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Global governance has become an increasingly popular concept among international relations scholars for analyzing how non-state actors participate in the governance of various issues of global common interest. HIV/AIDS policy is one of the key fields in which the prominent features of global governance are found. This paper discusses how the global governance of HIV/AIDS intersects with state sovereignty issues by examining the case of South Africa, a country seriously affected by the disease and one of the principal loci of contestation over the direction of HIV/AIDS policy.

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Between Global Governance and State Sovereignty: A Case Study of HIV/AIDS Policy in South Africa[1]

Kumiko MAKINO

Abstract

Global governance has become an increasingly popular concept among international relations scholars for analyzing how non-state actors participate in the governance of various issues of global common interest. HIV/AIDS policy is one of the key fields in which the prominent features of global governance are found. This paper discusses how the global governance of HIV/AIDS intersects with state sovereignty issues by examining the case of South Africa, a country seriously affected by the disease and one of the principal loci of contestation over the direction of HIV/AIDS policy. One of the most notable attributes of the global HIV/AIDS governance is the diversity of actors participating in the process; in addition to state institutions and international organizations, the private sector, NGOs and organizations for people living with HIV/AIDS have played important roles both in planning and implementing HIV/AIDS policy. Under such a governance structure, the roles of the governments of countries severely affected by HIV/AIDS could be limited, and state sovereignly undermined, due to the influence non-state participants involved in the global governance have on the HIV/AIDS policy at the country level.

Introduction

Global governance has become an increasingly popular concept among international relations (IR) scholars for analyzing how non-state actors participate in the governance of various issues of global common interest (Dingwerth and Pattberg 2006). Challenging the state-centred

[1] This paper is an abridged translation from my forthcoming book chapter: 'Gurōbaru eizu gabanansu to Afurika,' in Gurōbaru gabanansu gakkai, eds., *Gurōbaru gabanansu gaku I & II,* Tokyo: Hōritsu bunka sha, forthcoming (in Japanese).

approaches of traditional IR theories, global governance has been utilized to analyze the 'system of rules at all levels of human activities – from the family to the international organization – in which the pursuit of goals through the exercise of control has transnational repercussions' (Rosenau 1995: 13).

HIV/AIDS policy is one of the key fields in which the prominent features of global governance are found. Since sub-Saharan Africa, the epicentre of the HIV/AIDS epidemic, is a region where state capacity is generally weak, responses to HIV/AIDS there have largely been led by external agencies, with African states tending to take up passive and secondary roles. Beginning from a small World Health Organization (WHO) programme in the mid-1980s, a number of worldwide or regional programmes and institutions focusing on HIV/AIDS have been subsequently established, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter the Global Fund) and the President's Emergency Plan for AIDS Relief (PEPFAR) of the Unites States. In addition to national and international institutions, actors in the private sector and civil society have also actively participated in global HIV/AIDS governance.

There are multidimensional aspects of HIV/AIDS policy, including the prevention of new infections; treatment, care and support for people living with HIV; research into and the development of new drugs and vaccines; and strategies for addressing discrimination and the stigma attached to HIV/AIDS. Among other developments, the rapid expansion of antiretroviral therapy (ART) has brought about a tremendous change in the HIV/AIDS landscape in low- and middle-income countries. Indeed, ART has literally saved the lives of millions of people living with HIV who otherwise could not have survived. In addition, there is growing evidence that ART contributes to the prevention of new infections, which is dubbed 'treatment as prevention' or TASP these days. According to a recent UNAIDS report, fewer than 1% of people living with HIV had access to ART in 2000; this has since changed dramatically, and in 2014 the global coverage of people receiving ART was 40%. Since 2000, new HIV infection rates have fallen by 35%, and AIDS-related deaths have fallen by 42% (UNAIDS 2015: 3).

