CHAPTER–VII

CHAPTER - VII

GLOBALISATION AND NGO RESPONSE TO HIV/AIDS

Globalisation has affected all facets of life. In recent years, we have witnessed an unprecedented debate on globalisation. Attentions have been focused on the origin and main features of globalisation and its potential impact on world economic, political and social order. This policy debate is quite understandable, as the pace and consequences of globalisation have implications for every individual, community or nation. It is changing the lives of people in developed as well as in developing countries. Recent financial and economic regional crises ranging from Mexico to Russia and East Asia, the failure of the New Millennium 'Development' Trade Round in Seattle, hot debates at the UNCTAD-10 Conference in Bangkok, and the recent South-South meeting in April 2000, have brought the discussion on globalisation to a new peak of rhetoric and passion (McCarty, 2001). Several statements and judgements are made by different distinguished personalities on the nature of globalisation, but the debate is still far from over. Some of the common questions asked by the people are: What is globalisation? Is it good or bad for human development? Is it something new, or part of a longer historical process? How does it affect the developing countries? How to protect vulnerable groups from the volatility of the globalisation wave?

What is Globalisation?

The term "globalisation" has been given a number of meanings. The definition of globalisation can be quite elastic, going beyond economic integration of the world to encompass political and cultural integration as well (Osmani 2005). At its broadest, it has been used as a term encompassing any form of societal change with transnational dimensions. In general, globalisation is the term used to characterise the processes of growing interconnection and interdependence in today's world, generated to a large degree by growing international economic, cultural and political cooperation and links, as well as by the need to respond together to global problems which can be solved only on a planetary scale (Dommen 2001). Globalisation is a process of change. It is a process, which increases economic and other interactions between countries due to the persistent decline in international transaction costs. According to

Prof Galal Amin (1999), "Globalisation is a multifaceted phenomenon, which includes the acceleration of international trade, of the flows of labour, capital and technology as well as of the transfer of ideas and patterns of living".

Some of the specific characteristics of globalisation include the rapid development and expansion of information technology, including internet links and cellular phones; the speed of communications, including cheaper and faster international transport; the intensification of international trade and foreign direct investment flows; the increase of financial flows, with globally linked foreign exchange and capital markets, operating 24 hours a day; the growth in the size and power of private corporations; global business competition and global consumer choice; and the sheer number of people affected by globalisation. In this sense globalisation has been defined as "a process of rapid economic integration among countries, driven by the liberalization of trade, investment and capital flows as well as rapid technological change" (Held 1999); and one of its main characteristics is the convergence of globalising tendencies within all the key domains of social interaction.

Globalisation is not new

The numerous definitions of globalization emphasize different aspects of the process and in doing so express different evaluations and ideological stances (Went 2000). Globalization is not a new phenomenon. When people make comments like "globalisation is fundamentally new" only make sense in this context but are yet misleading. It is better to speak of globalism as a phenomenon with ancient roots and of globalisation as the process of increasing globalism, now or in the past. The issue is not how old globalism is, but rather how "thin" or "thick" at any given point of time (Held, 1999). The Silk Road provided an economic and cultural link between ancient Europe and Asia is an example of "thin globalisation". But the route was used by a small group of traders and the direct impact of the trade was primarily on small and relatively elite consumers along the road. In contrast, "thick globalisation" involves many relationships that are intensive as well as extensive: long-distance flows that are large and continuous, affecting the lives of many people through out the world. Often, contemporary globalisation is equated with Americanisation, especially by non-Americans, who resent popular culture of USA and the capitalism that accompanies it. If we think of the content of globalisation being "uploaded" on the Internet and then "downloaded" elsewhere, more of this content is uploaded in USA than anywhere

else.[1] However, the ideas and information that enter global networks are downloaded in the context of national politics and local cultures, which act as selective filters and modifiers of what arrives. Political institutions are often more resistant to transnational transmission than popular culture. Globalisation today is America-centric and the central position of USA in global networks creates "soft power": the ability to get others to want what Americans want (Nye 1990). But the processes are reciprocal in many respects, rather than one way only. Soft power is a reality, but it cannot be credited with USA in all areas of life, nor it is the only country to possess it. This historical background is important as it shows that transport and communication inventions and innovations have been causing dramatic economic upheaval and development throughout the past 200 years. Globalisation refers to this process between countries, but it also happens within one country, as the economic history of America shows.

Is there anything about globalism today, which is fundamentally different? Historians can always find precursors in the past for phenomena of the present, but contemporary globalisation goes "faster, cheaper and deeper" (Friedman 1999). The thickness of globalisation is giving rise to increased density of networks, increased institutional velocity and increased transnational participation. As a result, it is expected that globalisation will be accompanied by uncertainty. On the one hand, there will be a continuous competition between increased complexity and uncertainty; and efforts by the governments, market participants and others to grasp and manage these complex interconnected systems, on the other.

General Impact of Globalisation

The impact of globalisation as it becomes evident in economic sphere has not left social and political sphere untouched. In the economic sphere as there is greater emphasis on privatisation and opening of economy for foreign capital. In political sphere too, the first world's institutions and standards are projected as a model. Individualism is re-emphasized in recognition of not only a form of individual's freedom of creating wealth and property but also as living a life of dignity that entails availability of basic necessities of life like food, water and shelter. Freedom from want, fear and insecurity is the basic condition to be human. Overall, many aspects of

[1] Professor Anne-Marie Slaughter of Harvard University Law School used the expressions of "uploading" and "downloading" content, at John F. Kennedy School of Government Visions Project Conference on Globalisation, Bretton Woods, N.H., 1999.

the functioning of the new global economy are still poorly documented and understood. This state of relative ignorance has provided fertile ground for the growth of anxiety over the effects of globalisation.

There are both positive and negative impacts of globalisation. A world-wide wave of trade and investment liberalisation (but, notably, not of general labour market liberalisation) is an important factor behind globalisation in recent decades, spurred in part by the rejection of central planning and similar protectionist development models in many countries (McCarty 2001). The average tariff rate across all countries has fallen steadily from 40 percent in 1940 to about 5 percent in 1995 (Dicken 1998). Globalisation is now also being driven by the notable improvement in the quality and declining cost. Mobile phones, facsimile machines, and the Internet have introduced new communication choices. The worldwide number of Internet hosts increased from about 3 million in 1994 to over 50 million in 1999 (World Bank 2000). The movement of financial and capital flows across borders is both a cause and effect of this "information revolution" and the liberalisation trend: the daily turnover of foreign exchange markets increased from $US1.1 billion in 1992 to $US1.6 billion in 1995; international liquid capital flows grew at an average 25% per annum during 1980-1995; and global foreign direct investment increased from US$193 billion in 1990 to US$400 billion in 1997 (World Bank 2000). Thus, while globalisation may not be new, it is different: faster, and driven by new information-based technologies and liberalising reforms to exploit the comparative advantages of nations. It is also, arguably, becoming more inclusive.

But in spite of all these advantages, why are we all not applauding globalisation? Because, a number of processes associated with globalisation have been considered to have had negative impacts. In normal use, globalisation tends to refer to just business transactions. So it values business transactions above all others – the social, cultural and other transactions between people. Therefore, globalisation really tends to be used to mean globalisation of markets, not the globalisation of society. But that is not the only problem. Agriculture has been devalued by the processes of globalisation. If we look at the wealth gap not between rich and poor countries, but between the rich and poor people, we will find that the gap is widening continuously and rapidly. In 1960, the poorest 20 percent of the global population received 2.3 percent of the global income. By 1991, their share had sunk to 1.4 percent and today it is only 1.1 percent of the global income. The ratio of income of

richest 20 percent of the people to that of poorest 20 percent was 30:1 in 1960, and by 1995 that ratio stood at 82:1 (Rao 2008). This is based on distribution between rich and poor countries, but when maldistribution of income within countries taken into consideration, the richest 20 percent of the world's people got at least 150 more than poorest 20 percent (UNDP 1992). This richest 20 percent of highest income countries account for 86 percent of the global consumption, while poorest 20 percent, only 1.3 percent. It has been argued that "globalisation is proceeding largely for the benefit of the dynamic and powerful countries" (UNDP 1997). It can also be perhaps described as a neo-colonial marriage between metropolitan financial interests and metropolitan industrial interests (Patnaik 1999). The supporters of globalisation may argue that the gap between North and South is reducing, not increasing. It is true that over recent years the growth rate of Southern countries is slightly ahead of Northern countries. It is because of just few countries, China and India in particular. If we take out China from the picture, we would see that developing countries are still falling behind the industrialized countries. Even if growth rate might be higher for the southern countries, it is not same as catching up with the North. The growth of an economy is like acceleration of the economy, its not to do with the over all size. "To say that the developing countries are catching up with the North is a little bit like saying that a bicycle that sets off to try to catch a racing car that is going at full speed. If we are able to maintain the acceleration, it would take 74 years at the current growth rate for the developing countries to catch up with the industrialized countries. And for the first 50 years of that progress, the absolute gap between North and South would continue to widen" (Clark 2003). Another thing is that inequalities are not just between North and South; it is very much present within different regions of the country, particularly between rural and urban areas.

