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Global Public Health

New life in old frames: HIV, development and the 'AIDS plus MDGs' approach

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There have been recent indications that AIDS' primacy amongst global health issues may be under threat. In this article we examine a new response to this perceived threat to have emerged from the AIDS policy community: the 'AIDS plus MDGs' approach which argues that the AIDS response (the focus of MDG6) is essential to achieving the other MDG targets by 2015, and which stresses the two-way relationship between AIDS and other development issues. In framing AIDS in this way, the AIDS plus MDGs approach draws on a well-established narrative on the existence of a 'virtuous circle' between health and development, but at the same time makes some important concessions to critics of the AIDS response. This article - the first critical academic analysis of the AIDS plus MDGs approach – uses this case to illuminate aspects of the use of framing in global health, shedding light both on the extent to which new framings draw upon established 'common sense' narratives but also on the ways in which framers must adapt to the changing material and ideational context in which they operate.

Keywords: AIDS, framing, AIDS plus MDGs; development, poverty, MDGs

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Introduction[1]

It has become almost a cliché to state that AIDS is not simply a health issue but rather a multisectoral one. Indeed, this insight is generally put forward as one of the key reasons for the creation of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 which took over the role of co-ordinating the UN-wide response to HIV and AIDS from the WHO, a body which had previously been widely criticised for its narrow, biomedically-focussed response to the epidemic (e.g. Das and Samarasekera 2008, Lisk 2010, pp. 22-3). Whilst many national ministries of health were initially resistant to adopting a multisectoral approach, the argument that the full engagement of all sectors of society is a prerequisite for an effective AIDS response was forcefully made throughout the 1990s, and widely institutionalised through the creation of National AIDS Commissions (NACs).[2] Linked to these ideas about the peculiarly multisectoral nature of AIDS are ongoing discussions concerning 'AIDS exceptionalism'. Proponents have argued that the challenge of AIDS requires an exceptional response, which in turn has positive spill-over effects for other global health issues and for development more generally. Others, however, have argued that the huge focus on AIDS has had a distorting effect upon global health and development priorities and that it should be normalized and treated like any other disease.[3] This debate continues.

One explanation which has been put forward in the literature for the degree of prioritisation which AIDS has enjoyed over the last 15 years is that the AIDS policy community have been particularly successful at framing and re-framing the issue at various times and in various ways to capture high-level political attention (Shiffman 2009, Rushton 2010). As Shiffman (2009, p. 609) notes, 'HIV/AIDS has been framed as a public health problem, a development issue, a humanitarian crisis, a human rights issue and a threat to security.' Whilst all these arguments have indeed been made to motivate and justify

responses to AIDS in the Millennium Development Goals (MDG) period (2000-2015), this paper views the linkage between AIDS and development as having been a particularly resilient and powerful framing of the issue, and one of the major reasons for its central place in contemporary global health governance.

There have, however, been recent indications that AIDS' primacy amongst global health issues may be under threat. It was widely noted following the MDG review summit held in New York in September 2010 that momentum seemed to be shifting towards a greater emphasis on other health issues such as malaria, child mortality and maternal mortality, potentially undermining political and financial commitment to the fight against AIDS. In this article we examine a new response to this perceived threat to have emerged from the AIDS policy community: the 'AIDS plus MDGs' approach which argues that the AIDS response (the focus of MDG6) is essential to achieving the other MDG targets by 2015 (UNAIDS 2010b, p.1) by stressing the two-way relationship between AIDS and other development issues. We see this as a rearguard action, involving the (re)framing of AIDS as a development issue through the forwarding of the claim that there is a mutually reinforcing relationship between AIDS and development, which infers positive external effects from AIDS investments to other areas of development and vice versa. In framing AIDS in this way, the AIDS plus MDGs approach draws on (or 'resonates with') a well-established narrative on the existence of a 'virtuous circle' between health and development whilst at the same time making some important concessions to critics of the AIDS response. However, the framing of future responses to AIDS in the AIDS plus MDGs approach presents it as necessarily co-dependent on other structural, social and developmental investments and needs (such as in terms of education or poverty alleviation), casting the AIDS-development dynamic in terms of a two-way, interdependent relationship. In this respect, it represents a subtle yet significant

shift from the framing of the disease associated with the decade following the initiation of the MDGs.

As the first critical academic analysis of the AIDS plus MDGs approach, we specifically aim to illuminate such use of framing in global health, shedding light both on the extent to which new framings draw upon established 'common sense' narratives but also on the ways in which framers must simultaneously adapt to the changing material and ideation context in which they operate. Consequently, the paper serves to ensure an original and significant contribution to knowledge which will extend and enhance existing literature on the framing of AIDS as a development issue in the context of contemporary studies of global health governance (GHG).

