation, Peter Lurie (Director, Center for AIDS Preventions Studies at the University California San Francisco), Essential Action Group, Treatment Action Campaign, Global Health Alliance, the Australian Federation of AIDS Organisations and even Jeffrey Sachs (in a capacity of the WHO Commission on macroeconomics and health Chair).

Finally, intellectual leaders/actors [should] “produce intellectual capital or generative systems of thought that shape the perspectives of those who participate in institutional bargaining” (Young 1991, 298). Intellectual leadership is based in ideas and the ability to convey them effectively and convincingly. Intellectuals have to offer decision-makers a better analytic grip both on routes to better cooperation and the nature of pandemic itself. Most importantly, they ought to transmit them to the predominant decision-makers with the ability to commit resources and override other consideration (that is, structural leaders).

HIV/AIDS is a tough issue-area to study. Intellectual actors can also be labeled as either knowledge-based actors, or members of epistemic communities (Haas 1992). In the past couple of years academics, practitioners, think tanks, and independent advocacy groups have been reformulating HIV/AIDS as the security issue (Altman 2000; Ostergard 2000; Fourie and Schonteich 2001; Price-Smith 2001; Nattrass 2002; Pharaoah and Schonteich 2003). Yet many analysts find themselves confused when observing politics around HIV/AIDS, while inquiring why such a “good” frame have not spurred a necessary level of international action and cooperation.

As the interplay of all three bargaining principles contributes to the observable institutional arrangements and the very existence of a given regime (Young 1991, 306), three following sections examine in greater details organizational principles and bargaining leverages of those actors involved in the AIDS regime formation. First, the paper looks at how intellectuals attempt to formulate better ways to understand the pandemic. Second, it explores

how two major international institutions created by the donor-states (structural leaders) contribute to the international AIDS regime. Third, it conveys major tactics and sentiments of activists—potential entrepreneurial leaders—as related to necessary integrative bargaining.

INTELLECTUALS: HIV/AIDS AS A SECURITY ISSUE

New trends in the pandemic evolvement

HIV/AIDS, along with diarrhea, malaria and tuberculosis, is the most devastating health pandemics of last century. The total estimated number of people living with HIV/AIDS in 2004 is 37.8 million, total people newly infected with HIV in 2004—4.8 million, AIDS deaths in 2004—2.9 million. Cumulatively, the toll of the pandemic has mounted. 20 million people have died from HIV/AIDS, and 18 million children will become orphans by 2010 because of HIV/AIDS (UNAIDS 2004, 10, 39, 61). However, it is important to realize that for more than twenty years of the pandemic span, HIV/AIDS has both continued to build on old trajectories and acquire new characteristics. The AIDS pandemic keeps on growing both in its magnitude and in the diversity of its impact (De Cock and Weiss 2000). Recently identified trends point out that there are new ways of the disease's spread, new clusters of vulnerable target populations, and poorly-explored links between AIDS and other social and economic problems.

One of the newest and most dangerous phenomena is severe penetration of the virus into the military. The military dimension is the focal point of many studies (Elbe 2002; Sarin 2003). It means, first of all, the vulnerability of military troops to the higher rates of the disease. The military is disproportionately affected by the virus: the average infection rate of African militaries is about 30 percent, but it reaches 50 percent in Congo and Angola, 66 percent in Uganda, 75 percent in Malawi, and 80 percent in Zimbabwe (Singer 2002, 145—158). This implies considerable weakening of the military and the policing forces, culminating in higher rates of crime and violence (Singer 2002, 147—149).