This paper discusses how the global governance of HIV/AIDS intersects with state sovereignty issues by examining the case of South Africa, a country seriously affected by the disease and one of the principal loci of contestation over the direction of HIV/AIDS policy. One

of the most notable attributes of the global HIV/AIDS governance is the diversity of actors participating in the process; HIV/AIDS is one of the fields where public-private partnerships and multi-sectorial partnerships are most actively pursued. In addition to state institutions and international organizations, the private sector (in particular the pharmaceutical industry), NGOs and organizations for people living with HIV/AIDS have played important roles both in planning and implementing HIV/AIDS policy (Bartsch and Kohlmorgen 2007). Under such a governance structure, the roles of the governments of countries severely affected by HIV/AIDS could be limited, and state sovereignly undermined, due to the influence non-state participants involved in the global governance have on the HIV/AIDS policy at the country level.

This paper is structured as follows. Following the introduction, there is a brief discussion of how the initial frameworks for global responses to HIV/AIDS have emerged and developed within the UN structure, and how HIV/AIDS has become one of the top global concerns at the turn of the century. The South African case study is then presented to illustrate how various state- and non-state actors interacted in the process preceding the introduction of the public ART programme in the country. The paper concludes by summarizing the main arguments and offering a brief discussion of the achievements and challenges of global HIV/AIDS governance.

Development of Institutional Global Responses to HIV/AIDS

In June 1981, the first cases of what was later called Acquired Immune Deficiency Syndrome, or AIDS, were reported in a publication of the Centers for Disease Control and Prevention. Because the first reported cases were among gay men in the United States, AIDS was initially thought to be a disease that only affected men who had homosexual relationships in Western developed countries. However, it was soon found that HIV, the virus that causes AIDS, was also transmitted through heterosexual contact, from mother to child or by blood transfusion. It was also discovered that HIV was much more widespread in sub-Saharan Africa than in any other region of the world.

The WHO was the first international organization to initiate worldwide programmes to address HIV/AIDS. Originating from a small-scale programme in 1986, the WHO’s responses to the epidemic rapidly expanded under the leadership of Jonathan Mann, who directed the

Global Programme on AIDS (GPA), which started in 1987. The GPA was exceptionally large for a programme focusing on a single disease (Lee 2009: 59), and was groundbreaking in incorporating human rights and socio-economic perspectives into its strategies. Yet it led to discord between Mann and other WHO leaders, including Hiroshi Nakajima, who became Director-General of the WHO in 1988, and eventually resulted in Mann's resignation from the WHO in 1990. Although the reasons for the fall-out have been explained in various ways (including personality issues), it presumably was at least partly due to the contravention of the GPA with the decentralized governance system of the WHO. Within the WHO, regional offices were conventionally granted significant autonomy, yet Mann completely bypassed these offices and sent his staff and temporary consultants directly to countries where the GPA supported the drafting of national AIDS plans (Lee 2009: 30–34; Lisk 2010: 20–21; Piot 2012: 176; UNAIDS 2008: 17). Furthermore, the imbalance between HIV/AIDS and other health concerns in terms of the distribution of resources was also likely to have been an issue, as Nakajima was quoted stating that he felt too much attention was being paid to AIDS, compared with other diseases (UNAIDS 2008: 17).

While the WHO's HIV/AIDS programmes lost momentum after Mann's departure, the epidemic became more widespread and claimed more lives. As HIV/AIDS primarily affected young adults in their reproductive and economically productive years, it had serious implications for social and economic development, especially in sub-Saharan Africa where the infection was concentrated. Due to recognition of the 'inefficiency of coordination between different UN agencies' (UNAIDS 2008: 20), UNAIDS was formally established in January 1996 to better coordinate the AIDS policies and programmes of different UN agencies or 'co-sponsors'. Notably, and unique for a UN agency, five representatives of NGOs became part of the UNAIDS Programme Coordinating Board, although as non-voting members. This NGO representation was secured by Peter Piot, the first executive director of UNAIDS, in the face of strong opposition from several countries (UNAIDS 2008: 34). This move was an extension of the principle of 'greater involvement of people living with HIV/AIDS' or GIPA, the principle AIDS activists had fought for since the 1980s, protesting against governments that labelled them as either 'victims' or 'patients', terms that implied passivity, helplessness and dependence. The GIPA principle was agreed at the Paris AIDS Summit in 1994, and was formally

incorporated into the governance structure of UNAIDS (Chan 2015: 65–67). In spite of its many challenges in coordinating different UN agencies and in terms of building good, constructive relations with NGOs and AIDS activists (Youde 2012: 69–72), UNAIDS has undoubtedly played an important role in raising awareness about HIV/AIDS globally.

