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Abstract:

After some hope from the mid-2000s onwards, when unprecedented resources were mobilized to provide life-saving treatment to the millions dying from HIV/AIDS in the Global South, donors are reneging on their promises, bowing to the imperative of austerity of a self-inflicted economic crisis. Drawing on Galtung’s typology of structural and cultural violence, this article examines how the rules and norms of global governance have shaped the context of policy responses to the pandemic in sub-Saharan Africa, and how these material struggles are intimately bound up with struggles over the frames through which the disease is portrayed and perceived by key policy actors and the public. Firstly, we argue that the strikingly differential global distribution of the disease is, at least partially, attributable to the structural violence of Africa’s encounter with neoliberal capitalism. Secondly, we focus on two dominant frames - behavioral and philanthrocapitalist - and examine how they contributed to a depoliticization of the AIDS crisis, negating the counter-framing work of transnational AIDS activism. The latter, which has done so much to unmask our shared responsibility for the unequal distribution of vulnerability and death, is critical to countering the threat the economic crisis poses to the global HIV/AIDS response.

Keywords:

HIV/AIDS, sub-Saharan Africa, philanthrocapitalism, neoliberalism, structural violence, cultural framing
Framing AIDS in Times of Global Crisis: ‘Wasting’ Africa yet again?

‘AIDS has finally gone out of fashion, almost 30 years after the pandemic began...’
(Boseley, 2010).

Introduction

Global health priorities are shifting. HIV/AIDS no longer commands the same privileged place in development politics. Only weeks after global leaders had affirmed their commitment to the Millennium Development Goals (MDGs) at the 2010 UN Summit, donors showed their true face as they left the multilateral Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM) in the cold, pledging just over half of the requested $20 billion to accelerate scale-up of treatment and prevention programmes (GFATM, 2010). As a result, for the first time in its history, the GFATM was forced to effectively cancel its next round of funding in November 2011. After some hope from the mid-2000s onwards, when unprecedented resources were mobilized to, at last, provide life-saving anti-retroviral (ARV) treatment to the millions of people dying in the Global South, Northern countries are reneging on their promises to fight the global pandemic, bowing to the ostensibly unassailable imperative of fiscal austerity due to a self-inflicted economic crisis. According to Eric Goosby, the United States Global AIDS Coordinator, this crisis ‘has had an impact on resource availability’, rendering universal access to treatment by 2015 not ‘realistic’ (IPS, 2009). While billions are spent to keep the financial system afloat, Bill Clinton urges the world ‘to save more lives - with less’ (2010), reviving the discourse of ‘cost-effectiveness’ which, until recently, rationalized the denial of treatment to the poor (MSF, 2010).

The tragedy of AIDS unfolding across sub-Saharan Africa (SSA) cannot be grasped without taking into account the myriad ways whereby the ‘disease is linked to poverty and inequality’ in a globalized world (Barnett & Whiteside, 2002, p. 27). Drawing on Galtung’s (1990) typology of structural and cultural violence, this article investigates the relationship between HIV/AIDS and neoliberalism, which appeared as the dominant paradigm in development thought and practice at a time when the disease emerged. In the first part, we ask: how have the practices, rules and norms of global neoliberal governance shaped the capacity of African states and populations to respond to the pandemic? To what extent is the concentration of the pandemic in SSA and the strikingly unequal distribution of risk and vulnerability attributable to the structural violence of neoliberal globalization visited upon the continent?

In the second part we examine representations of ‘AIDS in Africa’ in policy and popular discourse, for material struggles over access to treatment, funding and wider global political and economic arrangements, are intimately bound up with struggles over the frames through which policy actors and the general public portray, perceive and interpret AIDS, poverty, Africa and its peoples. We identify two dominant frames - (i) behavioral and (ii) philanthrocapitalist - which, in our view, are compatible with a neoliberal rationality enveloping the global AIDS response. Furthermore, they have contributed to a depoliticization of the AIDS crisis, negating the important counter-framing work of transnational AIDS activism, which, we conclude, is critical to countering the threats posed by the economic crisis as the fight against HIV/AIDS, enters its fourth decade.
HIV/AIDS in SSA Today

It is encouraging that the number of people receiving HIV/AIDS treatment in the Global South has risen from a few thousand in the late 1990s to more than 6.6 million today (UNAIDS, 2011a). Global AIDS-related deaths have fallen by almost a fifth between 2004 and 2009 and infection rates continue to decline in most affected countries. Nevertheless, the pandemic remains overwhelmingly concentrated in SSA where 22.5 million people – ‘68% of the global total’ – are living with HIV/AIDS and where ‘72% of the global… 1.8 million [AIDS] deaths’ and most of new infections occur (UNAIDS, 2010, p. 25). In 2005, the G8 pledged to achieve universal treatment access by 2010 but in SSA treatment coverage in 2009 was below 40% and continues to elude the most vulnerable: ‘90% of the world’s children living with HIV reside in sub-Saharan Africa’ but the majority remains without access to ARVs (p. 99).