The higher infection rates among the armed forces make both internal and external stability and order vulnerable. In some African areas, the infected military force is a large danger to the civil population. Moreover, wartime rapes—atrocious instrument of war—spurs the next wave of infections. In Rwanda, for instance, in early 1993, between 250,000 and 500,000 women were raped during the genocide. As a corollary to this, the growing populace of the orphaned children is likely to contribute to the higher rates of crime and instability. In the North-West Uganda, for instance, 90% of soldiers consist of previously abducted children. As the result of these factors, the new wars could be harder to contain and more frequent (Healthlink Worldwide 2002, 2021). Refugee camps in Africa—the consequence of violence and wars—are becoming epicenters contributing to the rapid, violent and uncontrolled spread of the infection (Khaw et al 2000; Salama and Dondero 2001; Spiegel 2004). These new facts call for innovative thinking about fresh types of intervention.

Precariousness of a new interpretation

In this context, *military security frame* takes on importance. A special session of the Security Council was dedicated to the topic of the potential repercussions of HIV/AIDS for the global security. Then U.S. permanent

representative to the UN Richard Holbrooke and the U.S. Secretary of State Colin L. Powell addressed the impact of AIDS on peacekeeping and democracy, positing it as the leading challenge to global security. Among the proposed measures were greater commitment of resources, as well as open discussions on effective strategies of prevention, on potential treatments, and international, national, and community mobilization (Holbrooke 2000). According to the National Intelligence Council Report, *The Global Infectious Disease Threat and Its Implications for the United States,* the pandemic affects the interests of the United States as it may lead to the absence of the effective control over armed forces and especially the weapons of mass destruction, further separation and conflict of civilian and military parts of society, and HIV becoming a weapon of war—all these factors are potentially threatening to the U.S. military and homeland security. In general, this frame tends to narrow the understanding of security as it links the spread of HIV/AIDS and the U.S. strategic interests abroad. These beliefs reify the primacy of the unilateral nation-state mechanisms for limiting the spread of HIV/AIDS and reinforce the military component of security. It therefore addresses the notion that weak *states* are a threat to the U.S. security. This creates the danger of decoupling of the new AIDS trajectory from outlived state-centric solutions.

The relationship between HIV/AIDS and humanitarian crises has become a matter of much concern. African knowledge-based actors (KBAs) and non-governmental organizations (NGOs) are vigorously specifying AIDS as a *comprehensive (human) security frame*. The African KBAs (such as Centre for Social Science, University Of Cape Town, Institute of Democracy in South Africa and others) put a special emphasis on the condition of poverty (malnutrition, chronic parasitic infections, inadequate public health care, and high risk sexual behavior). Poverty is envisioned as the basic socio-economic determinant of the spread of AIDS (Whiteside 2002). This frame perceives HIV/AIDS as one of the most powerful factors contributing to economic decline due to the shrinking tax base and bigger financial burden of governments and surviving populations. Indeed, about 90 percent of people living with AIDS (PLWA) today belong to the most productive and reproductive cohort of population (15—49 years old). Poverty and HIV/AIDS create a vicious cycle that diminishes human security dramatically.

This perception of security underpins poverty reduction in general and economic empowerment of HIV-affected populations. Issues such as improving the food supply, providing dietary diversity, as well as generating income at the household and community level have been the focal point of many reports at the XIVth Bangkok International AIDS Conference (Emeka 2004; Ogunbayo 2004). Particularly acute has been the situation in southern Africa where extremely high levels of HIV coexist with a severe food crisis: food insecurity and famine lead to conflict over access to food and vital resources (Haddad and Gillespie 2001). At the end of 2002, over 14 million persons were at the verge of starvation in six southern African countries, including Lesotho, Swaziland and Zimbabwe, where adult HIV prevalence exceeds 30 percent.

In general, here the concept of security means protection of individuals and communities rather than states (Brown 2000). *International Conflict Research Group* research indicates a continuum of security dimensions: personal—economic—communal—national—international security. Among these communal security is pivotal, because HIV/AIDS directly affects police capability and community stability by breaking down civil institutions (ICG 2001). The disease also strikes hardest among the educated, more mobile, urban, younger generation. Valuable professions like civil servants, teachers, health care professionals, and police have been hard hit. The Pretoria-based Institute for Security Studies (ISS) found that HIV/AIDS could complicate attempts at post-conflict reconstruction in countries with high HIV prevalence rates. Implications for security and governance are ubiquitous.