The article proceeds in two stages. We begin by briefly discussing the historical framing of health (and subsequently AIDS) as an economic development issue, and the centrality of the idea of vicious and virtuous circles to this narrative. Indeed, the conventional wisdom that health and underdevelopment form a vicious circle – in which poor health (including AIDS) increases poverty and hampers economic development (which in turn undermines health) – or a virtuous circle – in which investing in health can promote productivity and economic growth, further improving health and opening up possibilities for further increased health investment – has become widely accepted as common sense. However, we suggest that the MDG 'period' has been characterised by policy approaches that have laid greater stress on health investments as the point of entry for solving the wider problem of development and poverty alleviation, or as the means of making a vicious circle virtuous. Indeed, the ways in which this idea has been operationalised in practice, including a focus on specific diseases, has been subjected to considerable criticism, not least because of the causal weight and significance that has been attached to the role of 'select' health

investments as a route out of poverty. AIDS – the largest 'select' single-disease programme by far – has borne the brunt of much of this criticism.

The second part of the paper moves to a detailed analysis of two of the key documents setting out the 'AIDS plus MDGs' approach. It notes that whilst in many respects the approach represents a continuation of established health-development arguments (including the idea of a virtuous circle) there is also significant evidence of adjustment to the framing of AIDS, and that the AIDS plus MDGs discourse responds to some of the criticisms of previous approaches and seeks to promote a more holistic vision of the links between AIDS and development. In our conclusion we offer some thoughts on what the AIDS plus MDGs approach can tell us about the changing landscape of global health governance, the position of AIDS within it, and the use of framing in global health.

Health, poverty and development: establishing a narrative

We begin with a discussion of how health came to be framed as a key causal factor in producing and reproducing poverty and underdevelopment. Framing poor health as a development issue – or, more accurately, as an issue linked to economic development and economic growth – has been a feature of the international development discourse for many decades. A seminal moment in the elevation of this narrative to the top tier of global development policy was the World Bank's hugely influential 1993 World Development Report *Investing in Health*. Not only did the report focus exclusively on health, it suggested that poor health was a primary obstacle to development and justified investment in health in terms of poverty alleviation, net economic return on investment, and in terms of horizontal spill-overs of such investments to other areas of development. Crucial to this case was the idea of the potential for a virtuous circle between health spending, productivity and economic development. Investments in health were held to be cost-effective (as compared to other

development stimuli), and justifiable in terms of the economic and social returns:

> Good health, as people know from their own experience, is a crucial part of well-being, but spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness. The economic gains are relatively greater for poor people, who are typically most handicapped by ill health and who stand to gain the most from the development of underutilized natural resources. (World Bank 1993, 17-8).

The virtuous circle narrative subsequently gained traction, coming to colonize the discourses of other high-profile development institutions, with the health-to-economic development linkage appearing increasingly natural and obvious. UNDP's 1996 Human Development Report, for example, noted that:

> Human development requires, among other things, considerable investment in education, health and nutrition. The result is a healthier and better educated population that is capable of being economically more productive. Indeed, many modern growth theories explain economic growth primarily in terms of expanded human capital... The links between human development and economic growth can make them mutually reinforcing. When the links are strong, they contribute to each other. But when the links are weak or broken, they can become mutually stifling as the absence of one undermines the other (UNDP 1996, 66).

For us, a critical juncture in the transformation of this narrative into a 'common sense' driver of global health and development policy occurred with adoption of the MDGs. Over the first decade of the twenty-first century the MDGs have become effectively synonymous with 'development', at least in global policy discourse. Concepts such as human development, poverty alleviation (which forms the focus of MDG1) and economic development have been collapsed into a more general notion of 'development policy'. Such has been the power of the

MDGs in channelling global development efforts that many of the previous debates over what development means (debates which continue within academia and civil society) have been dramatically downplayed. As Ollila (2005) points out, the policy space for other approaches to both health and development have shrunk as a result. The UN system, multilateral institutions and other actors have aligned themselves to the MDGs as an all encompassing multisectoral project, or the only development game in town.