These fragile and unevenly distributed achievements are being undermined by ‘a general trend among donors to reduce their funding support for the purchase of ARVs’ (MSF, 2010, p. 18). We should realize that many national treatment programmes - ‘the most ambitious service delivery exercise ever undertaken in Africa’ (Waal, 2006, p. 111) - are entirely dependent on external aid (UNAIDS, 2011b, p. 13). Consequently, stockouts have been reported in numerous SSA countries and doctors are rationing treatment, enrolling new patients only when others die (MSF, 2010). It is estimated that the flat-lining of AIDS funding by the Obama administration may ‘result in 1.2 million avoidable deaths in the next 5 years in South Africa alone’ (Walensky & Kuritzkes, 2010). Many practitioners fear worse is to come (UNAIDS/World Bank, 2009), returning perhaps, in the words of one patient, to the ‘old days, [when] people were dying like rats’ (The Independent, 2010).

Globalization and Structural Violence

The concept of ‘structural violence’ was first advanced by Galtung (1969) to escape the reductionism which limits the term violence to instances of ‘direct violence’ - when torture, terror, physical aggression and armed conflict rupture the seemingly non-violent patterns of daily life - and thereby obscures forms of violence which are not enacted by clearly identifiable human agents but woven into the fabric of social structures and endemic to the global political and economic order. Structural violence ‘shows up as unequal power and consequently as unequal life chances’ (Galtung, 1969, p. 171) and produces sites of avoidable human suffering and death. For anthropologists Scheper-Hughes and Bourgois, it refers to the ‘everyday violence of infant mortality, slow starvation, disease, despair, and humiliation that destroys socially marginalized humans with even greater frequency’ than war, terrorism or genocide (2004, p. 2).

The notion of structural violence, or what Žižek calls ‘the fundamental systemic violence of capitalism’ (2009, p. 11), is closely related to Pogge’s understanding of global poverty as both a foreseeable and avoidable consequence of the ‘present design of the global institutional order’ (2009, p. 23). It aids us to avoid viewing affluent countries, for lack of charitable impulse or moral indifference, as merely failing to fulfill the human rights of the poor. Rather, given the massive concentration of global wealth in the Global North, their control over the institutions
of global governance, and by demonstrably obstructing ‘feasible reforms’ (Pogge, 2009, p. 50) that would render much global suffering and death preventable, the affluent countries are directly implicated in the violation of fundamental social and economic rights of the poor.

According to Farmer, it is precisely in the context of these systemic human rights violations and ‘growing transnational inequalities’ that we need to situate our analysis of the epidemiology of HIV/AIDS since often ‘the same forces that structure risk for human rights abuses are also those shaping [the epidemic] of AIDS’ (2005, pp. 18-19). The concept of structural violence thus invites us to investigate how exploitative North-South relations and ‘the historically-given, and, often enough, economically driven conditions’ (p. 9) of poverty and inequality produce environments of risk and vulnerability to HIV/AIDS. To do so, a broad definition of poverty, avoiding the economic reductionism of ‘an overemphasis on income poverty’ (Sen, 1999, p. 108), is essential. Accordingly, we adopt Sen’s definition of poverty as ‘the deprivation of basic capabilities’ (p. 87), such as limited access to education, health care and essential medicines, insecurity, unemployment and income poverty. This is particularly important when analyzing the impact of neoliberalism on the severity of HIV/AIDS in SSA, to which we now turn.

Neoliberalism and AIDS

Exported to all corners of the world and embedded in the practices and norms of international financial institutions (IFI), the World Trade Organisation, central banks and mainstream development agencies, neoliberal doctrine - which identifies market-based solutions as the panacea to economic underdevelopment - has guided economic globalization and development policy since the 1980s, profoundly shaping Africa’s incorporation into global capitalism (Harrison, 2010; Ferguson, 2006). It is beyond our scope to comprehensively discuss the developmental implications of Africa’s encounter with neoliberalism, reviewed extensively elsewhere (Cheru, 2002; Rowden, 2010a; O’Manique, 2004). Instead, we focus on the elements that directly influenced the (in)ability of countries to confront the worst public health crisis in modern history by reviewing the illustrative case of Structural Adjustment Programmes (SAP) in Zambia, the impact of the IMF’s macroeconomic orthodoxy and the continuing expansion of the global intellectual property rights (IPR) regime.

Adjusting Zambia

Heavily dependent on copper exports, Zambia faced a crippling balance-of-payments and debt crisis following the sharp decline in global commodity prices in the late 1970s and was compelled to turn to the IMF and World Bank, relinquishing much of its power over macroeconomic policy for desperately needed aid. The first set of SAPs was implemented in 1982, but abolished when urban riots broke out. Nevertheless, despite early signs of devastating human costs, Zambia was subjected to a second, much more comprehensive, wave of SAPs during the 1990s, including trade, capital and price liberalization, privatization of parastatals, fiscal austerity, and public sector lay-offs and wage cuts. Although arguably necessary in some sectors, even on their own terms, the reforms were a catastrophic failure.
The period between 1988 and 1998 saw an average annual **negative** growth in GDP per capita of 2.6% (World Bank, 2011) and a decline of more than 20 per cent during 1991-1995 alone, as unemployment rose (Rowden, 2010a, p. 122) and ‘real wages tumbled’ (UNDP, 2007, p. 28). Despite steady economic growth in recent years, almost seven out of ten Zambians live below the national poverty line, a rate that has barely changed since 1990 (p. 27). Cuts in social expenditure were particularly damaging in the face of a growing HIV/AIDS epidemic. In a detailed study, Garenne and Gakusi (2006) note that “…health expenditures per capita in real terms increased substantially before 1975, but decreased very fast afterwards (13.1% a year)” (p. 1774) and “…the ratio of public doctors per million population declined from 88 in 1977 to 60 in 1992 (p. 1775) [4]. The combined socio-economic impact of Zambia’s economic crisis and SAPs contributed to the rise in under-five mortality during the same period (a rise that cannot yet have been affected by HIV/AIDS) and ‘the 1975-92 crisis had visible effects on linear growth of women, which could be linked to the decrease in food availability and increased in malnutrition over the same time period’ (p. 1778).