From human rights perspective also, globalisation has many negative impacts. The debt situation of the third world countries – itself a product of first world's lending policies in the past – became the vehicle for neo-colonial onslaught. Future loans from IMF and World Bank are linked with broad package of macroeconomic policies in the form of 'Structural Adjustment Programme (SAP)'. Indebted countries were obliged to accept this in order to qualify for loan rescheduling and continued international assistance (Gershman and Irwin 2000). The fundamental feature of SAP included a reorganization of poor countries' economic and social policy structures in line with the ideology of economic neoliberalism. The role of the state was

minimized, the private sector deregulated, and market forces freed. SAPs forced the privatization of many government assets, sharp public sector budget cuts especially on health and education, scaling back of labour protections, the elimination of price controls and subsidies on food, and the imposition of "user fees" for health services and education. In theory, SAPs were intended to stimulate growth and help reduce the burden of poverty; but in practice, the austerity measures often exacerbated poverty (Schoepf et al. 1992). The quality and provision of basic services in many countries are either decreased or privatized. It can result in significantly reduced poor people's ability to access to these services which are essential for the enjoyment of the rights recognized in human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). A decrease in the availability of public services can result in adverse affects on the rights to education, to health, to an adequate standard of living, and on women's rights. The right of everyone to social security may not be ensured by arrangements that rely entirely on private arrangements and on private schemes. The reduced quantity and quality of basic services can be further reduced if elites and middle classes "opt out" of national level systems of service (Dommen 2001). At the UN Millennium Summit in September 2000, countries recognized the potential of globalization but noted that it was also characterized by risks and uncertainties that could further exacerbate existing imbalances and further polarize the "haves" and "have nots".

Thus, the problem is not with the globalisation per se but with the selective way that the globalisation has been managed in a way that widens inequalities of wealth and power. Good governance of globalisation is a reality. One cannot escape its forces. And there is no denying that globalisation has led to the marginalisation of a large number of already vulnerable sections of society. The challenge before the state is not how to fight globalisation but how to manage it with good governance. The good governance is linked with what UNDP's Human Development Reports call "building capabilities and widening the choices of all". Of course, the capability building approach is better than the so called basic needs or minimum needs approach (Raj 2002). As Prof. Amartya Sen points out, needs is a more passive concept than capability and it is arguable that the perspective of positive freedom links naturally with capabilities (what can the person do) rather than with the fulfillment of their needs (what can be done for them).

Globalisation and Health

There are two broad views of how globalization affects health. The optimistic view sees the increased interdependence attendant upon globalization resulting in an increased willingness of nations to work together in pursuit of improved health because this would serve their rational self-interest. This offered an optimistic analysis of the health benefits of globalization to poor countries and to poor communities in rich countries. This view argues that increased pace of cross-national exchanges should facilitate diffusion of technological innovations such as new and effective contraceptive methods, techniques for enabling access to clean water, inexpensive refrigeration, efficient transport and communication technologies, and new and effective systems for prevention and treatment of infectious disease (Barnett 2000). From cultural and political level, it also includes acceptance and application of common human rights through out the world. Globalisation can play a positive role in facilitating exchange of information on health policies and exchange of health services. Globalisation can also facilitate the realization of human rights such as the rights to information and to education, which in turn are important for the realization of the right to health.

On the other hand, the pessimistic view sees globalization as a phenomenon, which because of the increasing loss of sovereignty by nation states means that states are less willing to pool resources (Barnett 2000). Increased movements of people seeking employment, changes in behaviour, and increased movement of goods across the world, for instance, have contributed to the more rapid spread of diseases such as malaria, HIV/AIDS, and tuberculosis. The adverse health effects associated with this are exacerbated by reductions in basic services as limited resources in developing countries constrain the governments' capacity. The right to health should not to be understood as a right to be healthy, but that it does embrace a range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

In addition to the fact that multinational pharmaceutical companies have fought to keep prices of important drugs high, making it harder for governments to protect and fulfill the right to health. These companies also tend to invest more into research into diseases that affect rich countries rather than those that affect the poorest

inhabitants of the low-income countries. For the more readily available large profits from treatments of diseases in rich countries, they have been paying less attention to the needs of the poor countries. That's why the pursuit of an HIV/AIDS vaccine has been of less interest to big pharmaceutical companies as they get more profit from development of treatments than vaccines. These concerns have been particularly evident in the some pharmaceutical companies' efforts to ensure strong patent protection for their products, and their obstruction of production of cheaper, generic versions of important medicines. Pharmaceutical companies have brought cases against countries like South Africa and Philippines for their initiatives to make drugs available at lower cost through compulsory licensing or parallel imports. The US government has brought legal challenges against Thailand, Brazil and other countries' initiatives to allow compulsory licensing for production of inexpensive generic versions of expensive drugs to treat HIV/AIDS.

In this context, role of the international agencies are also need to be discussed. Although neo-liberal economic ideologies and the World Bank have not always been identical, they have certainly been very close. The World Bank has had a profound influence on health provision in poor countries as the largest external financer of health activities in low and middle income countries. It has also been a major voice in national and international health policy debates and an important contributor to health policy research. Over the past two decades, the thrust of the World Bank's strategies was to emphasize the role of the market in health care provision. Government's role was to be mainly regulatory, by supervising the marketplace, insurance legislation, ensuring "acceptable" levels of access. But, it ignores the social ethics of health care and defines health services as commodities to be delegated to the market sector of an economy; ignores the provision of public goods such as immunization and public sewage; and generally seeks to shift the larger burden of curative services to the private sector, which makes it available to foreign investment. The WHO, whose work in this area is underpinned by human rights concerns because of its focus on equity of access to drugs, has taken a number of initiatives to this end. WHO says that patents should protect the interest of the patent-holder while safeguarding public health, and supports measures, which improve access to essential drugs (WHO 2000: WTO 2001). But, World Trade Organisation (WTO) did not agree to change Trade Related aspects of Intellectual Property Rights (TRIPS).

In addition to all these, brain drain is another problem. Less than a decade ago, the biggest problem in global health seemed to be the lack of resources available to combat the multiple scourges ravaging the world's poor and sick. Today, there is an extraordinary and unprecedented rise in public and private funding; more money is being directed toward pressing heath challenges than ever before. But poor countries could be pushed even further into trouble, unless these efforts are properly coordinated and directed mostly at specific high-profile diseases rather than at public health in general; and unless the brain drain from the developing world can be stopped. This danger exists despite the fact that today, for the first time in history; the world is poised to spend enormous resources to conquer the diseases of the poor (Garrett 2007). Virtually no provisions exist to allow the world's poor to say what they want, decide which projects serve their needs, or adopt local innovations. Besides it, the world is now short well over four million health-care workers and this fact is all too often ignored. As the populations of the developed countries are aging and require even more medical attention, they lure away local health talent from developing countries. As per the Journal of the American Medical Association (JAMA), already one out of five practicing physicians in the United States is foreign-trained and estimated that if current trends continue, by 2020 the United States could face a shortage of up to 800,000 nurses and 200,000 doctors. Data from international migration-tracking organizations show that health professionals from poor countries worldwide are increasingly abandoning their homes to take up jobs in wealthy countries. In Ghana, 604 out of 871 medical officers trained in the country between 1993 and 2002 now practice overseas. Zimbabwe, similarly, trained 1,200 doctors during the 1990s, but only 360 remain in the country today (Garrett 2007).