Suggested, not adopted

In the case of HIV/AIDS and security nexus, the loose network of intellectuals, who articulate dissimilar ideas, to date has not been transformed into a single epistemic community with shared principled beliefs. Although knowledge-based actors (KBAs) have suggested many innovative ways to curb the AIDS crisis, they exert little influence on powerful decision-makers and donors.

In fact, availability of negotiation venue between a variety of KBAs and global funders is crucial to assembling shared principled beliefs and strong commitment to active participation. This is important for two reasons. First, without a more or less formalized negotiation setting, convergence of ideas and rapprochement between KBAs and decision-makers is almost impossible. Global AIDS governance can benefit immensely from the linking-pin actor[s] that will link KBAs, programs, and donors. Unfortunately, today it seems unfeasible to create such negotiations for innovative scientists to access the high-level decision-makers.

Second, there is a potential threat that the new insightful framing of AIDS as a security issue can simultaneously be so broad and underspecified that it will hinder any particular efforts against AIDS. Counter-intuitively, framing HIV/AIDS as a security threat may create more potential choices for the decision-makers. Proliferation of security sub-frames may lead to obscuring necessary targets and complicating the process of choosing tools against AIDS.

A significant complicating element of any AIDS issue-framing is that it is supposed to serve not only to provide clear functional guidelines for medical and donor intervention, but also be a vehicle for general political commitment to fight against HIV/AIDS, which can elevate consciousness of local leaders and make them internalize the new security frame. This dual purpose of framing AIDS as security issue can complicate the global fight against the pandemic.

Reasons for a "fake" compliance

Many political observers have suggested that framing HIV/AIDS as a security issue will help place health issues on the global agenda and foster tangible results. As one scholar put it: "redefining it [AIDS] to encompass security issues almost inevitably pushes it far higher up governmental agendas, making it first-order concern" (Altman 2002, 422). Indeed, many state leaders are willing to respond to the HIV/AIDS challenge as a security threat.

Yet the reasons for the security frame spread can be far from rational and functional. Recipient states as uncommitted follower are always interested in financial influx and are not willing to challenge the spontaneous arrangements for the emerging regime against AIDS. Over time, many actors commenced reinterpreting AIDS as a security issue. Many regional state leaders have been willing to frame HIV/AIDS as a security threat as well. Some observers argue that many regional and local leaders were open to receive AIDS as security frame because of its convenience for attaining strategic goals, other than combating AIDS—that is, to retain and attract foreign investment, overcome conflict, or shift normative orientation towards the international community (Girshnik 2004). This means that the security frame has a strategic meaning primarily for potential utility-maximizers, which may not really care about the pandemic per se. Therefore, it is pivotal that the donor states set clear, tangible, well-targeted

priorities for current global AIDS programs in the line of both security frame and complex emergency frames and monitor them closely. In effect, knowledge suggested or knowledge adopted for the wrong reasons can be dysfunctional.

DONORS: COMMITTED RESOURCES AND ORGANIZATION OF ACTION

The Plan I: material leverages

The President's Emergency Plan for AIDS Relief is to date the biggest global program dealing with the HIV/AIDS pandemic. Announced in 2003 in President Bush's State of the Union Address, it commits $15 billion dollars over five years to combat the disease. Out of this amount, $9 billion in new money that will go to new programs to address HIV/AIDS in 12 African (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia), 2 Latin American and Caribbean (Haiti and Guyana) and 1 recently added Asian state (Vietnam). The selected countries are estimated to account for approximately 50 percent of the world's HIV/AIDS infections. Another big segment of contributions to global health—$5 billion—is committed to the already running HIV/AIDS programs around the globe. The smallest portion of the plan—$1 billion—is intended to support the Global Fund. In terms of scope of response, PEPFAR formulates its objectives in a straightforward manner: in the 15 focus countries, over the 5 years of the PEPFAR, it is supposed to provide anti-retroviral treatment for two million people, prevent 7 million AIDS deaths, and give care to 10 million people who are infected or affected by the disease in the focus countries. After the first year of operation, there is some progress towards its particular goals. It is estimated that in 2004, PEPFAR interventions through non-governmental organizations have prevented at least 660,000 new infections, and provided care for 65,000 people affected by HIV/AIDS, including treatment for 13,000 HIV-positive people (Tobias 2004, 15—17).