Whilst the MDGs rest implicitly upon the virtuous circle idea that investing in health (and other key areas) can kick-start economic growth in developing countries, that argument was set out far more clearly in the 2001 report of the WHO-backed Commission on Macroeconomics and Health (CMH), the result of two years' work by a committee of 18 individuals (many of whom were economists and/or and former IFI personnel) under the chairmanship of Jeffrey Sachs, the influential Harvard (and later Columbia University) economist. The report represents a natural and conscious counterpart to the MDGs themselves, not least because it economically justified the selection of specific – or 'select' – interventions in global health and the setting of targets and measures (vis-à-vis population health and impact on economic measures such as GDP), and did so in the direction of poverty elimination and development. Indeed, the CMH was in part set up to bolster international support for the wider MDG process, and the report makes constant reference to them, but with health framed in terms of a special relationship with macroeconomic change. Moreover, Sachs later became the Director (2002-06) of the UN Millennium Project and Special Advisor to the UN Secretary General on the MDGs. The CMH's report's shares a common approach with previous framings of health as a target of investment which can lead to improvements in economic productivity, and thereby economic development whilst also presenting poor health as an obstacle to development: the vicious/virtuous circle argument.

Like the World Bank's 1993 report, the CMH sought to place health investments at the centre of global development policy.

At the heart of the CMH report are a series of assumptions which have direct implications for global health and, indeed, our later discussion of HIV/AIDS within this broad policy landscape. These assumptions, and their implications, were systematically deconstructed in Alison Katz's seminal pair of articles for the *International Journal of Health Services* (Katz 2004, 2005). Katz's textual analysis of the CMH was prescient in that it anticipated the manner in which the CMH would interrelate with and justify the operationalisation of MDG6 (in particular) under vertical disease-specific programmes, and the process whereby the framings of such interventions in terms of economic development would come to constitute a 'blueprint' for global health policy making (Katz 2004, 752). Among other things, Katz questions the basic virtuous/vicious circle 'common sense' which underpins the CMH, namely the supposed obviousness of a reciprocal causal dynamic between health, poverty and human development. For Katz, 'development' within the CMH report is a thinly-veiled shorthand for the objective of economic growth under conditions of neoliberal globalised capitalism, and she argues that within the Sachs commission's framing of the virtuous/vicious circle too much importance (or causal force) is ascribed to health with respect to poverty:

> The relationship between health and poverty is two way but it is *not symmetric.* Poverty is the single most important determinant of poor health. But poor health is very far from being the single most important determinant of poverty. Poor health exacerbates existing poverty. Both the vicious cycle and the "virtuous" cycle of health and poverty are misleading images, as they imply equal weight of the two poles of health and economic development. (Katz 2004, p.752, original emphasis)

Subsequently, Katz highlights the existence of alternative and arguably more significant determinants of poverty in developing countries than health. These include the skewed

international terms of trade (2005, pp. 179-80); the burden of developing country debt as compared to aid receipts and the failure of the Highly Indebted Poor Country initiative (p. 179); and western intervention (both military and economic) in such countries (p. 182). Thus, she argues, poor health should be viewed as *only one* outcome of, rather than principal driver of, these wider relations and structures (p. 176), and whilst investing in health will benefit the populations of developing countries it will not succeed in fundamentally addressing the problems of poverty and underdevelopment unless some of the other (and more powerful) root causes are also addressed.

Another of Katz's critiques, which has also been widely echoed by others (e.g. Faubion *et al.* 2011), is that despite the claims about health investments as a route out of poverty, the CMH in practice prioritises investment in specific diseases rather than a more holistic approach to public health, such as investments in sanitation and clean drinking water, which have been recognised to play a long-term, and dramatic role in improving population health. The assumption that short-term 'vertical' select interventions will provide the key to economic development belies the fact that interventions outside the healthcare system (for example in basic public health and other infrastructure) will prove far more effective in lowering the disease burdens suffered in developing countries, and that basic health is more forcefully determined by wider 'socio-economic, political and cultural variables' (Katz 2004, p. 761). It also moves attention away from 'horizontal' efforts aimed at strengthening health systems. For Katz, the specific disease-focussed, short-term, technological and biomedical nature of investments recommended by the CMH (and which have indeed tended to be prioritised in pursuit of meeting the MDGs), are ultimately neither as sustainable nor as effective as the obvious (but unfashionable) alternatives. The point is that it is not only 'investing in health' that matters, and that investing in select diseases matters less. Whilst for Katz, and indeed for us, investments in select diseases are admirable in their own right, and

were surely needed at the turn of the millennium as they are now, the real problem lies in the belief that they can serve the basis for a health-to-development strategy, the basic assumptions of which are already deeply flawed. Furthermore, the ways in which health investments are targeted was also to have a huge impact on the manner in which poverty and underdevelopment were addressed in the MDG process to date.