The commodification of healthcare through the introduction of user fees has had pernicious consequences for already impoverished households, negatively impacting young women’s health and education, and widening existing inequalities (Poku, 2005, p. 43). Redefined by the World Bank from a public good to a commodity, the ‘brutal calculus’ of the market effectively denied millions of people access to health care, as hospital utilization ‘declined by one-third over two years’ after their introduction (Rowden, 2010a, pp. 156-157). Although solving the debt crisis was key to IFI intervention, Africa’s debt ‘…doubled between 1979 and 1985 and doubled again by the early 1990s’ (Woods, 2007, p. 146). As late as 2004, when almost a fifth of adults were HIV positive, 62% of Zambia’s budget was being devoted to debt servicing, compared to only 12.6% to health (Poku, 2005, p. 42). The debt crisis compounded by SAPs thus severely hampered ‘the ability of public sector institutions effectively to implement HIV/AIDS prevention and control activities’ and provide health and other elementary social services to the population (Ibid, p. 48; Cheru, 2002).

Ultimately, ‘by 1995, Zambia’s HDI [Human Development Index] value was lower than it was in 1975’, with only marginal improvement since. And although it ‘is the only country to experience such a reversal in the world’ (UNDP, 2007, pp. 27-28), other countries subjected to SAPs have suffered similar negative consequences. The deprivation of capabilities during the structural adjustment era largely explains why HIV/AIDS has had such a devastating impact in Africa. Stillwaggon’s (2006) detailed analysis of the bio-epidemiology of the virus documents how the ‘ecology of poverty’ marked by severe malnutrition, poor access to clean water and sanitation, weakens immune systems, making bodies more susceptible to specific STDs, which in turn remain largely untreated as even the most basic medicines, like antibiotics, are unavailable. Subsequently, these factors significantly increase chances of HIV infection and transmission. Stillwaggon provides crucial scientific evidence explaining this devastating heterosexual epidemic in SSA that hardly occurred in the North. In addition, Campbell (2003) and Poku (2005) document how everyday social reality in conditions of extreme poverty puts women at increased risk by exacerbating existing gender inequalities and abrogating their sexual rights, rendering many of the AIDS awareness, behavioral modification and ‘empowerment’ programmes ‘irrelevant and inoperable’ (Poku, 2005, p. 202).
Beyond Structural Adjustment

After a series of legitimation crises, IFIs eventually replaced SAPs with Poverty Reduction Strategies Papers (PRSP) in 1999, characterized by a softening of some core loan conditionalities and a heavy (discursive) emphasis on ‘country ownership’ and ‘civil society participation’. Yet, as Chandhoke has argued, ‘the post-Washington consensus…views protest and struggle, which happen to be an integral part of civil society, as problems that have to be resolved through managerial techniques’ (2006, p. 45). According to Harrison ‘PRSPs are based on the premises of SAP’ (2010, p. 57), albeit with a more ‘human face’. Thus, neoliberal rationality continues to shape the bounds of legitimate policy responses to public health crises, whereby the IMF remains a de facto aid gatekeeper, imposing its restrictive definition of macroeconomic stability on other development actors. A review of IMF programmes in 29 sub-Saharan countries implemented between 1999 and 2005 found that countries which exceeded the IMF’s (low) annual inflation targets ‘were allowed to spend…just $1.50 of every $10 in annual aid increases by donors’, whilst the remaining 85% was diverted towards strengthening currency reserves and servicing debt (Rowden, 2010a, p. 186). In other words, despite the enormous inflow of money from the GFATM and the US President’s Emergency Plan for AIDS Relief (PEPFAR), these countries, with the lowest per capita health expenditures in the world, are being prevented from scaling-up social investment for fear of violating the IMF’s articles of faith.[2] Yet, it is clear that ‘to achieve the MDGs and universal treatment access for ARVs, or reverse the spread of HIV, will take more expansionary fiscal and monetary policies than are currently permitted’ (Ibid., p. 175).

Further weakening the capacity to fight HIV/AIDS is the massive ‘brain drain’ of Africa’s health workforce in recent years. Facing low wages, dilapidating facilities at home and active recruitment by Northern governments and NGOs, 23% of doctors trained in SSA now work in just seven OECD countries - a situation condemned by the WHO as a ‘perverse subsidy’ of the rich (WHO, 2006, pp. 100-101). When the IMF refused Kenya to employ more doctors and nurses in its chronically under-staffed hospitals, the Chief Economist of Kenya’s Ministry of Health was unequivocal about the human consequences of the Fund’s orthodoxy: ‘The only difference from what happened in Rwanda is that here they don’t use pangas [machetes], they use policies’ (in Ambrose, 2006).