HIV/AIDS became one of the top global concerns around the turn of the 21st century, and several significant events in the period 2000–2001 pushed it to the centre of the UN's agenda. First, the UN Security Council discussed the impact of HIV/AIDS on peace and security in Africa in a meeting held in January 2000. As the Security Council is 'the locus of power in the UN' (Piot 2012: 274), the fact that it took up the subject of HIV/AIDS contributed to dramatically heightening its status as a global concern. Several months later, the UN Millennium Summit adopted the Millennium Development Goals, which included specific goals and targets concerning HIV/AIDS. The following year, the UN General Assembly held a special session dedicated to HIV/AIDS and adopted the Declaration of Commitment on HIV/AIDS, which regarded the situation in sub-Saharan Africa as 'a state of emergency' threatening the region's 'development, social cohesion, political stability, food security and life expectancy', and called for 'strong leadership at all levels of society'.[2] Thus, commitments were made at the highest level of the UN system.

These commitments had to be accompanied by concrete financing mechanisms to be meaningful. In this regard, the Global Fund has been by far the most important multilateral mechanism for funding HIV/AIDS programmes. It was established in 2002 as a multilateral financing entity for programmes to combat HIV/AIDS, tuberculosis and malaria in low- and middle-income countries. Unlike UN agencies, it was built as a 'public-private partnership' and established as an independent foundation under Swiss law. The way in which it operates is a useful representation of the characteristics of the global governance of HIV/AIDS, where diverse actors, both state and non-state, public and private, participate and share responsibility. The Fund's Board consists of 20 voting members, with equal representation for donors and implementers (recipients). In addition to state and regional representatives, NGOs, communities

[2] "Declaration of Commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001", available on the UNAIDS website (http://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf, last visited 14 March 2017).

affected by HIV, TB and malaria, the private sector and private foundations are also represented. Meanwhile, the representation of NGOs and affected communities is more substantial than their representation on the Programme Coordinating Board of UNAIDS, as they are voting members in the former but not in the latter. At the country level too, governance through a multi-stakeholder partnership has been institutionalized as what is called the 'Country Coordinating Mechanism (CCM)', in which the government of the implementer state, multilateral or bilateral donor agencies, NGOs, the private sector and representatives of people living with the diseases participate.[3] As of July 2016, disbursement by the Global Fund for programmes for HIV/AIDS, TB and malaria totalled US$30 billion, through which, according to an estimate by the Fund, 20 million lives had been saved by the end of 2015, and a decline of one-third in the number of people dying from HIV, TB and malaria since 2002 was observed in countries provided with the Global Fund money.[4] (The Global Fund 2016). The top donor to the Global Fund is the United States, which has contributed almost one third of all allocated money, followed by Sweden, Norway, France and Japan. Private foundations and companies have also made significant contributions; for example, the Bill & Melinda Gates Foundation has contributed more than US$1 billion to the Global Fund, an amount comparable to major country donors.[5]

In addition to being the main donor to the Global Fund, the United States has implemented the large-scale bilateral HIV/AIDS programme PEPFAR. Started by President George W. Bush in 2003, who committed US$15 billion over five years, PEPFAR continued under the Obama administration with an annual appropriation of between US$6 and US$7 billion, including the United States' contribution to the Global Fund. Initially, the PEPFAR funding concentrated on 15 'focus countries'; however, the number of target countries later increased, and PEPFAR-funded programmes were implemented in 41 countries in 2015.[6]

[3] "Country Coordinating Mechanisms", available on the Global Fund website (http://www.theglobalfund.org/en/ccm/, last visited 14 March 2017).
[4] "Results Report 2016", available on the Global Fund website (http://www.theglobalfund.org/documents/publications/annual_reports/Corporate_2016ResultsReport_Report_en/, last visited 14 March 2017)
[5] See the Global Fund website (http://www.theglobalfund.org/en/, last visited 14 March 2017)
[6] See the Henry J. Kaiser Family Foundation PEPFAR page (http://kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for/, last visited 14 March 2017) for a handy overview of PEPFAR. The number of PEPFAR recipient countries is still

