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The global governance of success in HIV/AIDS policy: Emergency action, everyday lives and Sen's capabilities

Hakan Seckinelgin *

Department of Social Policy, London School of Economics and Political Science, Houghton Street, London WC2A 2AE, United Kingdom

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ABSTRACT

The article explores how the social construction of 'success' by program funders foregrounds the role of biomedicine in advancing health, with no attention to the wider social contexts that make it possible for poor people to use this medicine to advance their health. The article considers the impact of the governance of the disease in Burundi. The case study highlights the disjuncture between the assumed ideal governance of the disease and people's needs to obtain healthy lives.

LADVENU Joan! Joan!
JOAN Yes: they told me you were fools *[the word gives great offense]*, and that I was not to listen to your fine words nor trust to your charity. You promised me my life; but you lied *[indignant exclamations]*. You think that life is nothing but not being stone dead.
(G.B. Shaw—Saint Joan/Scene VI/3)

1. Introduction

The aim of this paper is to critically reflect on the nature of the overall policy thinking that is currently framing international HIV/AIDS policies. I focus on the way program success is considered. Globally imposed and top-down understandings of success have often had little resonance with the lived realities, needs and possibilities of the lives of the communities that are targets of international policies and programmes. This dissonance between assumed boundaries of success and localized needs substantially reduces the potential benefits of drug treatments to improve people's lives. I am interested in the relationship between global policy logic in this field and how it frames the assessment of the success of policy interventions that are implemented. What should be the measure of success in relation to global HIV/AIDS policies? The paper takes it as given that treatment is a human right. Its aim is to consider antiretroviral treatment (ART) as an example of an international policy intervention within its larger social context.

The ongoing considerations of success in rolling out ART are broadly judged in terms of the number of people having access to these resources (see Economist 2011). This position is a function of the international HIV/AIDS policy thinking that has framed the disease from an emergency and medical crisis perspective. This framing focuses on reaching the largest number of people who have access to ARTs as a measure of the success of international policy on this issue. However, a more contextualized assessment that considers people's actual use of ART over time and the conditions under which they might potentially benefit from these resources is mostly missing.

This paper argues that this gap between 'numbers reached' and the likelihood that those reached will derive optimal benefit from the drugs is linked with the way the policy is framed within the international policy context. The paper seeks to assess the success of international ART policy through looking at ART delivery and efficacy in the context of real peoples' lives, seeking to go beyond more abstract considerations of ART being medically available. In order to do this the paper, in the first section critically considers the policy logic within which ART provision is made available in resource poor settings. It argues that the international context can best be understood as the result of an intersection of the emergency and medical crisis perspectives that have framed international policy thinking. The second section looks at a case study provided by research in Burundi. It also considers how overall HIV/AIDS intervention strategies set the context within which ARTs are made available in Burundi. In this section a number of obstacles to ART delivery are identified through drawing on people's reflections on the way they have taken part either in ART delivery or as the beneficiaries of ART. The discussion reveals a set of concerns based on people's experiences that show: (a) the importance of treatment in peoples' everyday lives; and (b) contextual real-world issues that are central for ART policies to achieve their aims. They point out a gap in thinking between success as *availability* and success as *effectiveness in people's lives in particular social contexts*. This

* Tel.: +442079556038.
E-mail address: m.h.seckinelgin@lse.ac.uk

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section highlights a much more contextualized set of needs and concerns for framing the assessment of the success of ART delivery programmes that go beyond the mere availability of the drugs. The paper's final section proposes a way of considering the assessment of success on the basis of people's experiences. This is done by engaging with Amartya Sen's ideas on capabilities.

2. Question of policy success and its interpretations

The question 'How do we think about success?' motivates us to unpack foundational assumptions driving policy thinking. According to David Mosse there is no single criterion to assess a given policy either as a success or a failure (2005). He states that '"development success' is not objectively verifiable but socially produced. It is an institutional process not an objective 'fact"' Mosse, 2005, p. 172). Thus, he urges us not to think about success as an abstract or ideal quality. If we agree with this thinking on success, there are a number of subsidiary questions that are relevant here: who decides what will be a success? Who are we trying to satisfy with success? These questions suggest an inherent link between narratives of success and the conceptual framing of policies that set out what these policies are trying to achieve. While underlying assumptions produce and support a particular view of success, such narratives of success in turn maintain the status quo for a given policy position. Mosse argues that success is about the way policy environments (projects in the case of Mosse) 'sustain [the] policy models offering a significant interpretation of events' (2005, p. 181). Another aspect of this argument is the way policy actors expand their reach by attributing agency to other actors such as non-governmental organizations, which gradually brings them into their policy domain representing their particular world view (Seckinelgin, 2006). The process of enrolling others into the network is a process similar to 'institutionalization' (Seckinelgin, 2008).The practices of institutionalization are underpinned by a set of assumptions both to facilitate communication among the emerging policy networks and to provide an interpretive framework for their activities. As Mosse's work demonstrates, these practices highlight commitments to specific ways of thinking and dealing with identified policy problems. These also become policy commitments and practices. The outcomes of such commitments are interpreted according to how far they fall within the framing assumptions. The experiences of policy or project *beneficiaries* are considered in relation to the already set limits of the expected success. This raises the question of how far members of target groupings and their experiences of a given policy contribute to the articulation of a success story. Thinking about policy success in the HIV/AIDS policy field urges us to consider the assumptions underwriting international HIV/AIDS policies, the way they are used as interpretive tools and the way they impact implementation processes.