Crucially for our argument here, the MDGs placed AIDS in a privileged position vis-à-vis other global health issues and even other 'select' diseases. Although the MDGs set out measurable targets in respect of three health issues: infant mortality (MDG4); maternal mortality (MDG5), and HIV/AIDS, malaria, TB and 'other diseases' (MDG6), of these three so-called 'health MDGs' it is clear that (notwithstanding a renewed vigour in the area of childhood vaccination, reflected in the recent substantial refinancing of GAVI) HIV/AIDS has received by far the most sustained focus and has captured a huge proportion of the global health spend,[4] often at the expense of the 'competing' health MDGs (not to mention those health issues not covered by the MDGs).

For us, one of the most interesting results of this focus on AIDS has been the transposition of the broader 'common sense' narrative of health-to-development to a new common sense of AIDS-to-development, and that this has occurred despite evidence that the causal relationship between poverty and AIDS is far more complex that merely being poor makes you more likely to contract HIV' (Gould 2009), or that AIDS is the principal driver of global poverty. Nevertheless, investing heavily in AIDS has come to be a central pillar of international development efforts, working on the basis that investing in HIV/AIDS prevention, treatment and care helps to address one of the most significant obstacles to development (although, as Katz noted in relation to the CMH, this can in itself obscure some of the other fundamental causes of poverty and underdevelopment).

Indeed, both the privileged status of AIDS and its 'exceptional' status with regards to development have recently come under challenge, both intellectually and in policy terms. For example, Shiffman (2008) traces how international aid for HIV/AIDS has had a number of distorting effects on other areas of health aid and development, claiming that this has led to some loss of focus on some other key global health challenges, including stagnation in funding for strengthening health systems. Roger England (2008), on the other hand, takes a more radical approach which highlights that whilst AIDS accounts for 3.7% of global mortality 'it receives 25% of international healthcare aid', a fact which he sees as distorting international health funding; as out of proportion; as having the potential to cause disruption to (fragile) national health systems; and as a reason for immediate institutional reform in the shape of dismantling UNAIDS. In policy terms, as we discuss below, there has recently emerged a pervasive feeling that political attention is shifting away from AIDS and towards some other pressing global health and development issues.

It is clear that the AIDS community, and major AIDS institutions, in responding to these challenges are seeking ways in which to shore up the special status of AIDS. As we argue in the next section, they are doing so in a way which mobilises the established virtuous circle arguments, but which both repackages them for the contemporary policy context (in which there is a global emphasis on the MDG deadline of 2015) and also makes some significant concessions to the kinds of criticisms of 'silo-based' global health strategies which we have examined here.

The AIDS plus MDGs Approach

The 'AIDS plus MDGs' approach has to date been driven by UNAIDS and UNDP, with discussion on it beginning at the UNAIDS Committee of Co-sponsoring Organizations in 2009 (UNDP/UNAIDS 2011, p. 23). The concept became a more prominent feature of

international discussions in 2010, and was a particular focus for UNAIDS in the context of the May 2010 World Health Assembly and the September 2010 MDG review summit. At the latter event, there was a widespread perception that other health issues, not least maternal health and malaria, were beginning to threaten AIDS' dominance of the policy agenda. During the summit, UNAIDS, along with the governments of China, South Africa and Nigeria, co-hosted a side event on the 'AIDS plus MDGs' approach which included keynote speakers from a number of heavily affected countries as well as WHO Director-General Margaret Chan and Michel Sidibé, Executive Director of UNAIDS (UNAIDS 2010a). UNAIDS has subsequently continued to promote the AIDS plus MDGs approach.

The AIDS plus MDGs approach highlights the intersections between AIDS (the focus of MDG6) and the other MDG targets, making the case that:

> AIDS and the other MDGs are fundamentally interrelated. An effective AIDS response is critical to the achievement of the other MDGs, particularly in high-prevalence areas. Conversely, making a substantial impact on the AIDS pandemic depends on simultaneously advancing progress in other MDG areas. (Kim *et al*. 2011, p. 144)

The crux of the argument is that an approach to AIDS which views it within the context of the MDGs as a whole would provide 'an opportunity to respond in a fresh way to the changing context and to accelerate progress in achieving the MDGs' (UNAIDS 2010b, p. 3).