Thus, we find that effective interventions exist for many priority health problems in low income countries; prices are falling, and funds are increasing. However, progress towards agreed MDGs related to health remains slow. There is increasing consensus that stronger health systems are key to achieving improved health outcomes. There is much less agreement on quite how to strengthen them. As a result, the health world is fast approaching in the road of uncertainty. The years ahead could witness remarkable improvements in the health of billions of people, or they could see poor societies pushed into even deeper trouble. The emerging outcome will depend on whether it is possible to expand the developing world's local talent pool of health workers, restore and improve crumbling national health infrastructures of

developing countries, and devise effective local and international systems for disease prevention and treatment.

Globalisation, NGOs and HIV/AIDS

Globalization forces have reduced state controls over the economy at the national level, increase pressure for democratic accountability, or raise questions about state sovereignty. These developments have created political space for civil society organizations as alternative sources of services once provided by the state, as watchdogs over and advocates for government policy formulation and implementation, as policy entrepreneurs or implementers with state partners, and as social innovators to guide improved services. In general, however, the more open the country is to globalization, the more we would expect civil society organizations to become important actors in the country's development. This is a function of three factors: (1) globalization has impacts on consciousness—both liberating and counter-revolutionary–that are likely to be expressed via civil society organizations; (2) globalization is likely to place enhanced emphasis on the political ideologies of individualism, freedom, and equal rights for which NGOs are both a product and an exemplar; and (3) globalization invites in international actors (INGOs, international agencies) that actively promote and strengthen the emergence of national civil societies (Brown et al. 2000). When globalization expands political space, civil society actors may emerge to respond to the concerns of impoverished and marginalized groups that would remain voiceless under prior regimes (Brown et al. 2000). Of course, neither globalization, nor a form of international governance, nor the emergence of a kind of transnational civil society undergirded by nongovernmental organizations is entirely new. NGOs and civil society alliances have been active in international governance and policy-making for many years. What is new is the recent explosion in numbers, activity, and visibility of international initiatives by civil society actors on a variety of issues, at least in part linked to the rapidly declining cost of communication. The emergence of international NGOs, networks, coalitions, and social movement organizations as potentially important political actors at both national and international levels has been stimulated by the need to create collective responses to threatening circumstances created by globalisation. By the count of the Yearbook of International Organizations, the number of international NGOs has grown more than fourfold (i.e. from 6000 to 26000) in the last decade (*Economist* 1999). While there is a great deal of variance in

the size and activity of the civil society across countries. the sector is growing rapidly in many countries and regions. It is estimated. for example. that more than 100.000 civil society organizations have emerged in Eastern Europe since the fall of the Berlin Wall. and more than 1.000.000 NGOs are operating in India (Smith et al 1997). International NGOs and NGO alliances are emerging as increasingly influential players in international decision-making. The focus of NGOs on official UN deliberations on the international policy agenda was evident at a number of major UN conferences and their preparatory meetings. Some of these conferences are: UN Conference on Environment (Rio de Janeiro. 1992). World Conference on Human Rights (Vienna. 1993). International Conference on Population and Development (Cairo. 1994). Fourth World Conference on Women (Beijing. 1995). World Summit for Social Development (Copenhagen. 1995). UNGASS (2001) and many more. These conferences attracted an unprecedented number of NGOs. There has been a dramatic increase in their importance in many arenas over the last two decades. This change has been characterized as a "global associational revolution" that may as important to the end of the 20th century as the rise of the nation state was a century earlier (Salamon 1994). NGOs formed coalitions and played a significant role in the accords to ban landmines. to establish International Criminal Court. to introduce code of conduct for baby food sales. to include women's reproductive health rights and on many more issues. NGO are also increasingly active in many different arenas like global warming. debt relief for heavily indebted poor countries (HIPC). elementary education for all children. trade related intellectual property rights (TRIPS). etc. At the international level NGOs and NGO alliances have identified emerging problems. articulated new values and norms. created or reformed institutional arrangements. fostered innovations in international practice. and helped to resolve conflicts and manage differences.

Thus the role of NGOs in society can't be ignored. This is true also in the field of prevention and treatment of HIV/AIDS. Two years after its first appearance in 1981. the AIDS virus had spread to 60 countries and it rapidly became a global pandemic. Globalisation is midwife both to the spread of the disease. as modern travel facilitates rapid dissemination of HIV infection across national borders. and. through concerted global action. triumphant conqueror over its devastating impact and expansion. William McNeill (1977) was among the first to draw our attention to the role of epidemic disease in human history. Many subsequent authors have noted its

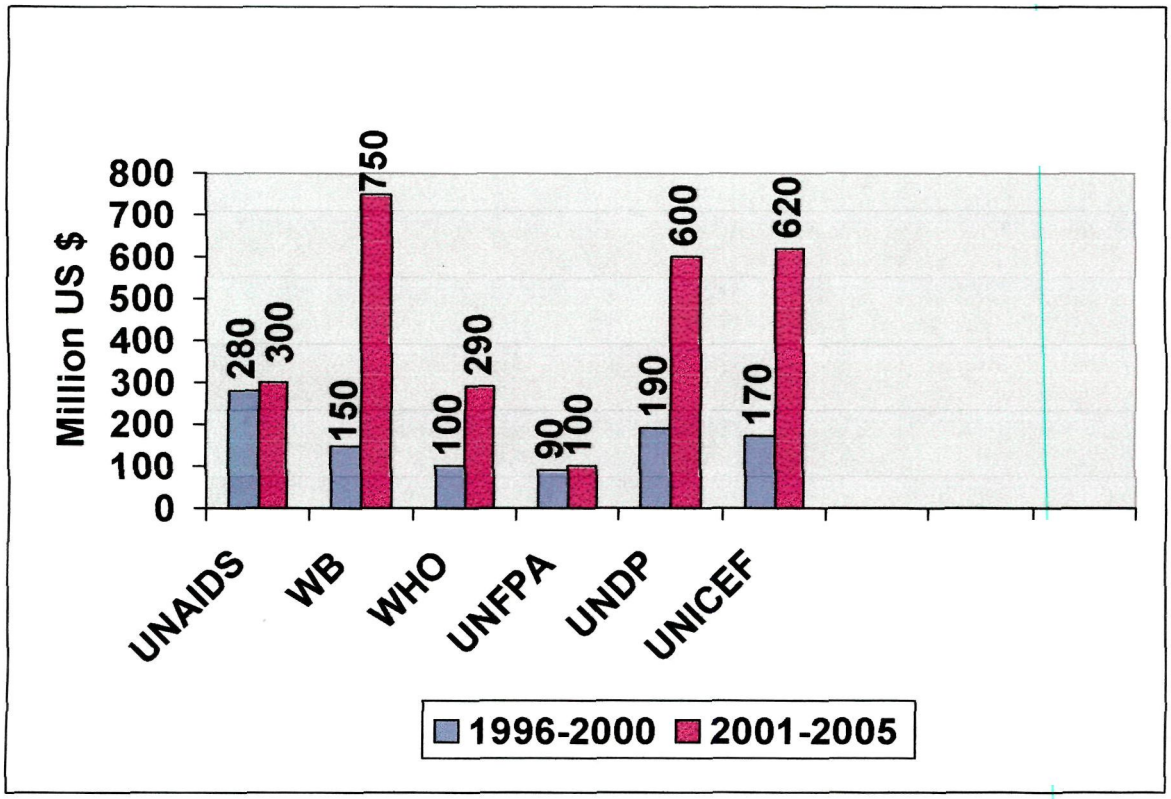
importance, and most recently Jared Diamond (1998) has informatively discussed its role in the increasing integration of human society and economy over the past 13,000 years (which may be another way of talking of "globalization"). HIV/AIDS is a global pandemic affecting the ultimate metapopulation – the entire human community. Its distribution is unequal: spatially, in terms of countries and parts of countries; socially, in terms of social and cultural groups; and economically, in terms of income and wealth classes (Barnett & Whiteside 2000).