Moral Economy of AIDS Treatment

A decade after life-saving ARVs became widely available in the North in 1996, neoliberal hegemony also provided the context for a consensus amongst virtually all development actors that providing treatment in ‘resource-poor’ settings was ‘cost-ineffective’, ‘unaffordable’ and ‘unsustainable’. Given the prohibitive prices of ARVs, the lack of adequate treatment delivery systems and meagre health budgets in the South, a crude cost-benefit calculus determined that the limited resources for addressing the pandemic were most efficiently spent on prevention. The same rationale continues to justify the sub-standard quality of treatment deemed appropriate for Africa, exemplified by the continued use of older, far more toxic ARVs, long discontinued in the North (Ford et al., 2009).
Cost-effectiveness approaches effectively depoliticize AIDS policy debate by transferring questions of resource allocation to the realm of technocratic decision-making, guided by ostensibly value-free principles of economic efficiency. In reality, they are anything but value-free but based on the tacit acceptance of the political priorities and grotesque global inequalities, which limit available resources and influence the cost to fight HIV/AIDS. Yet, ARV prices - a key factor of treatment costs - were shown to be kept artificially high by pharmaceutical corporations and global patent rules and hence subject to political change. Beneath the surface of this technocratic cost-effectiveness discourse thus lurks the ‘moral economy’ of AIDS policy (Nattrass, 2004) - the political, moral and, in the case of Africa, racial calculus of a standard of treatment deemed adequate for the poor.

Indeed, no issue in the struggle against AIDS has been as politically charged as the impact of the global IPR regime, which grants pharmaceutical companies rights to charge monopoly prices on patented drugs for a period of twenty years, on access to AIDS medicines. The patent injustice of a system, which effectively denied millions in the South access to ARVs, to which most HIV patients in the North had access through public health care systems and health insurance schemes, became a central rallying point of a broad North-South coalition of NGOs, grassroots activists, public health officials and lawyers. Through a series of symbolic, political and legal victories (Muzaka, 2009; Nauta, 2011), the movement eventually opened avenues to significantly cheaper, generic ARVs - a necessary, if not sufficient, condition for rolling-out treatment programmes across SSA.

But ten years after these initial important victories the fundamental tensions between the global IPR system and the right to health have not been resolved (UNGA, 2009). Rather, ‘biocapital’ (Comaroff, 2007, p. 213) remains a key frontier in the expansion of neoliberal capitalism as evidenced by US and EU efforts to entrench the global IPR system through various bilateral and multilateral trade agreements - a system, it ought to be stressed, that disincentivizes drugs research for poverty-related diseases. Hence the dearth of, for example, paediatric and infant ARV formulas. The planned EU-India Free Trade Agreement in particular has become a central battleground over access to medicines. Indian generic ARVs, instrumental to bringing down the cost of first-line treatment from $10,000 to less than a dollar a day, account for ‘more than 80% of the donor-funded developing country market’ (Waning et al., 2010, p. 3). But as patients develop resistance to treatment, they need the vastly more expensive second and third-line ARVs, for many of which no affordable generic copies exist. According to critics, some of the IPR provisions in the trade deal could imperil India’s role as ‘pharmacy of the poor’. With millions on ARVs and many more in urgent need, efforts to buttress the global IPR regime, together with the fall in treatment funding, may herald a return to a time when the poor were ‘condemned…to death simply because they could not pay for life-saving medicines’ widely available for the affluent (MSF, 2007).

There is, of course, no simple chain of causality between particular economic policies and the severity of the pandemic in SSA. Neither can all of Africa’s ills be attributed to external interventions. However, on the basis of available evidence we argue that the cumulative impact of Africa’s encounter with neoliberalism has produced disastrous context-specific developmental consequences, disproportionately borne by women, including persisting levels of extreme poverty and the unequal distribution of vulnerability and risk, access to life-saving medicines and capacity to cope with the disease. In other words, ‘neoliberalism creates the enabling environment for millions of avoidable deaths in sub-Saharan Africa’ (Ezeonu, 2008,
Stephen Lewis, the former UN Envoy for HIV/AIDS in Africa, witnessed the combined ravages of AIDS and neoliberalism: ‘It was a form of capitalist Stalinism. The credo was everything; the people were a laboratory’ (2005, p. 16). Any progress made in the fight against HIV/AIDS, we argue, must be placed against this legacy of structural violence.

Yet instead, ‘[t]he ‘neoliberal era’ has been a time of looking away, a time of averting our gaze from the causes and effects of structural violence’ (Farmer, 2005, p. 16). What then are the cultural mechanisms which efface structural violence from our collective imaginary? ‘What is it about Africa that allows the world to write off so many people – to make people expendable?’ (Lewis in Jones, 2004, p. 385).

Frames of AIDS and Cultural Violence

To address these questions, we need to move beyond an analysis of the political economy of the global response, for policies are always ‘informed by, and situated within, prior cultural interpretations of the disease’ (Jones, 2004, p. 386). When Barnett and Whiteside argue that HIV/AIDS is ‘a global epidemic that defines the excluded of the world’ (2002, p. 7), we must bear in mind that that is never merely a material condition. It is always enabled by what Galtung terms ‘cultural violence’, which ‘makes direct and structural violence look, even feel, right - or at least not wrong’ (1990, p. 291) and, following Butler (2009), renders structural violence unrecognizable as violence. To understand how the conditions necessary to sustain certain lives can be withdrawn without leaving a mark in public discourse, we need to interrogate the images, messages and narratives - the frames - through which policy actors and the general public portray, perceive and interpret HIV/AIDS and poverty, Africa and its peoples.