In the previous section we discussed amongst other things the fact that the central place AIDS has enjoyed in global health and development policy seems to have been coming increasingly under threat. In this section we interpret the AIDS plus MDGs approach as an attempt by key AIDS institutions to respond to this challenge by focusing in particular on the ways in which they frame AIDS as a development issue, and where this framing draws or deviates from, established approaches to understanding and doing international development. We argue that key parts of the international AIDS community appear to be adjusting their

approach to the virtuous circle. The adjustment is subtle but significant. Rather than only stressing the positive effects of investing in AIDS on other areas of development, the approach examined here supplements this with a more sensitive view of the positive effects on AIDS of wider investment in other MDG areas (education, maternal health, poverty alleviation and so on) as well as acknowledging the wider structural determinants of HIV and health status. The agenda forwarded by the AIDS plus MDGs approach therefore presents itself as a recontextualisation of AIDS' place within development and reframes the AIDS-development relationship in bidirectional and interdependent terms. AIDS is still cast as one of many obstacles to development, yet structural factors associated with underdevelopment are also included in the frame as obstacles to real progress on AIDS. This contrasts with the approach critiqued by Katz in the previous section, since it advocates for a more holistic view of international development efforts.

This shift in thinking, and the AIDS plus MDGs which it has engendered, can best be seen as a response (or policy adjustment) to a number of structural and contextual changes in the political and economic environment within which these institutions now find themselves. First, as Whiteside (2009) has indicated, the period from 2006 onwards has witnessed an unprecedented challenge to AIDS exceptionalism with regard to development policy and aid, or AIDS' dominance of those policy agendas. Debates surrounding the distorting role of AIDS on overall health and development spending; the desirability of shifting investment to health systems and Health Systems Strengthening; concerns about the absorptive capacity of countries; a growing belief that the global AIDS response may be reaching the limits of what can be achieved without taking a broader approach; and changing ideas about the nature of a 'sustainable' global response have all played a part in generating new thinking and changing priorities. The AIDS plus MDGs approach also explicitly seeks to address the changing economic context of international development, not least the impact of the global financial

crisis and apparent changes in political prioritization. The AIDS plus MDGs approach should properly be viewed as an attempt to provide a response to many of these criticisms and problems (which have come from both within and outside the AIDS policy community), but does so in a manner which seeks to limit damage to AIDS' status as a top tier health and development issue and provides an adjusted rationale for continued (and indeed increased) investment in AIDS.

The remainder of this section provides an analysis of two of the key policy documents laying out the AIDS plus MDGs approach, presenting evidence of both continuity and change vis-à-vis previous framings of health, AIDS and development. The first is a UNAIDS document entitled *AIDS plus MDGs: synergies that serve people* (UNAIDS 2010b). The second is a 2011 UNAIDS/UNDP publication entitled *The 'AIDS and MDGs' Approach: what is it, why does it matter, and how do we take it forward?* (UNDP/UNAIDS 2011)[5]. A version of the latter paper authored by members of the United Nations Development Program's (UNDP) HIV/AIDS Group was also published in the journal *Third World Quarterly* (Kim *et al.* 2011). The two documents clearly overlap in drawing from the same well-established discourses which link AIDS, poverty and development; in particular drawing on, or resonating with, the background 'common sense' notion of the virtuous circle. However, both documents also show strategic adjustment to changing circumstances and policy critiques that accrued during the first decade of the MDG period. We begin by laying out some of the areas of continuity before moving on to examine areas of change. In our conclusion we discuss the implications of this shift for our understanding of framing in global health, in particular how actors and their environment interact.

The clearest areas of continuity lie in the documents' situation of AIDS as being fundamentally linked to development. It is particularly notable that both documents place a considerable emphasis upon the structural determinants of HIV and the need for HIV and

development policy to be viewed holistically. For example, the UNAIDS document argues that:

> To be effective and sustainable, the AIDS response, working strategically with other development partners, must continue and ramp up its push for positive social change and become more holistic in approaching these drivers and the companion health, development and rights challenges that affect and are affected by the epidemic—like maternal and child health, gender violence and inequality, universal education and infectious diseases like tuberculosis. AIDS responses must reach beyond the artificial boundaries of a single disease. (UNAIDS 2010b, p. 3)

However, little attempt is made in the documents to explain what is meant by 'development', other than a focus on the other MDGs. Perhaps this MDG focus is natural enough since, as we noted above, the MDGs have formed a blueprint for health and development policy for the last decade, but again we find that the 'AIDS plus MDGs' approach collapses this broader (and highly contested) development paradigm into a narrow focus on MDG attainment. Obviously, this evades the complexity of defining development and clarifying the myriad dimensions of its relationship with HIV/AIDS, and obscures the highly politicised terrain which the relationship has traditionally occupied. However, as is often the case with the use of a contested concept, the use of development nonetheless introduces a tension. Whilst the AIDS plus MDGs approach embodies in theory a clear recognition of the myriad links between HIV and development more broadly, these documents were both written within a policy context defined by – and therefore naturally focusing upon – the eight internationally-agreed MDG goals rather than a more comprehensive understanding of development.