The Plan II: donors' interests

Although the Plan's general objectives are very coherent, its numbers seem almost arbitrary: that means objectives are decoupled from the actual solution. Hence, many inconsistencies occur. PERFAR by its mandate concentrates efforts only on 15 countries. But even among that limited number in 2004, Uganda (44.5 million), Kenya (34.6 million), and South Africa (31.8 million) are receiving the lion share of contributions. These are indeed the key African states in regard to the military issues (given that Uganda and South Africa's military capacities are among the best on the continent). That means that if AIDS is framed in terms of military security and stability, the support of these states is well-reasoned. And yet, on the other hand, one needs more specific information about what groups are provided with treatment—is that military, police, indigenous leaders, state leaders, etc. So far, PEPFAR does not seem to prioritize treatment for these groups of population and leaves the disbursement issues to the states' discretion.

Obviously, PEPFAR is a new enterprise, and the results are yet to come. At this point, it is becoming evident that PEPFAR obviously tries to use state-centric solutions as opposed to create some innovative response, offered by intellectuals. Bilateral collaboration is preferred to any multilateral and transnational partnerships (Sachs 2003). U.S. government spokespeople typically indicate that both the accountability and transparency of the African national health infrastructures are easier to be monitored under bilateral agreements. But on the other hand, bilateralism is prone to the so-called "slow moving grants" (euphemism for grants that are not working out), which

are all within the governmental sector and most of them in PEPFAR states. At the same time, multilateral initiatives prove to be more effective. That means that the strategic orientation to work with the states as primary agents and promoters of health is outdated and does not work as planned.

The Plan III: organizational effectiveness for the regime

Planning ambiguity is pervasive, too. PEPFAR is weak in matching its short-term planning with the long-term commitment to support global health. PEPFAR was designed with the vision that after five years of operation either some health problems can be solved, or the emergency relief will help countries combat the pandemic on their own. Judging by the absence of the commitments to long-term funding and projections of the pandemic, PEPFAR is intended to remain a temporary emergency relief for the hardest-hit country key partners.

Despite the abovementioned short-term planning, some of the PEPFAR's goals are far-reaching. PEPFAR purports to develop sustainable local infrastructure to continue local health programs *after* PEPFAR ceases to operate. PEPFAR helps create health infrastructure of central medical centers—primary satellites—secondary satellites—rural satellites and remote mobile units continuum, covering geographically the whole country. There is a clear hierarchy and division of labor in conducted activities: general HIV/AIDS expertise—treatment—test on infectious diseases—distribution of treatment and medication pack refills, respectfully. Primary satellites are envisioned as focal venues where many private and public clinics run by faith-based groups and non-governmental organizations will be in this category. Judged by its general design, this infrastructure-building plan looks relevant for the long-term combat against AIDS and helpful in scaling up states' capacities and the quality of their response. However, sustainability of this structure over the long haul is highly problematic.