We borrow the concept of a ‘frame’ from the study of political communication, where it is defined as the organizing mechanism with which the vast complexity of social reality is filtered and organized into categories of intelligibility. Framing is ‘the process of culling a few elements of perceived reality and assembling a narrative that highlights connections among them’. By ‘activating schemas that encourage target audiences to think, feel, and decide in a particular way’ framing privileges certain interpretations of the perceived reality over others (Entman, 2007, p. 164). How AIDS in Africa is framed in public discourse thus shapes not only the range of policy responses deemed feasible, appropriate and rational, but also our political and affective response to the suffering of ‘distant others’. The dominance of particular frames reflects and, in turn, reinforces existing inequalities of economic, political and cultural capital, such that certain interpretations of the pandemic ‘predominate not because they necessarily offer the most comprehensive framework for understanding AIDS, but because of power and legitimacy of the institutions from which they emerge’ (O’Manique, 2004, p. 4). Accordingly, Bardhan’s empirical frame analysis of five global news agencies shows that ‘Western conceptions of the pandemic’ and ‘dominant AIDS-related institutional forces of the West’ dominate media coverage of the pandemic (2001, p. 304).

Struggles over how the pandemic in SSA is framed have always been at the heart of the politics of HIV/AIDS (Sontag, 1990, Treichler, 1999). In what follows, we focus on two central frames and look at how their circulation in policy literature, the media and popular culture at large has played a key role in legitimizing the wider neoliberal paradigm within which the global response to AIDS has been enveloped.
Behavioral Frame: ‘African sexuality’ and the individualization of risk

Since its emergence, HIV/AIDS has been ‘overwhelmingly viewed first and foremost through a biomedical lens, and secondly through a narrow public health lens that focuses on individual sexual behaviour’ (O’Manique, 2004, p. 9). The production and circulation of knowledges about the disease in the public sphere has thus been predominantly shaped by the biomedical and public health establishment. Throughout the 1990s - the lost decade in the fight against AIDS in Africa - ‘biomedical sources, researchers, and policy players’ were the ‘dominant spokespeople for the pandemic’, making up almost 75% of all news sources (Bardhan, 2001, p. 300), and spasms of media attention closely correlate with annual International AIDS Conferences dominated by those same actors (Brodie et al., 2003, p. 4), constructing ‘a hegemonic reality’ (O’Manique, 2004, p. 6) which has profoundly shaped the global institutional response to the pandemic. While the biomedical dimension of this hegemonic reality is based on the belief in the scientific controllability of the virus, the behavioral dimension has its roots in public health and behavioral science and conceptualizes HIV/AIDS in terms of sexual norms, practices and behaviors.

When HIV/AIDS first emerged in the North, it became strongly associated with so-called ‘risk groups’ - homosexual men, intravenous drug users and sex workers - and early public health efforts were concerned with limiting the spread of the virus in these groups and preventing its spread into the wider population through various awareness-raising and behavior modification programmes. Yet, although the emerging epidemic in Africa was fundamentally different - being largely heterosexual in nature - the same frame was projected onto Africa, where it fell on and furnished the fertile ground of stereotypes marked by a long-standing fascination of Northern observers with ‘African sexuality’ (Griffin, 2011, pp. 234-236) and a tendency of ‘equating… ‘the dark continent’…with the savage, the alien, or the incomprehensible’ (Treichler, 1999, p. 101).

As a result, ‘African culture, poverty, ignorance and promiscuity’ were key explanatory themes advanced by the UK media for the emerging HIV/AIDS crisis in the late 1980s (Kitzinger & Miller, 1992, p. 40). The disease was portrayed as ‘something to do with Africanness and blackness itself’ (p. 49). When images of the ‘slim disease’ first appeared, they ‘fit neatly into the pre-existing Western image of a wasting continent’ (Patton, 1990, p. 83), where death is merely ‘a fact of life’ for media audiences and hardly newsworthy (Kitzinger & Miller, 1992, p. 36). In addition, depictions of the ‘Third-Worldness’ of Africa’s health care system reinforced the deeply entrenched Northern image of a helpless and hapless Africa in need of outside intervention (Treichler, 1999, p. 105).

Since no effective medication was known during the first decade of the mass outbreak of HIV/AIDS (1985-1995), these interventions focused on prevention. Yet, argues Stillwagon, ‘framing AIDS in Africa as something that results from an exotic and exceptional sexuality…has restricted the scope of acceptable research to sexual behaviour…and circumscribed actions taken’ such that prevention programmes in Africa have been primarily concerned with changing ‘risky’ behavioral and cultural norms during the past two decades (2006, p. 142). The assumption was that informing
people about the virus and how to avoid it is sufficient: ‘It’s as easy as A, B, C, (Abstain, Be faithful or Condomise)’ (Campbell, 2003, p. 7).