Also evident throughout the documents is the well-established 'common sense' notion of a relationship between health and development, and the claim that investing in AIDS has spill-over effects for other MDGs, creating a virtuous circle in which both AIDS and other development problems are addressed.

> An effective AIDS response is critical to the achievement of the other MDGs, particularly in high prevalence areas. (UNDP/UNAIDS 2011, p. 9)

This general argument is supplemented in both documents through the use of case studies to show the broader impacts of AIDS investments in practice in countries such as Rwanda, Ethiopia and Nigeria. Both documents also provide examples of a number of the ways in which HIV investments benefit the other MDGs. The UNDP document in particular provides a wealth of evidence of this impact on a number of the other MDGs (p. 21), in each case providing references to studies which evidence the link. This cross-cutting role of AIDS is also strongly in evidence in the final recommendations of the UNAIDS, emphasises that status in order to make clear the need to retain AIDS as a global health priority and 'for countries to sustain and increase their financial contributions to HIV' (UNAIDS 2010b, p. 10). Given the origins and purpose of the document it is perhaps unsurprising that, even with a more balanced and nuanced approach to the relationship (discussed below), there remains a subtle but tangible asymmetry to the circular AIDS-MDGs argument which privileges the contribution of AIDS to the other MDGs over and above the inverse. It seems that special pleading is natural here (given the institutional origins of the AIDS plus MDG approach), but it is also certain that the appeal to old logics in ostensibly new (and incommensurable) frames reflects the fact that a particular 'common sense' can have life well beyond its original purpose.

Despite these continuities, the change in rhetoric in these documents is striking. They seek to address some of the critiques of the AIDS response and its broader developmental effects, whilst continuing to forward the case for investment in AIDS as a key part of MDG progress. Both documents are clear that the AIDS response can no longer afford to 'operate in isolation' (and this is a rather frank admission that it previously did). This is a significant shift from older narratives of AIDS exceptionalism, and can be seen as a significant

concession by the AIDS policy community to some of its critics, as well as a giving of ground vis-à-vis the wider exceptionalism of AIDS with respect to development progress. Thus the AIDS plus MDGs approach seizes an opportunity to integrate AIDS approaches to a more holistic notion of health, and subsequently to reconnect the health agenda with a broader development paradigm. In a strategic sense this repositioning reflects the fact there seems to be little or no choice but to harness the fortunes of the disease (not least in resource terms) to emergent issues and priorities.

Thus the AIDS plus MDGs approach does not focus solely on the beneficial spill-over effects of AIDS investment, but places an almost equal emphasis on the 'two-way relationship' between HIV and the other MDGs, wherein AIDS can and does benefit from investment in areas such as education, gender equality, maternal health and food and nutrition, amongst others. The documents are replete with phrases such as 'cross-MDG synergy', 'ending AIDS isolationism', breaking down the 'artificial boundaries of a single disease', or synergies which 'flow both ways' and so on. Considering the asymmetric nature of the virtuous circle which we identified in the previous section, and the narrow focus on select diseases which underpinned the MDG blueprint, it is possible to see this emphasis on the two-way relationship between AIDS and the other MDGs as an attempt to address both the asymmetric nature of the circle and acknowledge the shortcomings of the silo-based approaches to development aid which have dominated. The AIDS plus MDGs proposal is not only 'investing in health (AIDS) for development', but simultaneously calling for 'investing in (other areas of) development for health'.

However, a tension is evident here between the rhetoric on cross-MDG synergy and a continuing (although less explicit) assumption of AIDS' exceptional status. If all of the MDGs have mutually-reinforcing relationships, why start with AIDS? In theory, emphasising cross-MDG synergy could actually undermine the AIDS plus MDGs strategy since, when