The Fund I: organizational principles

The Global Fund was launched in 2001 based on UN General Assembly resolution 1308 (A/RES/S-26/2), and it became operational the next year. GFATM's mission is to solidify the evolving related international AIDS regime (Morrison and Summers 2003, 180—181; Parker 2002, 343346). GFATM in essence is a financial organization, which should, according to its mandate, support programs that focus on the creation, development and expansion of partnerships, and strengthen the participation of communities and people affected by HIV/AIDS, malaria and tuberculosis. These guidelines are more of a broad policy statement and political commitment, rather than unambiguous articulation of the stone-set goals. After several years of operation, GFATM refuses to set clear-cut numbers in terms of how many people should be given ARV treatment, how many new infections should be prevented, and how many people should be taken care of in health facilities. Instead, GFATM sets forth only checks for its *organizational* effectiveness with clear idiosyncratic aftertaste. GFATM works primarily to fund NGOs and AIDS service organizations (ASOs), which can do effective groundwork. Ironically, the locals may never be truly satisfied with GFATM, because the potential and actual requests for funding will always exceed by far the potential financial inflows from the Fund. Being resource dependent itself, the Fund cannot possibly offer enough grants. On the other hand, the saturation of the local absorbing capacities as a sound and effective criterion for curbing AIDS is very problematic.

The Fund II: material leverages

The funding practices appear to be neither well-balanced in terms of countries and regions supported nor in terms of how well the local problem is targeted. Disproportionate funding—over $100 million—over four rounds have been disbursed for China, Ethiopia, India, Kenya, Tanzania, Uganda, Zambia. Note that Uganda is relatively well curbing the pandemic to date, and India has its own capacities (medicines manufacturing) to fight AIDS. Other countries that need a considerable support and still can halt the epidemic in its early stages—Armenia, Estonia, Kyrgyzstan, Malawi, Moldova, Mozambique and the Ukraine—on the contrary, received very inconsistent, unsustainable funding, or were excluded from some rounds at all. The poorest and almost dysfunctional states with no health infrastructure are almost left on their own. These inconsistencies stem from the internalized principle of ad hoc funding with no clear priorities in mind; they just exacerbate and justify the discord in what is supposed to be the transnational coordinated combat against the pandemic. It is unclear who can use the Fund for their advantage and what important local stakeholders are excluded. As a result, no clear new strategy can be implemented.

Although it is repeatedly argued that GFATM can disburse much more money than it currently does (van Oranje 2004), the figures do not support this line of argumentation. On the ground there is not so much absorbing capacity as the health activists and GFATM itself claim. Many local programs are structurally impaired. GFATM had to be in and out of the Ukraine because of the diminishing local capacities and cannot really by-pass the state (Russia's subjects of federation as example of regional incapacities). The same problems may be true in many African states.

In general, there is a diversion of big resources to minor goals. Related to this is the problem of targeted funding. Even programs that seem to be sufficiently funded (three projects in the Russian Federation) cannot reach the heart of the pandemic and remain very sporadic.

It was a pivotal goal for GFATM's existence to ensure sustainable funding for the local projects and to leverage additional financial resources from a variety of statist and private sources. Many global health activists blame the United States for underfunding the Fund and creating additional financial constraints to its existence. Indeed, there has been a significant gap between pledges and real inflows of money that becomes the gap between inflows and necessary disbursements to fight AIDS locally (Feachem 2004, 1139). According to the initial plan, the necessary funding was estimated to be $ 710 billion annually (Attaran and Sachs 2001). Ironically, despite the fact that no international actor pledged to support the Fund in full, no organizational mechanisms preventing the underfunding were put in place.

The Fund III: international support

International support for GFATM as a leading force in the AIDS regime creating was quite amazing. GFATM has been institutionally trapped, as different international players have been articulating drastically dissimilar expectations on the purpose, scope and future of the Fund. Actors as diverse as global health activists, members of transnational epistemic communities, the U.S. governmental officials, and the UN leaders all envisioned the Fund's role as close to their own aspirations and internalized norms. Obviously, too high a level of global expectations led to the dissatisfaction with reality, and spurred heated political debates. Initially, GFATM's potential leadership role of the new fund was envisioned as indispensable (Poku 2000, 294).

