Health & Place 18 (2012) 447–452

Contents lists available at SciVerse ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

Guest Editorial

# Local pain, global prescriptions? Using scale to analyse the globalisation of the HIV/AIDS response

A R T I C L E  I N F O

*Keywords:*
Globalisation
Local-global
Scale
Agency
Aid
HIV and AIDS

## 1. Introduction

How can we best characterise the contexts that shape opportunities for members of HIV-affected communities to respond to the challenges of prevention, care and treatment and to derive optimal benefit from associated interventions? Can the concepts of space and scale, and more particularly concepts such as 'local' and 'global', help us to develop actionable understandings of these contexts? What is the nature of HIV-mediated global interconnectedness, and how does it open up or close down opportunities for increased agency amongst the so-called beneficiaries of global funds and programmes?

Billions of dollars of aid have been poured into HIV/AIDS responses in low and middle income countries, often with disappointing results. Thousands continue to be infected every day, with new infections out-pacing the scale-up of access to antiretroviral therapy (ART) in a ratio of 5:2 (WHO, 2008a). Furthermore, in ever-shifting political and economic climates, the sustainability even of current levels of ART provision is not assured. Millions of people continue to die from a preventable and treatable disease, and the epidemic continues to be a massive crisis, wreaking untold levels of suffering.

A key obstacle to programme success is the lack of resonance between biomedically and behaviourally rooted interventions and the social identities of AIDS-vulnerable community members (Seckinelgin, 2008). This is particularly vital in the context of a disease that interfaces so closely with people's psycho–social experiences of the fraught areas of death, sexuality and gender relations (Campbell, 2003). In an attempt to accommodate this insight, the 'empowerment' and 'mobilisation' of vulnerable communities are now a pillar of international AIDS policy (AIDS2031, 2010; UNAIDS, 2007, 2010a). These are considered essential for (i) 'translating' intervention approaches into locally and culturally appropriate discourses and practices; (ii) building local capacity to sustain interventions once their funded period is over; and (iii) strengthening health systems in affected settings. The challenge of 'mobilising communities' is notoriously tough, however, with growing calls for greater attention to how the 'contexts' of community mobilisation programmes shape their possibilities for success (Campbell and Cornish, 2010).

To better understand the contexts of interventions, recent scholarship has begun to examine the workings of the 'global AIDS industry' (Nguyen, 2005) or 'global governance of AIDS' (Seckinelgin, 2008), as manifest in, e.g. global health initiatives, international drug trials and trans-national activism (Ingram, 2010; Richey and Ponte, 2011; Petryna, 2009). From a different starting-point, we recently co-edited a special issue of *AIDS Care* (Cornish and Campbell, 2010) addressing the contexts of local community mobilisation programmes in low income countries. Whilst no specific effort was made to focus on local–global relations, a central theme that emerged was how the uneasy interfacing of 'local' and 'global' systems of power/knowledge undermined programme success.

Papers illustrated how efforts to strengthen local responses to HIV were undermined by the top–down, prescriptive nature of the global funding architecture (Kelly and Birdsall, 2010), gaps between donor and local understandings of core concepts such as 'gender' (Mannell 2010) and 'health' (Vaughan, 2010), the positioning of communities as passive recipients of aid rather than agents of their own health (Aveling, 2010), and the uneasy fit between donor and indigenous styles of response (Campbell, 2010; Cassidy 2010). Papers repeatedly illustrated how the health-related experiences and worldviews of grassroots communities ('local' power, knowledge and interests) were subordinated to the imperatives of international experts and funders using western, individual-focused biomedical and behavioural models

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doi:10.1016/j.healthplace.2011.10.006

of health, illness and healing ('global' power, knowledge and interests).

Against this background we convened a workshop at the London School of Economics in September 2010, attended by geographers, anthropologists, social psychologists and scholars of development and social policy. The workshop discussed the value of the 'local–global' concept in making sense of the complex alignments and misalignments characterising the interaction between top–down international responses to HIV and the bottom-up needs of vulnerable communities. 'Local–global' was conceptualised in terms of dynamic and reciprocal flows of resources, knowledge and influence between donors and target communities, mediated by national and regional relations, and material and biological constraints, Within this context we sought to examine how internationally funded programmes served to open up or close down opportunities for HIV-affected communities to exercise agency in relation to their sexual health and well-being. A selection of workshop papers constitutes this special section of *Health and Place*.

By 'local' we refer to the spatially defined communities that are the target of HIV interventions (given that public health programmes almost invariably take spatially defined communities as their unit of focus). Of course, identities in what we call local communities are fluid and permeable, often intertwined with global processes across great distances—in ways that problematise a simple 'local–global' binary. By 'global' we refer to the self-styled cluster of mostly northern donors and policy-makers who overwhelmingly shape what issues are considered important in the HIV response, and who steer and fund programmes. The actions and identities of global actors and agencies are also hybrid, both constrained and enabled by their engagements with the local communities they target. However, as we will argue below, such constraints may be weaker where 'global' actors have greater access not only to political and economic power but also to life itself.