Together with the Global Fund, PEPFAR has played a vital role in the rapid expansion of ART programmes in low- and middle-income countries. At the time of writing, however, there is uncertainty over the future of PEPFAR and other AIDS-related funding by the United States, as the recently elected President Trump has expressed his intention to cut foreign aid following his 'America first' policy, and there is fear that PEPFAR could suffer significant cutbacks as a result.[7]

Discordancy over Treatment Access in South Africa: Mbeki's 'AIDS Denial' Revisited

The introduction of ART in 1995, which uses a combination of multiple antiretroviral drugs to suppress HIV from growing inside the body, dramatically changed the HIV/AIDS landscape in developed countries within a few years. However, due to the high prices of the antiretroviral drugs, which cost more than US$10,000 per person per year, they were beyond the reach of most people living with HIV/AIDS in low- and middle-income countries. This situation started to change around 2000, when the idea of creating a 'global fund' was becoming increasingly realistic after being discussed at various important international forums, including the G8 Summit in Japan in 2000 and the UN General Assembly Special Session on HIV/AIDS in 2001. At the same time, the cost of ART was set to reduce due to public pressure on the pharmaceutical industry over 'access to medicines' for people living in developing countries, and because of the competition caused by the development of generic versions of antiretroviral drugs.

The problem of 'access to medicines' was highlighted in the late 1990s by international NGOs such as Health Action International (HAI) and Médecins Sans Frontière (MSF), which campaigned against the World Trade Organization (WTO) agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) as limiting poor people's access to patented medicines (Hein 2007). This intellectual property issue was recognized as a critical barrier faced by poor

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significantly less than that of the Global Fund, whose funding is being used in ongoing programmes in more than 100 countries.

[7] See for instance, "Trump's 'America first' vow sparks fears for Africa initiatives", *Financial Times*, 7 February 2017, retrieved from http://www.ft.com/ on 3 March 2017.

people living with HIV/AIDS in gaining access to life-saving antiretroviral drugs, so they organized themselves and joined the international NGOs to raise their voices against giant pharmaceutical companies. South Africa was one of the main battlegrounds in the fight for access to antiretroviral drugs in developing countries. The following case study of South Africa shows how various actors in the global AIDS governance, such as the governments of countries in both the Global North and South, international organizations, NGOs and AIDS activists, experts and the private sector, had entangled interactions at the turning point of the global AIDS governance, when there was a rapid shift from prevention-oriented strategies towards expanding ART in developing countries.[8]

With 7 million people living with HIV/AIDS, out of its total population of around 53 million, South Africa is one of the countries to have been most seriously affected by the HIV epidemic (UNAIDS 2016). As many readers would know, the South African government's responses to HIV/AIDS were harshly criticized both domestically and internationally in the early 2000s because of then-president Thabo Mbeki's so-called 'AIDS denialism'. Mbeki repeatedly cast doubt on the mainstream scientific consensus about the effectiveness of antiretroviral drugs, and resisted introducing public ART programmes, despite strong demands from the South African people living with HIV/AIDS, who organized themselves as the Treatment Action Campaign (TAC) (Nattrass 2007; Makino 2009; Fourie and Meyer 2010). Despite apartheid being formally abolished, South Africa's health system is characterized by a structural inequality inherited from the past. There has been a deep division between the private healthcare sector for those who can afford to buy medical schemes (historically white), and the public healthcare sector for those who cannot afford this (historically black). In addition, while antiretroviral drugs became available in some private hospitals shortly after ART started in the United States and other developed countries, poorer people could not receive ART via the public sector until 2004, when the government finally introduced the public programme. While Mbeki's attitude towards ART was apparently incomprehensible, which was all the more baffling because he was known as a highly intellectual thinker, or a 'philosopher king' (Adebajo 2016), this paper proposes an argument that his resistance to the introduction of public-sector

[8] Some parts of this section are based on my previously published book chapters (Makino 2009; 2013).

ART programmes might have related to the bitter experiences of the South African government over its legislation for promoting access to medicines.