GFATM was envisioned to forge robust and durable IGO-INGO relationships and create a system of donor-leader-provider continuum, based not just on some ad hoc inflows of money, but rather to provide "… an alternative to the traditional isolation of the involvement of civil society, NGOs, faith based organizations and private sector…, ensuring that the public sector and private sector work side by side, enlisting the help of all segments of society to succeed in the challenge of controlling HIV/AIDS" (GFATM 2002). GFATM was also meant to be the central node of the loose AIDS network (including International AIDS Vaccine Initiative, Campaign to Stop Global AIDS, International AIDS Trust, International HIV/AIDS Alliance, Hope for African Children Initiative, Stop AIDS Campaign, AIDS Education Global Information System, AIDS-Bells, International AIDS Economics Network, and others). These big tasks have not been achieved yet. All their speculations reinforce the intra-organizational goals of the Fund and attack PEPFAR. As a result, less attention is paid to more practical issues identified above.

The commitment-building process "to fund the Fund" started relatively late. Most of the money comes from the U.S.—PEPFAR (which initially was never intended to finance the Fund as its major organizational priority). Over several years, President Bush urged the rest of the developed countries to contribute at least 1/3 of contributions, compared to the U.S.'s amount of financing. The possible option for ensuring financial sustainability and to survive in the long-term perspective was to bring the private sector on board. At the same time, the private sector itself was regarded with some suspicion at the Fourth Board meeting (GF/B4/6b), as only Bill Gates and Kofi Annan have made substantial contributions to the Fund so far. Resource dependency precludes the Fund from becoming a central node of the global health governance. Financial dependence, among other things, implies that GFATM cannot be overtly critical of what it may perceive as malpractice and cannot be aggressive to pursue its own global health agenda.

Summary

To sum up, the activities of both programs reify narrow intra-institutional preferences, but in their own peculiar ways. If PEPFAR is part of the U.S. agenda and does not pay much attention to the locally affected population, GFATM is led only by the local proposals and is not implementing its own strategic vision, while constrained by the level of financial inflows controlled by the US. Indeed, GFATM's objectives are set towards satisfying the locals (outsiders to the Fund itself). As a result, both programs serve their own purposes, as opposed to creating a new regime.

ENTERPRENURS: FRUSTRATION AND DISTRUST

Today, political leaders, activists, experts and NGO workers are still divided on crucial question who should lead in response to the pandemic, how to be most effective in its curbing and which knowledge is most relevant? Identity-based political debates aggravate the whole situation around potential AIDS regime. Global activists confuse the nature and the scope of the problem even more, as they tend to take sides on moralistic, not knowledge-based grounds. Critique of PEPFAR is often delivered in a very generic way. At the Bangkok XIV International AIDS Conference, groups of health activists (Treatment Action Campaign—South Africa, Global Health Alliance, and the Australian Federation of AIDS Organisations), vehemently attacked and shamed PEPFAR as the U.S.'s hypocritical project, motivated by the U.S. political and corporate self-interests and also supporting

religious fundamentalists in African countries. This argument may have only limited credibility, as PEPFAR supports abstinence as one of the prevention techniques, but, at the same time, it sponsors treatment even more.

The other point of frustration is the low level of funding for GFATM. According to Paul Zeitz*,* funding should be based on the perceived needs and the estimated costs of countries and ASOs proposals, and ad hoc funding should be replaced by regular annual contributions (Macdonald 2005, 299). This calls not only for the primacy of the international institutions over the donor-countries and their leadership, but sets up unrealistic expectations. At the same time, the majority of global health activists (Citizens for Global Action, GAP, and Essential Action Campaign) cast a blind eye to all the inconsistencies and rising problems of the Fund. They tend to speak about it as if there is the widely-shared consensus on its efficacy, leadership role, and the hindering role of PEPFAR in underfunding the Fund (*Fund the Fund campaign*).