Using 'local–global' language as a strategy for asserting power (Swyngedouw, 2002), it is these actors themselves that have styled themselves as the 'global' community, singling out HIV/AIDS (rather than e.g. tuberculosis or malaria) as an issue of 'global' significance, labelling it as a global 'emergency' and a 'threat to global security' (Elbe, 2009; Ravishankar et al., 2009). It is through the use of such language that powerful groups justify their claims to intervene in the lives of millions around the world, and to shape the terms of intervention (Fassin and Pandolfi, 2010). As such, HIV is as much an ''epidemic of signification'', as a medical epidemic (Treichler, 1988:357). This preoccupation with HIV has been linked to its anxiety-provoking connections with the taboo issues of death and sexuality (Crawford, 1994), where globalisation increasingly facilitates opportunities for sexual contact across the tightly policed unconscious cultural boundaries between the west and its imaginary 'Other' (Douglas, 1991; Said, 1995).

Below, we begin by framing this special section within a brief overview of the 'global health initiatives' (Hanefeld, 2010) that dominate current responses to the epidemic. We then discuss current debates about the use of scalar concepts such as 'local' and 'global'. Finally we provide a brief reference to research in this area, concluding with an overview of the special section's papers, and calling for the more explicit and self-conscious use of scalar concepts as tools for analysis and action.

## 2. Background: global policies, local agency?

Worldwide 33.3 million people are living with HIV/AIDS (UNAIDS, 2010b). Whilst the interface between poverty, marginalisation and HIV vulnerability is a complex one, globally women and young people tend to be the most vulnerable, with poor people and people in rural areas having the fewest opportunities to access and benefit from services (ibid.). A significant proportion of funding for interventions emanates from the global North. For example, in 2006, money from the US PEPFAR (President's Emergency Plan for AIDS Relief) constituted 62% of AIDS resources in Zambia, 73% in Uganda and 78% in Mocambique (Hanefeld, 2010). Funding has often been allocated through top–down processes with little consideration of community interests (Edström and MacGregor, 2010). There is often an emphasis on short-term programmes, evaluated in terms of numbers reached, with relatively little investment in local infrastructures, and the bulk of funding paid to international rather than local development agents. Where international agencies engage with states in poor countries, this often takes the form of efforts to transform state understandings of their national interests, and of the costs and benefits of particular policies, to fit agency perspectives (Seckinelgin, 2009).

Such funding has resulted in a deluge of technical programmes: HIV awareness, condom distribution, peer education, voluntary counselling and testing, home-based care, drug treatments, support groups, cash transfers for impact mitigation and so on. These constitute a complex edifice of responses seeking to change people's sexual behaviour or improve their access to services through intervening in their customs, relationships and worldviews. There has been less attention to the strengthening of health systems, and the building of in-country capacity to exercise effective programme leadership or to optimise the 'goodness of fit' between programmes and communities.

The greater a country's economic dependence on donor funding, the less they are able to shape the conditions under which funding is accepted, no matter how much lip service is paid to country consultation mechanisms and community representation (Hanefeld, 2010). There are growing calls for systematic attention to the impacts of the 'global' health industry at country and sub-country levels, and the extent to which 'local' communities benefit from programmes (Biesma et al., 2009).

Critics of the international development apparatus (e.g. Escobar, 1995; Ferguson, 1994), have long argued that it sustains social inequalities through 'depoliticising' social problems—conceptualising them as technical rather than political, and solvable through neutral systems of (e.g. biomedical) expertise, with no attention to the role that redistribution of political and economic resources would need to play in tackling inequalities (WHO, 2008b). Harcourt (2009) highlights how the Millenium Development Goals draw attention away from the impacts of women's oppression on poor levels of female reproductive health, emphasising instead the need for increased medical services (opening up markets for western health and pharmaceutical interests), with little attention to factors that prevent women from benefiting from services. Harman (2010) argues that the funding of AIDS interventions is often motivated more by wealthier countries' desire to extend their economic and political interests, than by a commitment to tackling the social drivers of poor health.

However, others argue that even in conditions of an apparent one-way flow of money and influence, less powerful countries and communities may subvert international donor agendas and appropriate resources in ways that are more reflective of their own needs and interests than radical critics would suggest (Cassidy, 2010; Mosse, 2005). They shy away from viewing power as a monolithic entity, possessed by some groups and not others, and inevitably wielded by the strong against the weak, and reject the implicit dualism between all-powerful international development agencies and the powerless impoverished sick. Citing Foucault, they argue that power can be productive as well as repressive, and that wherever power is wielded, there lies the

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