In 1980s, when AIDS started gaining public attention, close friends, family members and other individuals came from the same interest group. People living with HIV/AIDS (PLWHA) were amongst the first to provide care and support. Despite reluctance and slow actions from many governments, these NGOs, particularly AIDS Service Organistions (ASOs) came forward to provide critical care and support to HIV affected people mainly because of their closeness and trust of the people on the ground. Beyond this personal support, many of these organizations have evolved into effective advocates who helped put issues squarely on to the national agenda (Bogasao 1998). Several CBOs and NGOs have since emerged from these groups hardest hit by AIDS. AIDS is no longer a concern for just health authorities. The potential impact of AIDS makes it a challenge in economic, political, social and religious spheres as well. Amongst the organizations responding to the crisis, NGOs are emerging as a powerful force in the effort to contain the epidemic Diverse groups at risk of HIV infection have been reached by NGOs in a wide variety of innovative programmes (Mercer et al. 1991). In areas of the industrialized world hardest hit by AIDS, NGOs helped set trend that have now been institutionalized within AIDS prevention. In the developing world, the NGO response to HIV/AIDS emerged somewhat more slowly. It reflects both lack of resources and experience, and a widespread reluctance to publicly acknowledge or recognize the threat. However, as the epidemic progressed, both well established and newly formed NGOs among the first to respond, promoting the need for PLWHA to have access to counseling, support and health care. They have mobilized impressive efforts for training, education and other supportive services while official declarations denied the existence of the problem (Morna and PANOS 1991; Haslegrave 1988; Mercer et al. 1991). The importance of NGOs in the NACP of developing countries has also evolved overtime.

The journey from the denial of early years to the AIDS bandwagon, and from these into infinitely complex world of HIV/AIDS awareness and control, has brought perceptible shifts of emphasis in interventions. Until the late 1990s, the governments of the majority of acutely threatened African States were silent about AIDS – the epidemic that ravaging their countries. The UN was of little help either. Its agencies were slow and resistant to responding to the threat that HIV posed to developing states, prone to intense institutional rivalry and bickering, and overly protective of vulnerable, established budgets and mandates. As the epidemic of HIV/AIDS continues to expand to all corners of globe, it is clear that every sector of the society must respond. It was not until 1987, six years into the pandemic that the WHO, the UN's leading public health arm, responded to the reality that millions of people had been infected with HIV in all continents. The WHO established the Global Programme on AIDS (GPA) in 1987 under the leadership of late Dr. Jonathan Mann. GPA successfully mobilized national responses, initiated needed research and became a voice for those living with AIDS. At that time, it was the WHO's largest programme. But it soon was plagued by conflict with other bodies of UN system. These rivalries, as well as concerns over WHO's senior leadership, an increasing preference by the wealthy nations for bilateral programmes in the face of declining foreign aid budgets and for UN reform after the cold war – led to calls for a more multi-sectoral response (Merson 2005). Accordingly the decision was made in1996 to disband GPA and replace it with a Joint UN Programme on AIDS (UNAIDS), to coordinate AIDS targeted programmes. In its leading advocacy role for worldwide action against HIV/AIDS, UNAIDS along with its eight co-sponsors – United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations population Fund (UNFPA), United Nations Educational, Social and Cultural Organisation (UNESCO), United International Drug Control Programme (UNDCP), International Labour Organisation (ILO), World Health Organisation (WHO), and World Bank (WB) – states its mission to " lead, strengthen and support an expended response to HIV/AIDS epidemic aimed at preventing the transmission of HIV, providing care and support for those infected and affected by the disease, reducing vulnerability of individuals and communities to the HIV/AIDS and alleviating the socio-economic and human impacts of the epidemic" (UNAIDS 2002). UNAIDS is actively engaged with leading global advocacy efforts, establishing baseline global facts on the pandemic, and coordinating accordingly the efforts of its

eight co-sponsoring agencies, all of which maintains their own substantial HIV/AIDS programmes. The ILO focuses on the pandemic's impact on the workers and employers; UNICEF focuses on disproportionate impact of HIV/AIDS on children and mothers; UNDP and World Bank have taken leadership roles in addressing the threat to development posed by HIV/AIDS in building national capacities across key ministries; UNDCP increasing focuses on preventing HIV transmission through illicit drug use; the UNFPA focuses on the connection between reproductive health and HIV. Later on, United Nations High Commissioner for Refugees (UNHCR) and the World Food Programme (WFP) are also included in UNAIDS as co-sponsors. The Figure 7.1 shows the spending of UN Agencies on HIV/AIDS during 1996-2005.

Figure-7.1: UN Agency Spending on HIV/AIDS



Source: UNAIDS 2007.

During 1990s, all countries established National AIDS Control Programme and adopted strategies and intervention to prevent the spread of HIV/AIDS. The strategies broadly included: (a) preventing HIV infection and (b) providing care and support to those living with HIV/AIDS. Lessons learnt from the experiences of last two decades clearly indicate that national responses should not wait for AIDS cases to soar. Instead they should focus on responding quickly, mobilizing all sectors and

recognizing and collaborating with NGOs and the private sector. Involving vulnerable groups at every step of policy and programme development and implementation is crucial for programme success.

In 1996, the same year when UNAIDS was established, researchers announced a new therapy to prolong the lives of people with AIDS. This highly active antiretroviral therapy (HAART) promptly saved millions of lives in developed countries. The HAART costs over US $ 10,000 per patient per year – a price affordable to few in developing countries. Wealthy nations increasingly disenchanted with the UN system and facing less in the way of AIDS mortality seemed more and more disengaged from the pandemic, despite its increasing devastating impact on the resource- poor countries. This wide gap separates the yearly per-patient cost of HAART from the average per capita income in the countries with highest HIV/AIDS burden. Despite two decades of austerity measures adopted under structural adjustment programme (SAP), many poor countries' foreign debt continues to grow. A recent Oxfam briefing paper draws the connection between unsustainable debt and the HIV/AIDS pandemic. It points out that the one-third of total PLWHA live in countries classified by World Bank and IMF as heavily indebted poor countries (HIPC). Through out the late 1990s and into the present decade, activist organizations like AIDS Coalition to Unleash Power (ACT UP), Health Global Access Project (Health GAP), South Africa's Treatment Action Plan (TAC) and others have carried on sustained campaign targeting large multinational pharmaceutical firms to introduce different pricing system for the developing countries that would open the possibility for government and NGOs to purchase ARVs at discounted rates (Irwin et al 2003). Activists' direct actions were complemented by the policy and advocacy work of US watchdog Consumer Project Technology (CPT), Health Action International and Medecins Sans Frontieres (MSF). In October 1999, MSF was awarded the Nobel Peace Prize and became a vocal leader in demanding AIDS treatment for the world. A month later, AIDS activists joined anti-globalisation protesters at the "Battle for Seattle"— the venue of WTO meeting, which led to a violent clash and grabbed more international attentions. They made similar protests during subsequent WTO and G-8 Summits for changes in the TRIPS and cancellation of debts of HIPCs along with other demands. Jubilee 2000 (another NGO, who launched 'Drop the Debt' campaign for African countries) pointed out that Africas' debt repayment totals around US$ 15 billion annually – far surpassing the US$ 10 billion needed for the global AIDS