American-based pharmaceutical companies remain the primary source for providing antiretroviral treatment. Critics of PEPFAR indicate that the drugs for Africa will be purchased from the U.S. pharmaceutical giants at the American price and cheap generics will not be allowed, and therefore much of the given money will be returned to the United States. This issue is of course more problematic than presented by activists. There are three interrelated problems often conflated into one: "safe" regulated drugs vs. generic drugs move to the markets, "patent right vs. patient rights," and differential vs. uniform pricing for therapies. Tobias, for instance, has clearly articulated his position that only safe and regulated drugs should be disbursed for the PEPFAR needs, but remained somewhat silent on the other ones. To date it is not clear how all the issues will be resolved, whether the treatment funds will be expanded or not, whether generic drugs will be fully allowed or with some restrictions.

Many observers hail international AIDS conferences as a potentially advantageous place for transmitting new knowledge to decision-makers. Yet, historically there is not a very strong U.S. presence in the international conferences (Gordenker et al 1995). At these conferences, health activists essentially call for the strict agreement on norms of anti-AIDS combat as understood by activists themselves, which—for practical reasons—is not necessary, if the global programs can aggregate these diverse perceptions into procedural consensus. In this light it is not surprising that international conferences (Johannesburg, Barcelona, and Bangkok) seem to have little influence on the decision-makers. Large-scale international conferences were not productive in building an agreement among the AIDS-related organizations. Sometimes, in the processes of talks more cleavages, disagreement, and almost hatred were raised. Put differently, these conferences precluded institutional bargaining among major actors in the leadership roles to occur.

Bush seems to push PEPFAR, but its leadership in terms of legitimacy and credibility is very much challenged by global policy entrepreneurs and local practitioners. Indeed, Bush's appointment of Tommy Thompson and Randall Tobias to the positions of global health leaders seems to be quite problematic. Randall Tobias, formerly CEO of Ely Lilly and a member of the Pharmaceutical Research and Manufacturers of America (PhRMA), was appointed to administer PEPFAR as the US Global AIDS Coordinator in the rank of ambassador. He has good credentials for his work as CEO, but he lacks of any experience with AIDS, Africa, or complex interorganizational relationships. He also lacks any experience about how to deal with activists and how to promote an attractive image for a global social program. Furthermore, Tobias is often believed to sneak his corporate agenda into the public health area (Talbot 2003). Thompson had been chosen as chairman of the board of GFATM, while keeping his appointment at Human and Health Services. He replaced a representative from Nigeria, and

demonstrates little interest in fighting AIDS per se. In a recent meeting in Abuja, he spent virtually no time at GFATM. It seems that both Tobias and Thompson are entangled by their institutions' constraints and are not communicating with epistemic communities, who can potentially clarify the nature and scope of the pandemic and can pinpoint focal points for resource application.

CONCLUSION

The president of the international council of *Medicins sans Frontières* (MSF) James Orbinski in 2001 called for a more prominent and assertive role of the World Health Organization (WHO). But many analysts ascertained WHO's actions as policy leadership failure. WHO—an organization that is by definition in the center of the global health governance—even in the early 1990s lost its leadership, which never has been reasserted (Lee et al 2002). The current wave of participants has to deal with those unclear legacies of the past choices, which seemed either irrelevant or irreplicable.

As the epidemic itself is immensely complex and multidimensional, the process of issue-framing is relevant as to providing necessary updates of new aspects and changing trajectories of the problem, to give an innovative and relevant grip on its curbing. Contrary to the expectations of many, it seems that framing AIDS as a security issue has not improved global governance of AIDS much, because the new knowledge was little reflected in global programs. In general, design of AIDS programs and the way resources are disbursed demonstrate diversion of money and efforts among too many possible points of application—generally reflecting AIDS as a medical and health infrastructure problem. In essence, the initial idea to frame AIDS as a security issue was obscured over three years. From this assessment, several ideas emerge on ways how the failure of regime formation can be overcome.