Global HIV/AIDS policy thinking emerged from dealing with HIV/AIDS-related problems after a long activist battle within industrialized countries (Seckinelgin, 2002). Many felt that the situation in developing countries represented a major crisis. Comparisons between developed and developing countries in how resources were allocated to deal with the problem created a moral outrage that 'demand[ed] response' (Redfield, 2010, p. 174). In this vein international debates on HIV/AIDS and policies associated with them followed what is broadly defined as an emergency framework (Barnett and Whiteside, 2001; Seckinelgin, 2008). This framing was closely linked to the 'crisis' language that was used to define the situation as an imminent disaster in relation to HIV/AIDS across in the global south and particularly in Africa. The identification of the situation as a crisis allowed action to be considered within the idiom of emergency. However, in time two descriptions of the situation, crisis and emergency, have reinforced the existence of each other. As suggested by Redfield, these conceptual frames imply 'temporality focused on the present and closely tied to action' (2010, p. 187). There are two important implications of this move to talk about crisis requiring emergency action. On the one hand it designates the situation as exceptional, in comparison to the normal state of affairs (Huysmans, 1995; Fassin and Pandolfi, 2010). On the other, it immediately authorizes action by certain actors while particular others are designated as the beneficiaries of this action. If both sides are brought together a 'zone of exception' is created as a domain for those actors authorized to intervene. The process of articulating the zone of exception, as argued by Adi Ophir, also defines the populations and regions exposed to the crisis (2010). The emergency framing is 'one way to account for the condition of a given population' (Ophir, 2010, p. 62). This accounting constitutes the social body that needs to be protected. In moving into the zone of exception, everyday lives become recalibrated and narrated according to the crisis framing. Furthermore, this move locates people within the temporality implicit in the emergency logic, which is framed according to the perceptions of the actors framing the situation. This creates a disjuncture between a person's life course and her life in relation to the emergency.

In the context of international HIV/AIDS policies the zone of exception is created on the basis of the medical authority of the international experts. McFalls argues that this process leads to 'therapeutic domination,' which 'without any reference to culture or to history … reduces social agents to human bodies' (2010, pp. 322–323). There are several important implications of this: a) the scientific rationality of medicine operates as the mechanism to legitimate the claims of agency by international actors; b) people with or affected by HIV/AIDS are constructed as passive receivers of policy interventions and c) people's lives are constructed according to the medical priorities of HIV interventions independent of their actual lived experiences within their context. International actors and their associates such as non-governmental organizations, become 'dominant actors' as they are considered to have authority to make claims about HIV/AIDS either on policy content or implementation priorities (McFalls, 2010, p. 322). The framing of the disease together with proposed solutions to many problems it articulates is referenced to the agency of external experts.

Within this international HIV/AIDS discourse, policy instruments have been broadly based on targeted interventions that select and define their target groups and structure their policy directly in relation to a defined policy imperative. This approach, known as vertical policy intervention, has dominated thinking and implementation in this area. In this approach the central assumption is the consideration of the disease as an emergency, both for people who are sick and for the communities and societies in which they live. People are targeted to enable them to survive and deal with the implications of the disease. They are also targeted so that they can continue to perform their socio-economic roles within their communities.

The ART roll-out campaign in Burundi represents a typical case of vertical intervention policy. A recent joint progress report by the WHO, UNAIDS and UNICEF: *Towards Universal Access* (WHO, 2009) elaborated the criteria by which to measure progress by explaining what is meant by access. According to the report access is a multidimensional concept: it defines ART availability in terms of reachability (physical access), affordability (economic access) and acceptability (sociocultural access) of services. 'Coverage is defined as the proportion of people needing an intervention who receive it'. It 'is influenced by the supply or provision of services, and by the demand from those who need services and their health-seeking behavior'; 'outcome and impact are defined