For most of the second decade (1996-2005), as noted above, treatment available for the affluent was deemed unsuitable or uneconomical for the poor. The ‘only practical course’ for African countries was still ‘to concentrate on prevention’, according to The Economist (1998), although ‘this, too, will be hard, for a plethora of reasons’, namely Africans’ untamable sexual urges fuelled by ‘myths’ - which lead ‘Ugandan men’ to ‘seduce schoolgirls’ who ‘believe that without regular infusions of sperm, they will not grow up to be beautiful’ - ‘sexism’, ‘drinking’ and ‘poverty’, naturally, since ‘[t]hose who cannot afford television find other ways of passing the evening’. Similarly, examining South Africa’s AIDS crisis, the BBC’s Panorama concluded that ‘the culture of casual, unprotected sex is quite literally killing South Africa. And no amount of expensive medicine can change human behaviour’ (BBC, 2000).

Yet, even after the dramatic fall in ARV prices from 2000 onwards, most global health actors continued to argue against rolling-out treatment in Africa by drawing on the same repertoire of racial and neo-colonial stereotypes. Anti-retroviral therapy was considered too sophisticated not only for Africa’s primitive health care systems but for impoverished, illiterate Africans themselves. As the head of USAID explained: ‘Ask Africans to take their drugs at a certain time of the day, and they don’t know what you are talking about’ (in Jones, 2004, p. 397). Treating incapable Africans was deemed wasteful and money was best spent on ‘cost-effective’ prevention and self-help programmes. The message was clear: the poor simply have to learn to ‘cope’ with their suffering while ‘the rich will show them how to do it’ (Barnett & Whiteside, 2002, p. 325).

Nowadays still, the perceived sexual depravities of Africans, given renewed impetus by the neo-conservative religious agenda of PEPFAR (Nauta, 2010, pp. 370-371), are frequently cited to justify behavioral modification interventions and as the root cause of failure to control HIV/AIDS in Africa. In the New York Times, a ‘consultant to U.S. health agencies fighting AIDS’ declares categorically that ‘Nowhere more than in sub-Saharan Africa is AIDS so vividly a disease bred by life-threatening cultural attitudes,’ African ‘cultural norms’ are ‘devastating’ and ‘[c]hanging a culture that casually accepts dangerous sexual behaviour is the only way to save lives’ (LaPorte, 2004). Even according to UNAIDS: ‘effective HIV prevention often requires changes to deep-seated traditions and social norms regarding human sexuality’ and ‘persuading sexually active individuals to accept partner reduction and monogamy as valued norms may be critical to the long-term success of HIV prevention efforts’ in SSA (UNAIDS, 2006, p. 127).

In the late 1980s, AIDS activists in the United States began to challenge the insular world of the biomedical establishment and expose the tacit sexist, homophobic and racist premises of scientific research and prevention schemes.[3] Activists effected radical changes in the power structures, practices and discourses of the national public health apparatus and ‘redefined people living with a disease from the objects of pity (and sometimes judgement) to the arbiters of how that disease should be dealt with’ (Smith & Siplon, 2006, pp. 155-156). Yet, the hegemonic framing of the African pandemic has proven extremely resilient, a point to which we shall return below.

To be sure, sexual behavior is an important factor in the pandemic but by itself it ‘cannot explain HIV prevalence as high as 25 per cent of the adult population in some African countries and less than 1 per cent in the developed world’ (Poku, 2005,
Moreover, this preoccupation with Africa’s ‘exceptionally high-risk sexual cultural system’ (Leclerc-Madlala, 2010) finds little empirical grounding as ‘it has become increasingly clear - by almost all measures of risky behaviour… - that sub-Saharan Africa is little different from other regions around the world’ (Sawers & Stillwaggon, 2010, p. 202). Already in 1995 the WHO predicted that ‘AIDS will become…largely a disease of the poor’ (1995, p. 21). Yet the individualization of responsibility for risk intrinsic to the behavioral frame (and, incidentally, to a neoliberal conception of society) effectively abstracts our understanding of the pandemic’s strikingly non-random distribution from the structural violence of abject poverty and pathologies of inequality. It is this framing of AIDS in Africa which, according to Poku, has enabled IFIs ‘to pursue their abhorrent structural adjustment programmes…on the continent, uninterrupted’ (2005, p. 9). And even when global health agencies today readily acknowledge food insecurity, gender inequality and poverty as key socio-economic determinants of risk and vulnerability, the call for a ‘structural approach’ to HIV prevention (UNAIDS, 2010, p. 76) remains silent about the underlying structural forces of neoliberal globalization sustaining and exacerbating these conditions.

**Philanthrocapitalist Frame: the corporate-celebrity takeover of AIDS**

Parallel to the behavioral framing of AIDS, a second frame, described as ‘a liberal humanist view of AIDS as a terrible tragedy that demands care and compassion’ (Treichler, 1999, p. 317), has played an important role in popular representations of the pandemic:

‘perhaps no single view of the epidemic has done more important cultural work [and] served important social ends, asking citizens to rise above prejudice, discrimination, and fear and help the suffering’ (Ibid.)

Recent years have seen numerous corporate-celebrity campaigns - Product RED, Fashion against AIDS, Live8, and Digital Death - adopting this narrative and the plight of African AIDS ‘victims’ as their principal cause. Part of the much wider phenomenon of philanthrocapitalism[5] – “the use of business thinking by large new donors to transform philanthropy” (Edwards, 2009, p. 237) and an unashamed embrace of the ideology, strategies and practices of transnational capitalism as a means of affecting positive change in the world – it is particularly these initiatives that signal a wider shift away from the ‘pornography of poverty’ of past representational strategies of Northern charities towards a rebranding of development as ‘sexy’ (Cameron & Haanstra, 2008). Images of wasting bodies and emaciated children are out. Instead, celebrating affluence in the North, concern for Africa is repackaged in the ‘glitz, glam and fashion-magazine gloss’ of commodity fetishism (Richey & Ponte, 2008, p. 720).