Before the controversy over its HIV/AIDS policy arose, the post-apartheid South African government actively sought better access to medicines as part of its attempt to improve the healthcare system for its historically disadvantaged population. In 1996, just two years after the political transition, the Mandela administration, in which Mbeki served as deputy president, introduced a new National Drug Policy, under which Essential Drugs Lists were developed. The following year, the Medicines and Related Substances Control Amendment Act included provisions for parallel importation and compulsory licensing to make essential drugs cheaper and more available for South Africa's poor, including those living with HIV/AIDS. However, the Act was strictly opposed by the pharmaceutical industry; the Pharmaceutical Manufacturers Association (PMA) and 40 multinational pharmaceutical companies tried to block it by taking the South African government to court, claiming that the Act was infringing their intellectual property rights.

Both parallel importation and compulsory licensing were standard practice in developing countries, and the contested provisions were not a clear deviation from the TRIPS agreement. According to analysis by a leader of the TAC, which participated in the court case as an *amicus curiae*, the pharmaceutical industry tried to strategically use the court case to put pressure on the governments of developing countries in the context of ongoing WTO negotiations to strengthen TRIPS (which was called 'TRIPS plus') (Heywood 2001). Therefore, the court case was arguably not only significant for South Africa, but it could have affected the global patent rule for balancing intellectual property rights and public health interests in developing countries. That is why the court case drew strong interest internationally; NGOs such as MSF and Oxfam joined the TAC in demanding the pharmaceutical industry drop the case, organized campaign actions such as collecting signatures for petitions and helped ensure the court case was extensively reported by media around the world (Mayne 2002). Given the negative publicity, the pharmaceutical industry dropped the case in April 2001. In November that year, a special declaration on the TRIPS Agreement and public health was adopted at the WTO Ministerial Conference in Doha, which responded to the concerns of developing countries that patent rules might restrict access to affordable medicines, and affirmed that 'the TRIPS Agreement does not

and should not prevent members from taking measures to protect public health'.[9] The South African court case represented an important moment in reversing the tide in the WTO from strengthening intellectual property rights to prioritizing public health.

Amid the Medicines Act court case, the XIII International AIDS Conference was held in Durban, South Africa, in July 2000. It was the first annual International AIDS Conference held in a developing country, and the issue of access to medicines, including antiretroviral drugs, in developing countries was highlighted. The International AIDS Conferences, which are held biennially, are gatherings of not only academics and experts, as all major stakeholders in HIV/AIDS policy, including international organizations, government health officials, pharmaceutical companies, medical practitioners, NGOs and people living with HIV/AIDS, gather in one place. Organizers of the Durban conference recall how it provided rare opportunities for interaction between people of different backgrounds, and created momentum for exploring financing mechanisms to run ART programmes in developing countries:

> The conference itself became a melting pot for new opportunities and for unlikely interactions – drug company representatives were speaking at community forums in the Community Village about their commitment to affordable treatment; healthcare providers explaining the pain of watching their AIDS patients die helpless […]. Speaker after speaker talked about the pain, the suffering, the stigma and the orphans. At the same time, speakers described new options for financing treatment access […]. By the time the audience streamed into the [conference venue] for the closing session, it was clear that a new era in AIDS was dawning. (Karim and Karim 2016)

Going against the enthusiasm participants had for increasing treatment access in developing countries, Mbeki stated in his conference speech that 'the world's biggest killer and the greatest cause of ill-health and suffering across the globe […] is extreme poverty', therefore he 'could not blame everything on a single virus' (Cullinan 2000). Conference participants received this as

[9] "Declaration on the TRIPS Agreement and Public Health", adopted on 14 November 2001, available on the WTO website (https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm, last visited 14 March 2017).