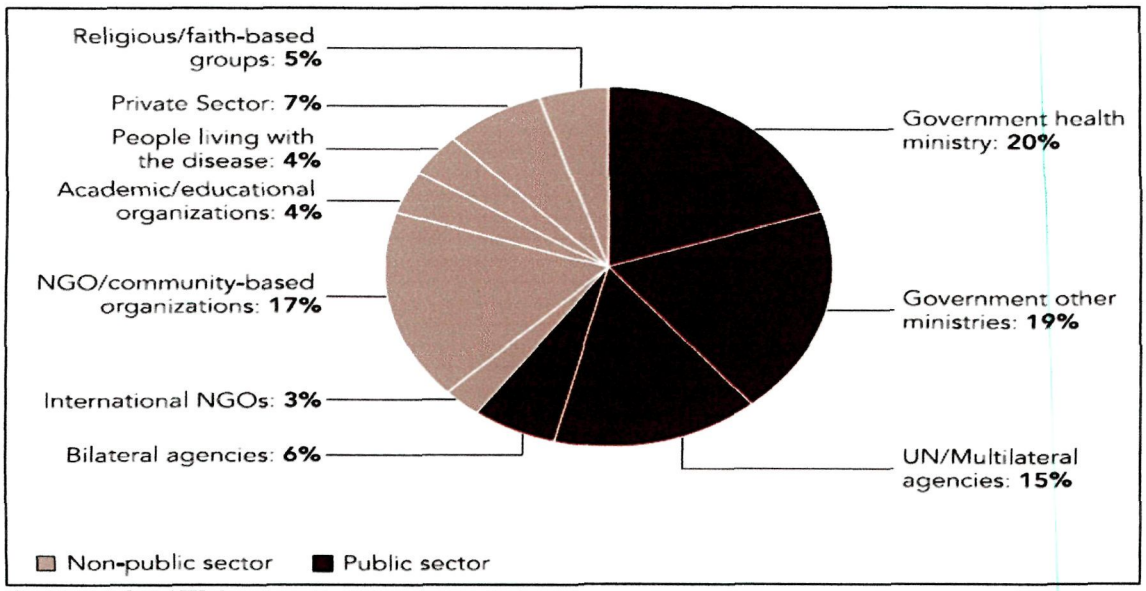
treatment. In response, Accelerating Access Initiative (AAI) was started in May 2000 and began to provide steeply discounted drugs to the least developed countries based on country's GNP. The AAI is an alliance between five UN organizations and five big pharma companies (later six), but it failed to deliver enough treatment to Africans. In the same month, the big firms made a complain with WTO to prevent Brazil from acquiring and making generic drugs and two months later they revived their lawsuits against South Africa (D'Adesky 2004). The turning point in the global battle was the pioneering decision by Cipla – a leading Indian generic drug manufacturer to offer ARV medicines to the frontline groups of African countries like MSF for $360 a year (i.e. less than $ 1 a day per patient) or for $ 600 if purchased by the governments. Overnight, the single biggest obstacle to global access fell away; setting the stage for what has become the era of treatment (*Reuters* 2001). Responding to the pressure of public opinion and market competition from the generic drug companies, major research based pharma companies announced initiatives to lower their own prices on AIDS medications in poorer regions. Later on, they also settled the matter with Brazil and withdrew the lawsuit against South Africa (D'adesky 2004).

However, NGOs' roles are not just restricted to the role of advocacy and implementing agencies in the HIV/AIDS field. It is also actively participating in the decision making process at the local, national, regional and international level. Since UNAIDS was set up in 1996, civil society or NGO has been a key partner. Among the various UN entities UNAIDS has had one of the most diverse and extensive set of civil society partners. Historically, the relationships with civil society developed at a time when many governments were reluctant to even acknowledge AIDS. Early partnering started with AIDS activists and gradually expanded to a wide diversity of civil society partners. UNAIDS was the first United Nations programme to have formal civil society representation on its governing body. At present, the Programme Coordinating Board (PCB) allows for an NGO Delegation of 5 representatives and 5 alternates. The Delegates have formal terms of reference, can serve for up to three years and have non-voting status. The UNAIDS model helped inform the governing structures of the GFATM. Civil society members hold three seats on the GFATM Board, namely the Developed Country NGO, the Developing Country NGO and the Communities Affected by the Diseases (referred to as the "Communities Delegation"). Each of these constituencies has full voting rights. Country Coordinating Mechanism (CCM) is central to the Global Fund's commitment to local

ownership and participatory decision making (See Figure 7.2). These country-level partnerships develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation.

Figure-7.2: Structure of Country Coordinating Mechanisms (CCMs).

(Entities participating in preparation of Round Four proposals. 100% = All representatives of all 78 surveyed CCMs.)



Source: GFATM

NGOs are also represented in other UN bodies and similar international organizations. They are also engaged in training, research, documentation, networking and consultancy work. In 1992, the Global Network of People Living with HIV/AIDS was officially launched, which had a huge impact at the regional and national level. For example, Asia Pacific Network of People Living with HIV/AIDS (APN+) and Indian Network for PLWHA (INP+) were formed respectively at the regional and national level. Another organization – International Council for AIDS Service Organisation (ICASO) similarly influenced and maintains a strong network with other such organizations at the regional and national level. For example, there are regional level organizations like Latin America and Caribbean Council of AIDS Service Organisation, Asia Pacific Council of AIDS Service Organisation (APCASO), etc. ICASO played a significant role in the development of a consortium of NGOs in 2005 to support civil society-led monitoring, advocacy and reporting around the implementation of the UNGASS Declaration of Commitment. The International AIDS Alliance produced a toolkit to help NGOs evaluate and build their capacity to respond

to the epidemic (International AIDS Alliance, 2004). In December 2004, NGOs from around the world came together and created the nongovernmental organization HIV/AIDS Code of Practice. It provides a set of principles of good practice for advocacy and AIDS programming, to which NGOs can commit themselves and be held accountable. Thanks to the combined efforts of organizations and networks, the basic principle of ensuring meaningful involvement of civil society, and particularly of people living with HIV, is now being written into the policies and strategies of many organizations, institutions and AIDS programmes.

Around the turn of the millennium, several key changes made these same rich nations to be receptive again to UNAIDS advocacy. Firstly, the significant spread of HIV into Russia, China and India in a post - 9/11 environments prompted concern that AIDS could destabilize global political and economic systems. Secondly, the agitation of international NGOs led to generic production of ART drugs at a globally reduced price. Brazil showed the way in demonstrating how the use of these drugs could dramatically reduce AIDS mortality in a developing country setting. Thirdly, after their long reluctance, the politically powerful faith-based communities in USA extended support to this global fight including support for condom promotion. As a result of all these changes, millions of persons saw the impact of the pandemic, when the XIII International AIDS Conference was held in 2000 for the first time in a developing country (Durban, South Africa). This has resulted in increasing partnerships, greater involvements and enhanced political commitments to scale up effective interventions to fight this global adversary (GFTAM 2002; WHO 2001). For example, United Nations Millennium Development Declaration adopted unanimously in 2000 by all members, encompasses eight Millennium Development Goals (MDGs), three of which are health related: reducing child mortality, improving maternal health and to have halted and begun to reverse the spread of HIV/AIDS and the incidence of malaria and other diseases by 2015. In June 2001, the ground–breaking UN General Assembly Special Session on HIV/AIDS (UNGASS) mobilized political and financial commitments from both the developed and developing countries. In Doha Summit (November 2001), WTO issued a ruling allowing the poorest countries to use compulsory licensing and other trade mechanisms to access generic drugs in case of public health emergencies such as AIDS, TB and malaria. But, it put a condition that generic drugs could only be produced for domestic consumption, not for export. This ruling affected many poor countries, who don't have the capacity to produce the