Product RED, launched by U2 singer Bono in 2006, is among the most prominent and invites Northern consumers to purchase RED products from partner corporations of which a share goes to the GFATM.[6] Thanks to savvy corporate branding, Bono’s stature in the development industry and the enrolment of other celebrities, it has received extensive media coverage and endorsements by diverse publications such as The Lancet, The Independent (UK) and Vanity Fair. In addition, more than 80 global iconic landmarks were lit red on World AIDS Day[7] and ‘a
concert series that saves lives’ supported the initiative.[8] More recently, Digital Death, launched by Alicia Keys on World AIDS Day 2010, sets out ‘to help save millions of real lives affected by HIV/AIDS in Africa and India’. Dozens of celebrities seized their Twitter and Facebook communication to raise money for Keys’ ‘Keep a Child Alive’ charity. Only when fans donated one million dollars, would the celebrities revive their digital lives. By donating, texting, purchasing a ‘BUY LIFE’ T-shirt or scanning a barcode imprinted on the T-shirt using their ‘smartphones’, fans were called upon to join the fight against ‘this terrible disease’ and ‘give millions of real people the care, love and hope they deserve.’ [9]

Although these campaigns avoid the stereotypical imagery of Africa, they do little to challenge the symbolic politics governing donor-recipient, North-South power relations. Deprived of agency and voice, Africans are framed as distant others to be rescued by affluent, ethical, cosmopolitan shoppers, while celebrities have become their self-appointed spokespeople. Bono even admits ‘They haven’t asked me to represent them. It’s cheeky but I hope they’re glad’ (in O’Neill, 2006). Digital Death takes the silencing of the ‘Other’ a step further by the total absence of its intended beneficiaries on its website. Instead, stylized, sexily-clad celebrities in coffins have become the avatars of dying Africans.[10]

The growing pervasiveness of these schemes in popular culture marks an important shift in the production and circulation of knowledges about the pandemic, which is increasingly being shaped by the burgeoning corporate-celebrity-NGO philanthrocapitalist complex. Drawing on Biccum’s analysis of Live8, the ‘megaspectacle’ organized by Bono and other self-proclaimed saviors of Africa during the Gleneagles G8 summit, these campaigns are thus best understood as ‘theatre[s] of legitimation for the neoliberal agenda’ (2007, p. 1112), seeking to recruit their audiences as active subjects in the reproduction of neoliberal hegemony. Comaroff’s reading that Africa constitutes ‘an axis of irrelevance’ (2007, p. 201) from the vantage point of the North therefore misses the point. Rather, Africa, AIDS and poverty - themes around which the alter-globalization movement had coalesced in the late 1990s - have now become key symbols around which popular consent for the contemporary global capitalism is being mobilized (it is no coincidence that RED was launched at the World Economic Forum). As forms of agency compatible with capitalism are made sexy, anti-capitalist resistance is not’ (Cameron & Haanstra, 2008, p. 1484). Northern consumers can continue what they do best – shopping: ‘Buy RED, save lives. It’s as simple as that.’[11] The call to action is: ‘Become a walking charity box with your own, scannable BUY LIFE T-Shirt’. [12] Or as Keys says, simply do ‘what you always do’ (Wallace, 2010) - consume, communicate - and, almost inadvertently, save a few Africans.

In sum, the philanthrocapitalist frame produces and circulates an understanding of the pandemic which erases any contradiction between the hegemony of global capitalism and the fight against AIDS and masks the structural relationship between mass consumption and global relations of production and trade that sustain poverty, inequality and the differential distribution of HIV/AIDS. It shifts attention from the way we are implicated, by doing ‘what we always do’, in the structural violence of the global order. A framing that reduces the public response to the AIDS crisis to a matter of compassion and charitable consumption creates the cultural conditions for structural violence to take place and at the same time renders it invisible. In Galtung’s words, it makes it feel right, or at least not wrong, and as such constitutes the archetypal form of cultural violence.
Transnational AIDS activism: counter-framing and its limits

As the legacy of World AIDS Day becomes usurped by corporate-celebrity schemes and donors succumb to a growing ‘AIDS fatigue’, there is a danger that much of the progress in breaking down the wall of global medical apartheid, owed largely to the mobilization of an extraordinary North-South coalition of AIDS activists since the mid-1990s, becomes undone. South African campaigners took on the monopoly power of pharmaceutical giants in courts and violated global patent rules by ‘illegally’ importing cheap generic drugs from Thailand (Nauta, 2011). MSF’s pilot project in the poverty-stricken Khayelitsha township blew apart the prevailing myth that treating the poor is unfeasible (MSF, 2003), while other groups challenged the complacency of rich governments and obstinate international bureaucracies.