a sign of his negative attitude towards antiretroviral drugs, deriving from 'AIDS denial'; thus, he was strongly criticized by AIDS activists and the domestic and international media. While there was much speculation regarding the background to his speech, two factors seems relevant for the purpose of this paper. First, Mbeki had developed distrust and suspicion of the pharmaceutical industry through his experiences of dealing with Al Gore, then the US vice president, who proposed that '[h]e would use his leverage with the pharmaceutical companies to get them to make a cost-reduction deal for antiretroviral drugs with South Africa, if in return that [South Africa] dropped its campaign for intellectual property rights'; according to his biography, Mbeki felt that 'Gore was trying to buy him off' and he refused the offer (Gevisser 2009: 281). Activists advocating access to drugs were sometimes dismissed as being part of a pharmaceutical industry conspiracy (van der Vliet 2001: 174), as advocacy for treatment access was regarded as equal to drug sales promotion. Second, at that time Mbeki was spearheading the reform of international organizations such as the UN, the WTO, the World Bank and the International Monetary Fund, with the aim of increasing African countries' leverage in their governance (Adebajo 2016: 111). Putting Mbeki's AIDS denial in this context, it could be interpreted as a kind of self-determination claim, or an objection against the limitations imposed on state sovereignty by global governance institutions, as the locus of substantive decision making in globally important policy was increasingly shifting from the national to the transnational level (Makino 2013: 299–302; Powers 2012).

Whichever the reason, Mbeki's resistance to introducing an HIV/AIDS programme that incorporated the use of antiretroviral drugs was nothing less than a tragedy for poor people living with HIV/AIDS in South Africa. A study by Harvard University researchers estimated that more than 330,000 people died prematurely from HIV/AIDS between 2000 and 2005 due to the Mbeki government's misguided HIV/AIDS policy, and at least 35,000 HIV-infected babies were born who could have been protected from the virus if antiretroviral drugs were available (Chigwedere et al. 2008). Antiretroviral drugs to prevent mother-to-child transmission, as well as for ART, became available in the public healthcare sector only after many years of advocacy, mass actions and court cases raised by the TAC, which having supported the South African government as *amicus curiae* in the Medicines Act court case now had to protest against the government to secure access to treatment in the public healthcare sector. Through its

experiences of working together with well-known international NGOs to organize civil society actions at the Durban AIDS Conference, and of its work in relation to the Medicines Act court case, the TAC had earned a positive reputation in the international media and among transnational networks of AIDS activists as a group that could represent the voices of people of the Global South, with a strong ability to articulate their needs and demands using the vocabulary of human rights. In supporting the TAC's demands, international NGOs and AIDS activists, and international organizations and donors, put pressure on the South African government (Makino 2009; Mbali 2013), which would eventually lead to the introduction of the public ART programme in South Africa in 2004. A decade later, it is now the biggest national ART programme in the world, with 3.2 million adults receiving ART in South Africa in 2015 (UNAIDS 2016).

In recent years, the South African government's responses to HIV/AIDS have been highly regarded by international organizations including UNAIDS, marking an about-turn from the negative reputation of the Mbeki administration.[10] However, that the South African ART programme has successfully reached so many people living with HIV does not mean it is flawless. For instance, the problem of stock outs and a shortage of essential medicines including antiretroviral drugs, which mainly occurs in regions with a weak health infrastructure, is gravely concerning.[11] In addition, the financial burden on the South African government cannot be overlooked. Although PEPFAR and Global Fund funding have contributed significantly to the ART programme in South Africa, the majority of spending on the country's AIDS-related programmes comes from the government's coffers; the South African government reported to the UN that 'in 2009/10, public sources contributed on average 75.3% of total HIV/AIDS funds, while external and private sources contributed 16.4% and 8.3% respectively' (Republic of South Africa 2012: 67). The same report stated that the funding needed to respond to HIV/AIDS was 'continuing to escalate rapidly, especially as hundreds of thousands of additional South Africans enter[ed] ART programmes' and there were 'huge financial dangers and risks for the country

[10] See for instance, "South Africa Takes Bold Step to Provide HIV Treatment for All", UNAIDS Press Release, 13 May 2016 (http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/may/20160513_UTT, last visited 14 March 2017).

[11] See the Stop Stock Outs project website for more information (http://www.stockouts.org/, last visited 7 March 2017).

[…] to maintain its government budget for a wide range of pressing needs, beyond HIV and AIDS' (Republic of South Africa 2012: 66).