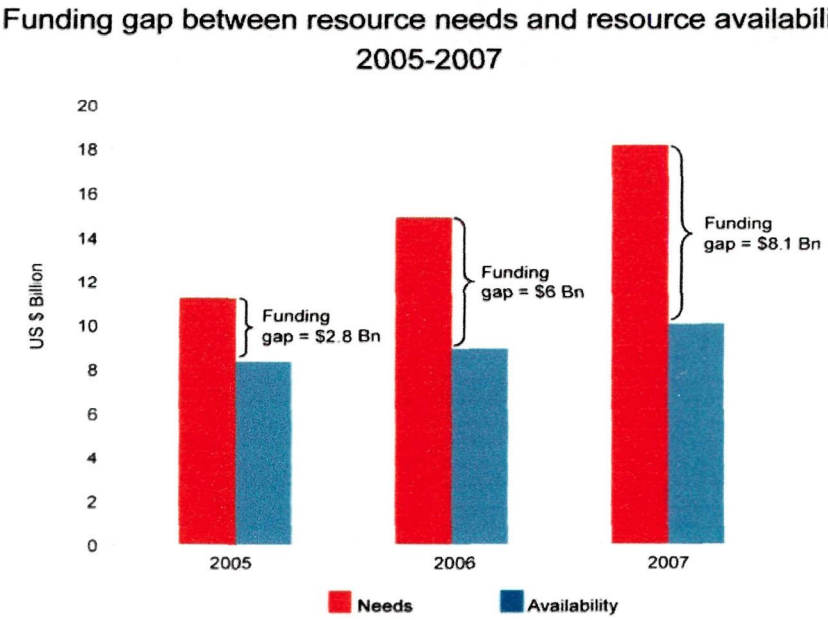
generic drugs. In January 2002, the Global Fund to Fight AIDS, TB and Malaria (GFTAM) was established. The Global Fund is a unique global public-private partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organizations to supplement existing efforts dealing with the three diseases. The Global Fund provides more than 20 percent of international funding to fight AIDS, as well as two-thirds of international funding to fight malaria and tuberculosis. This provided an unprecedented opportunity to mobilize and disburse additional resources through public-private partnerships to enable countries to substantially scale up interventions to check the spread of HIV/AIDS (WHO 2001). Since its creation in 2002, the Global Fund has become the dominant financer with approved funding of US$ 8.6 billion for 450 programs in 136 countries (GFATM 2007). In September 2003, the WHO set a target of providing ART to 3 million people in developing countries by 2005 ('3 by 5' initiative). But, it took two more years to achieve the target. Besides these, many international organizations have been set up to assist in funding and implementing HIV prevention and care programme and related health initiatives worldwide. These include the President's Emergency Plan For AIDS Relief (PEPFAR) set up by George W. Bush, the Global Alliance for Vaccines and Immunization (GAVI), the Global Health Council, the Bill and Melinda Gates Foundation, the Rockefeller Foundation, the World Bank's Multi-country AIDS Programme (MAP), the William J. Clinton Presidential Foundation, etc. In 2003, PEPFAR pledges US $ 15 billion for a period of 5 years to fund AIDS programme in 12 African nations, Haiti and Guyana. But most of the money would be spent through USAID (i.e. through bilateral arrangement) and only US $ 1.0 billion was channeled to GFATM. Despite global progress in expanding HIV treatment access, including in some of the world's most resource-limited countries, more than 70% of individuals who were medically eligible for antiretrovirals lacked access to these drugs in 2006(UNAIDS 2007). As HIV disease progresses among HIV-infected people who are not yet on therapy, the number of people needing therapy will grow much larger in the future.

In 2005 (14-16 September), UN General Assembly World Summit adopted a resolution towards the universal access to HIV prevention, treatment, care and support by 2010. The African Union and the G-8 countries have also endorsed this move. In 2006 at a High Level Meeting of the UN General Assembly, countries

embraced a Political Declaration on HIV/AIDS that committed UN Member States to "pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards achieving the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010." (UNAIDS 2007). Considering the national specificities with the need for global accountability, the Political Declaration on HIV/AIDS encouraged countries to develop their own national targets for key interventions and to report on progress as an integral part of existing monitoring obligations. As of June 2007, 93 countries had established time-bound targets to move towards universal access.

However, despite marked increases in financing for the HIV response during this decade, the Figure 7.3 shows the gap between resources available and the amounts needed during 2005-2007.

Figure-7.3: Funding Gap between resource needs and resource availability (2005-07).

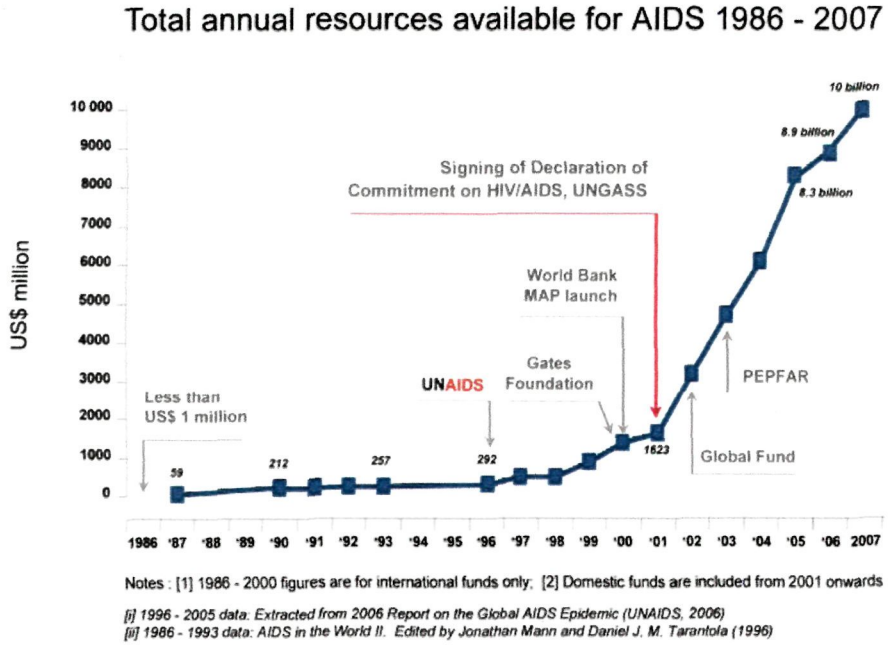


Source: UNAIDS, 2007.

This gap would be wider over the next several years if current funding trends continue. Substantial progress has been achieved in bringing essential HIV services to those in need in the low and middle-income countries where 95 per cent of all people living with HIV reside. The number of people receiving antiretrovirals in these

countries increased five-fold between 2003 and 2006, and declines in HIV prevalence have been reported in several countries following the implementation of strong HIV prevention measures. If the scale-up of HIV services continues at the same pace as in the recent past, the necessary funding is projected to reach US$ 15.4 billion in 2010 (US$13.4 – US$ 17.6) and US$ 22.5 billion in 2015 (US$ 18.8 – US$ 26.9). Yet the current pace of scale-up will not achieve universal access by the agreed target date of 2010, endangering the world's ability to halt and begin to reverse the HIV epidemic by 2015, as provided in the Millennium Development Goals (MDGs). If current trends continue, only 4.6 million people would receive antiretroviral in 2010, or roughly two-thirds of the number of people who needed antiretrovirals in 2006. By 2015, an estimated 8 million people would be on antiretrovirals, instead of 21.85 million as estimated by UNAIDS if resources expanded to achieve universal access in 132 low and middle-income countries. If current trends continue, only 4.6 million people would receive antiretrovirals in 2010, or roughly two-thirds of the number of people who needed antiretrovirals in 2006. By 2015, an estimated 8 million people would be on antiretrovirals, instead of 21.85 million as estimated by UNAIDS if resources expanded to achieve universal access in 132 low and middle-income countries.

Figure-7.4: Global resources available for AIDS during 1986 to 2007



Source: UNAIDS, 2007.

The Figure 7.4 indicates the global mobilization of resources from 1986 that is unprecedented with respect to the management of chronic illness in low- and middle-income countries – generating an estimated US$ 10 billion in financing in 2007.

An urgent worldwide mobilization of technical resources is required over the next three years to overcome the many impediments that have slowed programme implementation and scale-up, such as weak procurement and supply management systems and overburdened health delivery systems. Table 7.1 shows that to meet the goal of global universal access by 2010, available financial resources for HIV must be more than quadruple by 2010 compared to 2007 – up to US$ 42.2 billion (US$ 31.9 – US$ 51.4) – and continue to rise to US$ 54.0 billion by 2015 (US$ 44.6 – US$ 63.3).

Table-7.1: Financial Resources Needed for HIV Services by Scenario

(US$ Billion)

Sl. No	*Types of HIV Services*	*2009*	*2010*	*2015*
1.	Prevention	11.4	15.0	15.4
2.	Treatment & Care(including palliative care)	10.8	15.4	22.7
3.	Orphan and Vulnerable Children	2.4	4.4	4.5
4.	Programme Costs	5.0	6.1	10.1
5.	Prevention of violence against women	0.6	1.3	1.3
	Total	**30.2**	**42.2**	**54.0**
	Range	**(24.7 - 36.1)**	**(31.9 - 51.4)**	**(44.6 - 63.3)**

Source: UNAIDS, 2007.