taken to its logical conclusion (i.e. suggesting the possibility of synergy between all MDGs, not just HIV and the other MDGs), it provides a basis for further integrating the MDGs into a more holistic programme, rather than justifying AIDS as a starting point or the basis of a cross-cutting approach. If the aim of 'AIDS plus MDGs' is to secure AIDS' position vis-à-vis other development issues, the logic presented seems to suggest that a similar exceptionality argument could in principle be used in support of alternative prioritisations by the advocates of, say, education or maternal health. Indeed, even more fundamentally, the emphasis on cross-MDG synergy could be read as a critique of the entire MDG project, suggesting that the approach of isolating specific issues, setting goals and targets around them, and the silo-based responses which have resulted, is itself is to blame for MDG underachievement. Would it not be rational to fold in other areas of development and health into such a synergistic project, such as sanitation or health systems? The fact is, the MDGs were about the selection of a small number of development priorities. The problems inherent in that approach, which have long been discussed, are now becoming impossible to ignore. If the AIDS plus MDGs approach is accepted as a broader critique of this, then a radical restructuring of international development efforts in the post-2015 era could follow, which would extend the outlined synergetic approach whilst rejecting the hierarchy of particular health in development issues which results in their selection as targets over others.

However, notwithstanding the possible aforementioned interpretations of the approach, both documents *do* proceed from an assumption that in some ways AIDS constitutes a natural starting-point for understanding the relationships between all MDGs. In part this is no doubt a legacy of AIDS exceptionalism and a natural result of the mandates of the institutions behind the AIDS plus MDGs approach. But it is also the product of a view that the massive global focus on AIDS over the past decade has generated some important lessons which can be applied to other MDGs. The documents go to considerable length to

explain the ways in which some of the key successes of the history of the global AIDS response should pollinate approaches to the other MDGs, especially with regard to the centrality of human rights, the mobilization of civil society and ways of galvanizing political will and resources. In the words of the UNAIDS document

> Investing strategically to address multiple MDGs, and releasing the power, capacity and innovation of the AIDS movement, may provide one of the best opportunities to "do the MDGs" differently. (UNAIDS 2010b, p. 1)

There is also another notable shift evident in the emphasis on the demedicalisation of the AIDS response and the need to engage more broadly with the underlying social and economic determinants of health. Claiming to learn the lessons from the history of the response to AIDS, the UNDP document notes that:

> The most successful programmes have combined biomedical technologies and behavioural interventions with multi-sectoral strategies that address human rights and the underlying socio-economic conditions that render a population more vulnerable to infection. It is these multi-sectoral strategies that are at the heart of UNDP's mandate on AIDS, the new UNAIDS Outcome Framework and the MDGs themselves. (UNDP/UNAIDS 2011, p. 6)

Of course, this goes to the heart of at least 10 years of criticism of the manner in which vertical disease-specific programmes, including AIDS, have pursued heavily biomedically-oriented approaches. As one aspect of this, the debate over the appropriate balance between treatment and prevention has remained unabated for many years, There have been recent signs of a move back towards a greater emphasis on prevention, not least in recognition of the fact that it is increasingly evident that we cannot 'treat our way out' of the AIDS crisis. There are signs in the AIDS plus MDGs approach of this subtle shift back towards prevention,

broadly understood:

> Exacerbating the sense of crisis has been the limited efficacy of conventional biomedical and public health approaches, the bulwarks against disease throughout the 20th century. While an expanding array of biomedical tools (e.g., condoms and antiretroviral drugs), behavioural approaches, and increasingly, structural approaches (what has been termed 'combination prevention') have yielded important progress, they have ultimately been unable to halt the epidemic's course over the past 30 years. ... It is clear that health sector interventions and biomedical technologies (either existing or in development) alone are inadequate to meet the challenge of the AIDS pandemic. (UNDP/UNAIDS 2011, p. 3)

This also ties in with the critique of the short-term nature of contemporary select disease-specific approaches and with discussions around a redefined understanding of 'sustainability', one which is based not on the goal of self-sufficiency of domestic health systems, but rather on domestic efforts being supplemented by a predictable and reliable level of international support (Ooms *et al.* 2010). As Ooms *et al.* have noted (2009), the global AIDS response was to a great extent responsible for bringing about this new thinking (or reframing of what sustainability can mean), and Michel Kazatchkine, Executive Director of the Global Fund, has been a high-profile supporter of viewing sustained international support as central to sustainability. The significant scale-up AIDS treatment has led to millions more people receiving the drugs they need and, as noted above, this has only been possible because the massive international investment, especially from the G8. There exists a clear (and widely-recognised) ethical imperative to continue to provide these treatments to those who have begun them for the remainder of their lives. Sustaining this level of provision – even without adding to the numbers receiving treatment – will require a continued and reliable commitment from international donors. The AIDS plus MDGs approach is clearly influenced by these developments, and explicitly seeks to make a case for a shift 'from emergency mode to a long-term response.' (UNDP/UNAIDS 2011, p. 8).