It must be emphasized that the expenditure required for the ART programme should not be regarded as a pure 'cost', but instead it should be considered as a reasonable 'investment' from which a good return could be expected, not only because it saves millions of lives, but also because it could reduce the medical expenditure needed to treat people who develop AIDS. Having said that, however, the government must ring-fence a significant portion of the finite government budget each year to maintain and expand the ART programme, which invites the question of the programme's sustainability, especially in a country such as South Africa that is suffering from economic stagnation.

Conclusion

As discussed, a salient feature of the global HIV/AIDS governance is that various non-state actors, including those in the private sector and civil society, participate in substantial ways, and much emphasis has been placed on 'public-private partnerships' in combating the disease. It is particularly notable that international NGOs and organizations representing people living with HIV/AIDS have had a significant influence on the direction of global HIV/AIDS policy (Chan 2015: 67). This paper has discussed how the global governance with such characteristics intersects issues relating to state sovereignty by examining the South African case.

With regard to foreign aid in general, there have been vigorous debates on how effective it has been for economic development and poverty reduction in developing countries.[12] Yet the impact of foreign aid on HIV/AIDS programmes is obvious; with large-scale funding, in particular through the Global Fund and PEPFAR, ART became widely available in developing countries, and AIDS-related deaths have decreased by 42% from the peak levels of 2004. The challenges are not over, however, as around two million people were newly infected with HIV and 1.2 million died of AIDS-related illnesses in 2014 (UNAIDS 2015). There are still many aims to be achieved, and more financial and other resources must be mobilized to end the AIDS

[12] The most well-known debate on the topic has been one between Jeffrey Sachs, who has advocated for the 'Big Push' or a large aid increase aimed at reducing poverty, and William Easterly, who has been sceptical of the effectiveness of aid.

epidemic by 2030, which is the most recently declared goal of the UN.

While the narrative on the global responses to HIV/AIDS is predominantly positive, there has also been criticism that the exceptional attention paid to the disease among the many health issues that exist, and the concentration of aid resources in AIDS-related programmes as a result, has skewed health policy planning around AIDS in developing countries (Harman 2015: 470). A study on PEPFAR in sub-Saharan Africa shows that its relative success in light of its goal of saving the lives of people living with HIV/AIDS indeed came at the cost of weakening the capacity of the state health system. The authors point out three mechanisms through which the negative externalities of targeted aid programmes like PEPFAR are brought about: (1) crowding out cheaper and more cost-effective interventions; (2) triggering an internal brain drain, for instance from the public sector to aid-funded NGOs; and (3) influencing recipient governments' resource allocation in favour of sectors or issues supported by donors (Lee and Izama 2015). Such criticism is not new, but it has drawn more attention recently in the context of a 'return to Alma-Ata' (Chan 2008), the resurgence of a primary healthcare approach in the WHO and the growing recognition of the importance of strengthening health systems, which could work as a downward pressure on funding for programmes focusing on specific diseases such as HIV/AIDS.

For governments of countries dependent on external funding for their HIV/AIDS programmes, the problem of aid dependency is a major issue. It is more than simply a financial problem; it also concerns state sovereignty, because if '[c]itizens are reliant on external governments and agencies for the drugs that keep them alive', '[t]heir governments have no choice but to accept even though the programmes may distort their priorities' (Whiteside 2015: 458). In addition, there is a recent notable trend to concentrate aid on low-income countries and to expect middle-income countries to mobilize more of their domestic resources,[13] which could affect the state sovereignty of middle-income countries. While policy discussion and coordination with regard to responses to HIV/AIDS mainly take place within a global public sphere where various actors besides sovereign state governments play important roles, governments, including those of middle-income countries less dependent on aid, are expected to

[13] 'Domestic resource mobilization' is becoming a buzzword not only in relation to HIV/AIDS, but also in development finance in general. See for instance the following article on the World Bank website: http://www.worldbank.org/en/topic/governance/brief/domestic-resource-mobilization.

adopt policies in accordance with the global consensus on policy direction. This means that middle-income countries such as South Africa have to allocate their limited domestic financial and human resources for HIV/AIDS responses in a manner that means it is not fully autonomous, which could arguably be a source of tension between the global governance and state sovereignty. Mbeki's 'AIDS denial' was arguably the most tragic manifestation of this tension.

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