Dissimilar epistemic groups are not transmitting effectively their particular understanding of the pandemic to the powerful decision-makers and important stakeholders. One of the possible ways of rectifying this is to have WHO's Commission on International Security and Health work in collaboration with the Commission on Macroeconomics and Health. These two commissions could become a linking-pin between several security sub-frames, which are disjointed now. Some complimentary initiatives (including the Holbrooke-led Global Business Coalition against AIDS) need to be supported and thus create a critical mass of global health entrepreneurs. Today, we face an opportune moment, when many global leaders can serve as facilitators. Among the potential facilitators are Dr. Peter Piot (UNAIDS head), Richard Holbrooke (Global Business Coalition) and former President Clinton (Clinton Foundation HIV/AIDS Initiative). Kofi Annan, one of the creators of the Fund, can be asked to serve as its executive director, after stepping down from the secretary-general position. Many health activists groups should be encouraged and provided real incentives to stop their role as obstructers. They should be integrated in the daily on the ground work of both PEPFAR and GFATM. Deepening antagonisms between donors and recipients, the United States and GFATM, and Thabo Mbeki of South Africa and local interests groups proved to be counterproductive and should be meaningfully addressed and mitigated. Private-sector actors should be addressed more vigorously. There is no space for incredulity towards the private sector actors.

As mentioned above, on the positive side, the initial framing of AIDS as security issue has already elevated President Bush's initial commitment to the cause of HIV/AIDS. It is important at this point to indicate how both PEPFAR and GFATM programs can reflect AIDS issue-framings as a security issue, how they can actually incorporate recent insights of the KBAs. Among the first measures, PEPFAR and GAFTM ought to select countries

where it is still possible to catch the pandemic at the early stage and reverse its effects. If some societal groups are decimated, they will contribute to the overall societal degradation and destruction. These subpopulations include military, police, civil servants and teachers. Innovative programs to reintegrate orphans as productive members of the developing countries should be developed. Also, more vigorous attempts should be made to deal with the disastrous situation in the refugee camps, which today are among one of the most powerful and rapid vehicles of the virus transmission.

We should anticipate new waves of complex AIDS-related emergencies, including the second wave of HIV crises in major regional powers, such as China, India, and Russia. In those countries, along with enduring local military conflicts, HIV/AIDS can increase the likelihood and severity of acute crises. Leaders of these countries should be invited to international fora to discuss AIDS as security issue. These countries are of paramount importance to keep regional stability intact. Estonia, Kyrgyzstan, Moldova, Iraq, etc and others desperately need to be included into PEPFAR. GFATM also should prioritize these countries, and stop disproportionate funding for the states that either have an excellent record in curbing AIDS (Uganda), or have enough resources to do so without active intervention.

PEPFAR and GFATM should make their general disbursement conditioned on the success of eradicating the disease within critical subpopulations. The donor states must make sure that the increase in funding for GFATM and PEPFAR, as well as other potential emerging programs, is conditional on the abovementioned factors. Increasing funding for any such intermediary funding programs should be based on demonstrated effectiveness toward achieving concrete objectives not simply because a program can distribute them. The fact that GFATM can disburse more money for the awaiting grantees does not ensure the quality of targeting and prioritizing. GFATM is awaiting an organizational reform. The breakthrough is yet to come.

There is an urgent need to create a donor-recipient continuum, where International Governmental Organizations, Nongovernmental Organizations and AIDS Service Organizations are part of a sustainable chain. Closer interorganizational partnerships should be established, especially between GFATM and PEPFAR on one side and the World Bank, IMF, and especially Food and Agricultural Organization (FAO) on the other. If global leaders want even to approach to tackle AIDS as an economic problem, the intervention along with other organizations breaking famine and chronic poverty cycles is required. This challenging task requires as unprecedented level of awareness, intra-organizational coordination and committed resources. Agencies should recognize they are only part of a much larger international response, and should therefore be clear about what they can and cannot do.

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