But, perhaps most importantly of all, the transnational AIDS movement exposed the moral economy at play in the denial of life-saving medicines to the poor and, for a brief moment in the early 2000s, ruptured the hegemony of frames which had until then naturalized the millions of silent deaths taking place throughout the SSA. Through protests, civil disobedience campaigns and clever media work, the movement successfully ‘countered the prevalent market- and charity-based approaches with a compelling right-based narrative that had tremendous resonance with many target audiences’ (Smith & Siplon, 2006, p. 156). It did so by framing the issue of access to ARVs as a David versus Goliath story - ‘a brave band of activists coming together for a pitched struggle against a callous, profit-driven pharmaceutical industry being aided by a complicit government in the quest to keep affordable medications out of the hands of dying people’ (Ibid., p. 160; see also Olesen, 2006). When activists re-branded GlaxoSmithKline as ‘Global Serial Killer’, the company was compelled to react by lowering the prices of its patented ARVs.[13] It was a counter-frame, in the words of the UK’s leading global health correspondent, ‘that everyone could run with’. [14]

These crucial achievements were made possible by a form of strategic reductionism: a narrow focus on treatment. Today, however, all global health actors support the cause of universal access to treatment, prevention and care, robbing the crude David versus Goliath frame of its oppositional force. Inevitably then, ‘framing the next chapter will be more difficult’ (Smith & Siplon, 2006, p. 160). As a leading activist explains, the achievements confront us with the important issues consciously ignored in 1999:

‘Keeping people with HIV alive requires controlling TB and malaria; treatment without effective prevention will never control the epidemic; anti-poor economic policies perpetuate poverty and inequality and block people from accessing care and treatment. We have now opened the Pandora’s box of the world’s ills that we always knew was there’ (Berkman, 2006, p. 165).

In order to effect such a radical transformation of present global political and economic arrangements, the transnational AIDS movement will have to partner with other movements struggling for democracy, human rights and social justice, within and beyond the immediate field of global health politics.

Concluding remarks
In this article we have argued that the system of global governance - its rules, practices and norms - has not only failed to fundamentally address but, in fact, has directly contributed to the deprivation of capabilities of the poor and the unequal distribution of risk and vulnerability to HIV/AIDS. Without a decisive departure from the neoliberal paradigm, the disease will continue to exact a devastating toll throughout SSA. Two frames, through which the pandemic is portrayed and perceived, play a dominant role in this process. The behavioral frame reduces HIV/AIDS to its clinical and behavioral dimensions, while largely ignoring the wider political and economic arrangements that consistently produce sub-standard solutions for the poor. Moreover, we have shown how the AIDS crisis in SSA is being incorporated into popular culture by philanthrocapitalist initiatives, further evacuating politics from public discourse about the pandemic and silencing counter-hegemonic voices that played a major role in the progress that has been recently achieved in the fight against HIV/AIDS. This is now in peril.

Addressing the structural factors negatively impacting the progress necessitates a continuous disruption of the mainstream frames, which mask transnational responsibility for the unequal distribution of risk and vulnerability to the disease. For frames are not just post-facto impositions on an already established social reality. Rather, their power resides in the ability to shape the terrain on which the struggle for life in times of HIV/AIDS takes place. As the deepening global economic crisis exposes the fissures in the edifice of Northern hegemony, opportunities arise for alternative imaginaries of North-South relations: ‘For decades the Washington consensus lorded over the developing world; now the lecturing has changed direction and emerging societies ‘talk back’” (Nederveen Pieterse, 2011, p. 42). Of course, shifting balances in global politics and new Southern arrangements such as BRICS [15] carry no inherent ‘emancipatory potential’ (Ibid.). Left unchallenged, however, it is clear that the seemingly inexorable logic of austerity unleashed by the crisis threatens to undo the important work done by the global AIDS movement and create the conditions whereby the denial of life-saving treatment and care is ultimately seen as rational and unavoidable.

Notes
The authors would like to thank Josephine Liebl for her helpful comments on ideas presented in this article.
1 See Harrison (2010, pp. 18-35) for competing definitions of neoliberalism and Harvey (2007) and Rowden (2010a, pp. 53-77) for its historical and political origins and trajectories.
2 See also Stuckler et al. (2011) about the relationship between IMF programmes and health aid displacement. However, it is also African governments that often under-spend their health budgets and over-spend their military budgets (de Waal, 2006, pp. 103-106).
3 Note the early association of HIV/AIDS with the ‘4Hs’ - homosexuals, heroin users, haemophiliacs, Haitians - codified by the US Centres for Disease Control and Prevention.
4 Senior Anthropology Advisor to USAID
5 There is a growing body of literature on the powerful agenda-setting role of the biggest philanthrocapitalist actor dealing with HIV/AIDS in Africa: the Bill and Melinda Gates Foundation, whose multi-billion budget thwarts the resources of most traditional global health actors (see Edwards, 2009; McCoy, et al., 2009). In this section we focus on a particular corporate-celebrity strand of philanthrocapitalism that plays an increasingly prominent role in Northern popular culture.
6 Partner corporations include, amongst others, Apple, Gap, Nike and Starbucks.
The increasing prominence of celebrities also aggravates African AIDS activists: ‘We find it unacceptable that activists who come from regions most affected by HIV/AIDS are given less of a voice than those people who are rich and famous…’ (Green, 2006). Furthermore, Youde’s argument that Product RED offers a ‘pragmatic response to augmenting funds for AIDS treatment in Africa’ (2009, p. 201) rings rather hollow, since its proceeds represent less than 1 per cent of the GFATM budget.
References