The AIDS plus MDGs approach, therefore, is not merely reactive to the current political and economic context, but is also future-looking, seeking to secure AIDS' place in the future of international development and to ensure that the global AIDS response is sustainable in the long term.

Conclusion

Here we offer some concluding thoughts which examine what the AIDS plus MDGs approach can tell us about the changing landscape of global health governance, the position of AIDS within it, and the use of framing in global health. It is clear from the preceding discussion that the AIDS plus MDGs approach represents a significant modification of old narratives, despite building upon a well-established framing of AIDS as a development issue. Rather than being presented as *the* route for wider development and policy alleviation – with AIDS's status in global health policy and the MDGs arguably being 'exceptional' – the rhetoric of the AIDS plus MDGs approach indicates a move in the direction of 'de-exceptionalisation'. In doing so, the proponents of the AIDS plus MDGs approach within the AIDS community appear to be strategically repositioning AIDS as a co-dependent of a wider development project, stressing AIDS' dependency on broader development progress rather than merely its contribution to it, a move which is quite unexpected and unprecedented.

The framers are clearly responding to a changing political and economic context, and indeed this fact is explicitly stated within the documents themselves. Awareness of the impact of the financial crisis and the waning political traction of AIDS as a priority issue vis-à-vis 'rising' health issue areas looms large over both documents. Nonetheless, also evident is a response to some of the criticisms of the AIDS response, in particular complaints over the selective disease-focussed nature of the MDGs, short-termism, the biomedical bias of current responses, and the need to escape from the silo-based nature of discrete development

interventions. What can this changing AIDS-development narrative tell us about framing in global health more generally?

First, this case highlights the fact that framing is a strategic activity, used in order to forward particular claims about prioritisation, and in order to secure (or in this case maintain) resources. It is clear that the AIDS community is not only conscious of the present vulnerability of AIDS to competing priorities, but is capable of responding and adapting to that context. It is clear that the MDG period has been characterised by reflection not only as to the efficacy of the targets themselves, but as to how to achieve them. Lessons have been learned from both successes and failures, not least with the relationship between the three health-related MDGs and the health systems on which they depend. Attitudes within the AIDS community, in particular over the desirability of closer collaboration with other sectors, have gradually been changing and in the AIDS plus MDGs approach are set out clearly as a forward-looking policy proposal.

Second, frames are malleable as they often draw on contested concepts – in this case 'development' – with the meaning of the particular concept being taken as 'common sense'. In framing AIDS as a development issue, the proponents of the AIDS plus MDGs approach avoid being drawn into a convoluted debate over the meaning of 'development'. In both sections of this paper we have seen how 'development' has been captured in particular ways, leading to certain dominant policy frameworks, most notably the MDGs, setting the terrain on which interventions and action on 'development' are carried out. Katz is correct to describe this as a blueprint, both in the sense that it 'governed' development and health policy in the MDG period, but also in the sense that the blueprint had real ideational power. In the relationship between AIDS and development, the documents analysed here appear to suggest a shift from 'AIDS to development' to 'AIDS *and* development', but despite the rhetoric about the need to engage with broader structural determinants, the focus in practice is on the

relationship with the other seven MDGs. The question remains, of course, as to whether this call for partnership and 'de-silo-isation' is merely a rhetorical strategy for securing continues resources for AIDS amongst other development priorities, or whether is it a genuine case of 'lessons learned', since frames rarely 'start from scratch' and the AIDS plus MDGs approach relies for its ideational power on a longer history of the framing of health (and AIDS) as a development issue.

It is too soon to tell whether the AIDS plus MDGs approach will have a genuinely transformative policy impact, despite the significant change in rhetoric. Whilst the 'new' approach could be characterised as a rearguard action of a community feeling under siege, there are also signs that it is looking further to the future, not least in terms of the looming end of the MDG period in 2015, and ongoing discussion over future development targets.

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Notes

(1) This paper draws on insights on AIDS as a development issue gathered during interviews conducted by the authors in 2010-2011 with key individuals and organisations in London, New York, Washington DC and Geneva.

(2) NACs were heavily promoted by the World Bank and UNAIDS as the appropriate form of national response mechanism (Putzel 2004). They stand outside of the national Ministry of Health and bring together representatives from across government departments as well as civil society and the private sector.

(3) Roger England is one of the most high-profile critics of AIDS exceptionalism: e.g. England 2008.

(4) To take one example (and it is a major one), in 2010 the President's Emergency Plan for AIDS Relief (PEPFAR) accounted for over 70% of the overall US global health budget.

(5) For clarity this is referred to in this paper as 'the UNDP document'.

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