UNAIDS also calculated the financial resources needed to achieve universal access by the countries in terms of the income category. Table 7.2 shows the breakdown of resource needs by income level of country. As in the past, upper-middle income countries will continue to finance almost the totality of their responses to HIV, particularly in Latin America, Eastern Europe and Asia. Thus, it is anticipated that domestic public sources will supply roughly one-third of the global amounts needed to close the looming resource gap. External sources will be required to cover roughly two-thirds of the global amounts needed to achieve universal access, with the majority of such assistance focused on low-income countries, especially in sub-Saharan Africa.

Table-7.2: Financial Resources Needed Categorized by income category (US$ Million)

Sl. No.	*Countries*	*2008*	*2009*	*2010*
1.	Low income	9,117	13,916	20,286
2.	Lower - Middle income	5,814	8,944	12,511
3.	Upper – Middle income	5,276	7,308	9,448
	Total	**20,207**	**30,168**	**42,245**

Source: UNAIDS, 2007.

Although the level of resources needed for HIV is higher than comparable estimates for other MDGs, it is important to note that nearly one quarter of total resources required for HIV will support health systems strengthening, which in turn will substantially buttress efforts to achieve other health-related MDGs. Table 7.3 indicates the UNAIDS estimated financial resources needed to achieve universal access in terms of activity area. These investments in the health sector include those with both direct and indirect impact on the epidemic. Overall, approximately one-third of these HIV resource needs estimates are for selected activities addressing the social drivers of the epidemic, for social mitigation and other services that are termed non-health activities. Cross-cutting activities include: civil society strengthening, global advocacy and coordination, policy, human rights and stigma. UNAIDS has calculated the financial requirements by computing the number of people in need, the target coverage and the unit cost of the intervention, with amounts expressed as funds needed for each year as cash flows.

Table-7.3: Financial Resources Needed Categorized by Activity Area (US$ Million).

Sl. No.	*Activity Area*	*2008*	*2009*	*2010*
1.	HIV specific health services	10,060	15,068	20,807
2.	Health system strengthening and Cross-cutting activities	4,938	6,019	7,227
3.	Non-Health services	5,209	9,081	14,211
	Total	**20,207**	**30,168**	**42,245**

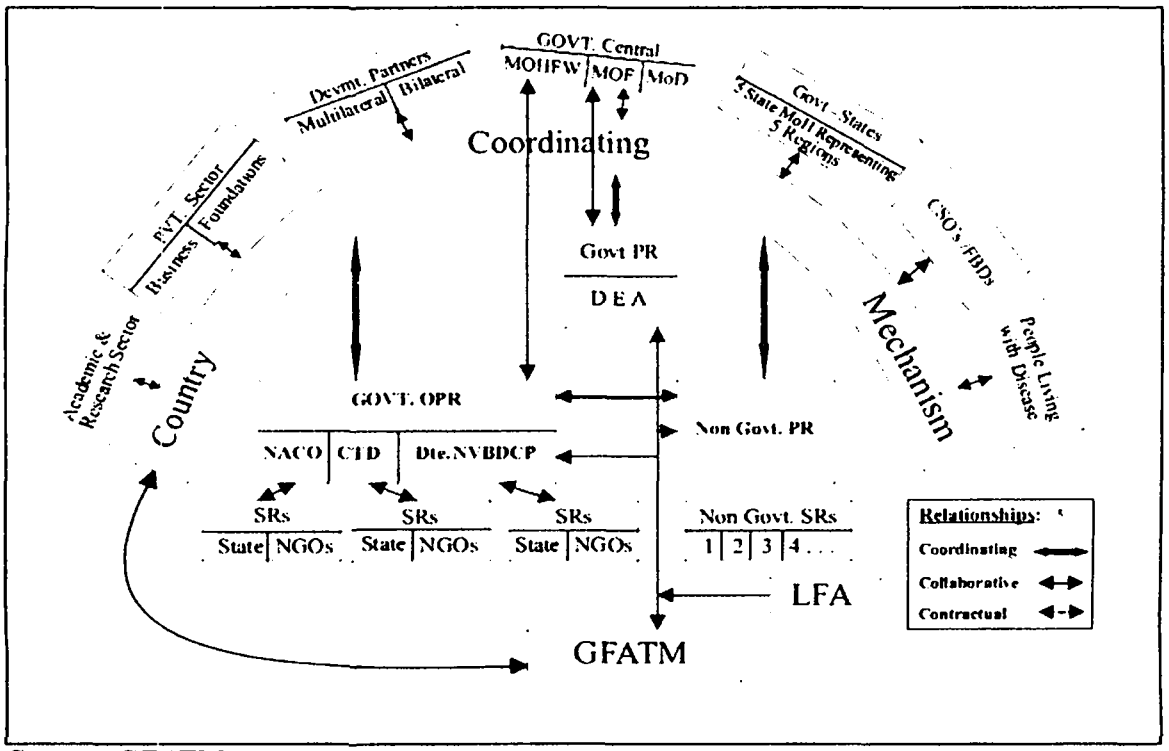
Source: UNAIDS, 2007.

The high levels of funding that will be needed to move towards universal access in the coming years reflect the world's failure to respond to the epidemic before it achieved crisis dimensions. Had the world made prudent investments 10-20 years ago – in prevention, in strengthening health systems in low and middle-income countries, in preserving and building essential human resources, in addressing the corrosive effects of gender inequities and other drivers of the epidemic – much smaller amounts would be required today. This same principle holds true today-we cannot afford the costs of inaction. A comprehensive, scaled-up HIV prevention response would avert more than half of all new infections that are projected to occur between 2005 and 2015 (Stover et al 2006). Unless we can prevent new infections, future treatment costs will continue to mount. While these obstacles are significant, the global community stands a better chance of overcoming them than ever before. Never before has this level of funding been achieved. Never before have major world leaders focused so intensively on a global health problem. The challenge now is for all players – including recipient nations – to continuously surmount the national obstacles to a unified AIDS response. Only then real progress will be made in addressing this disease that threatens to kill 60 million more people in the next 15 years (Merson 2005).

So far as India is concerned, NGOs like other countries were first to respond especially in the initial years when response to HIV/AIDS from the government was slow. This has been already discussed in detail in the Chapter-I. In response to international as well as national pressure created by the NGOs, the government of India started a medium term plan in 1989 for three years in collaboration with WHO. Since its establishment in 1992, NACO recognized the importance of NGOs and involved them in NACP-I (1992-1999) and NACP-II (1999-May 2007). NACO in consultation with SACS and representatives of NGOs prepared a comprehensive guideline for the involvement of NGOs in different activities of NACP. NACP-III (2007-2012) was prepared after thorough discussion with NGOs, PLWHA and other stakeholders, which took more than a year. The plan outlays of NACPs are increasing significantly as per the demand of services required in the country. NGOs put pressure on government to provide ART at free of cost, to improve health infrastructure, to ensure protection of human rights of PLWHA, etc. The government introduced free ART from April 2004. At the national level, Indian Network of PLWHA (INP+) along with its different state branches established strong network with regional (e.g.

APCASO, APN+, etc.) and international level organizations like GNP+, ICASO, etc. They have also tied up with different International NGOs and implementing different projects financially aided by these INGOs. With this strong networking, Indian NGOs have been putting more pressure on the government by demanding introduction of second line ART, amendment of Immoral Traffic Prevention Act, abolition of Indian Penal Code (IPC) Section 377 that treats MSM behaviour as a crime, recognition of sex workers as workers and provision of social security through labour laws, etc. Because of their efforts, NACP-III has incorporated several provisions like supply of second line ART, introduction of 'Smart Card' for PLWHA receiving ART, establishment of PLWHA's Network and Civil Society Forum at the district level, promotion and active involvement of CBOs more in future, etc. But, within the country, there is no networking between NGOs in HIV/AIDS care and NGOs working in other fields. Even there is no federation of NGOs working in HIV/AIDS field at the national and state level. However, Indian NGOs are represented in different international forums like UNAIDS, GFATM, etc. They are participating in GFATM through CCM and the Figure 7.5 indicates the structure of Indian CCM. Thus, in India too, NGOs are actively participating in decision-making process, advocacy, training and capacity building, research and documentation along with service delivery work.

Figure-7.5: INDIA-CCM Structure & Inter-Relationships.



Source: GFATM.

In West Bengal, the situation is no way exceptional from the national scenario. WBSAP&CS regularly consults NGOs and implementing different programmes of NACP through NGOs in the state. There is no state level federation or networking among the NGOs in HIV/AIDS care, nor with NGOs working in the other field. It implies that may be HIV/AIDS is considered by the NGOs as an isolated phenomenon, not as a threat to the development of the country. To know about the impact of globalisation on the NGOs working in HIV/AIDS field, mailed questionnaires were sent to all implementing NGOs of West Bengal. Out of 60 NGOs, responses received from the 27 (45%) NGOs are discussed below.

It is found that 81.5% of the NGOs are of the opinion that fund flow will increase due to globalisation. All the NGOs feel that the role of NGOs will also be increased in the era of globalisation and justified their opinion with reasons. Some of these reasons are: (A) government is not capable alone, (B) NGOs are more effective and (C) this is a global trend. Table-7.4 shows that 44.4% of total NGOs under the study feel that NGOs' role will be increased due to government's inability and global trend (AC). While 37% NGOs feel that the government is not capable alone and NGOs are more effective than the government (AB).

Table-7.4: Reasons responsible for the increasing role of NGOs.

Sl. No.	*Reasons*	*No. of NGOs (%)*
1.	A	3 (11.2%)
2.	B	1 (3.7%)
3.	AB	10 (37.0%)
4.	AC	12 (44.4%)
5.	ABC	1 (3.7%)
	Total	**27 (100%)**

Source: Responses received through mailed questionnaire.

All the NGOs under the study are of the opinion that networking with national and international NGOs will help to fight against HIV/AIDS. They have also expressed the benefits of networking in this regard. Some of these are: (A) through exchange of information, (B) through training and exposure of staff in abroad or foreign NGOs and (C) by creating pressure on the policy makers. Table-7.5 indicates that about 70%

NGOs under the study feel that all the above benefits will be available from networking, while 22.2% NGOs think about first two benefits only.

Table-7.5: Benefits of networking.

Sl. No.	*Benefits of networking*	*No. of NGOs (%)*
1.	B	1 (3.7%)
2.	AB	6 (22.2%)
3.	AC	1 (3.7%)
4.	ABC	19 (70.4%)
	Total	**27 (100%)**

Source: Ibid.

Considering the increasing future needs and demands of PLWHA, NGOs have expressed their views on the ways through which these demands can be fulfilled. Some of the ways are: (A) unified efforts of the government, NGOs, private companies and common people, (B) multinational companies will have to lower price for ART drugs for the developing countries, (C) government will have to ensure supply of ART at free of cost and (D) international agencies like WHO, UNICEF, ILO, etc. will have to play more active role for the developing countries. Table-7.6 shows that most (88.9%) of the NGOs under the study have suggested all the above mentioned measures for meeting the future demands of PLWHA.

Table-7.6: Ways to meet the future demands of PLWHA.

Sl. No.	*Ways to meet future demands*	*No. of NGOs (%)*
1.	A	1 (3.7%)
2.	D	1 (3.7%)
3.	AB	1 (3.7%)
4.	ABCD	24 (88.9%)
	Total	**27 (100%)**

Source: Ibid.

With regard to the over all impact of globalisation on NGOs working in HIV/AIDS care, none of the NGOs under the study express that impact will be worst. While 66.7% of them feel that impact will be good, remaining 33.7% NGOs can't predict the impact just now.

From the above discussion, we understand that HIV/AIDS is considered as a global problem and this globality of the disease has given importance in the international development and aid policy agendas. Alongside this, certain practices for coordination, communication and implementation are established. This formulation around the HIV/AIDS pandemic is very much similar with Gordenkar and Weiss's (1996) definition of global governance: "efforts to bring more orderly and reliable response to social and political issues that go beyond capacities of the states to address individually". We also find that globalisation has created enough space for the NGOs to play a more active role in all spheres including HIV/AIDS prevention, care, support and treatment. Globalisation has also helped to strengthen the networking at the national, regional and international level not only among the NGOs working in HIV/AIDS field, but also with NGOs working in the other fields. It has also brought together NGOs of the North and of the South. These networking help the NGOs in terms of sharing experiences, capacity building, training, research, etc., not just advocacy and seem to continue in future too.

We, from the above discussion, have also tried to understand the role of NGOs within the emerging international governance of HIV/AIDS and its impact in the national and local level governance of the disease. The international policy makers believe that the existing intervention mechanisms are providing correct channels for policy interventions and have recognized that lack of adequate funding as one of the most important challenges in scaling up HIV/AIDS. As a part of the existing intervention mechanisms, civil society organizations or NGOs have been at the centre for HIV/AIDS pandemic in the world. So far, NGOs were successfully able to bring more funds by their advocacy efforts especially from the reluctant industrialized countries. Recently, US House of Representatives sanctioned US$ 50 billion to PEPFAR for next five years (2009-2013) and out of it, US$ 2 billion will be channeled to GFATM for 2009 (*Washington Post*, 2008). In September 2007, Donors meeting held at Berlin and pledges US$9.7 billion over three years to GFATM. The pledges constitute the largest single financing exercise for health ever, and it will allow the Global Fund to move towards annual commitments of US$6 - 8 billion by 2010 (GFATM 2007). Therefore, it is expected that financial sustainability will be continued in future too.

However, considering the large number of NGOs, it is difficult to conclude whether the interventions of these NGOs are coherent or sustainable and whether they

will have a societal impact in the long run. The external resource dependency of NGOs is one of the reasons for this situation. In the governance of HIV/AIDS, most NGOs choose the intervention mechanism as prescribed by the donors or policymakers (e.g. NACO in India). Otherwise their participation would be questioned leading to their exclusion from the system. Due to the same reason, local NGOs and networks of PLWHA are not raising their voices about the problems and issues associated with the intervention programmes. Because, it is considered to be controversial and may influence the support and funding arrangements that resemble a competitive market whereby donors/policymakers are choosing those NGOs who are willing to accept and implement their policies and priorities. Besides it, their activities like condom distribution, STI management, VCT counseling, training workshops, etc. are evaluated respectively on the basis of exact numbers distributed, treated, tested and trained. But, to effect a change in the behaviour of the target group, the concern NGO requires sustaining the efforts over long term to eliminate the causes of disease, while at the same time dealing with immediate problems. This reflects the donors'/policymakers' interests in concrete measurable outcomes for accountability purposes within a limited project cycle instead of an assessment of actual long-term impact of an intervention. In this way, the relationship between the donors/policymakers and the implementers once again influences the way latter function (Seckinelgin 2005). In some ways, it is possible to agree with Fowler (1997) and suggest that NGOs are rich in potential capacities, but very much limited in their capabilities, which according to Giddens (1984), is creating poverty in the NGOs. At the same time, a new challenge that NGOs will have to face is the side effects of ART and huge number of PLWHA. Because of the increased access to ART, the life span of PLWHA will be increasing. As it is already known that ART has many side effects, which requires special attention and professional services. NGOs must be prepared and ready to deal with such new demands successfully in future. But, there is no doubt that innovative and effective interventions are created and implemented by NGOs.

Thus, globalisation brings with it many benefits in addressing the spread of HIV throughout the world. However, these benefits can only be realized if appropriate programmes are available in areas of need. As part of the generous supply of aid aimed at addressing problems specific to HIV/AIDS, attention needs to be paid to

building capacity in recipient countries so that such funds may be effectively disseminated and the epidemic effectively curbed.

In brief, governments, donors and civil society, as in the past, will remain at the forefront of efforts to move towards universal access to HIV prevention, treatment, care and support. Governments will have to increase funding for AIDS – both domestically and as development assistance. It will be critical, for example, to ensure that the Global Fund and other important initiatives, such as PEPFAR, are fully funded. Therefore, efforts must be made to develop new funding sources and mechanisms (such as the recent Airline Tax for AIDS, TB and Malaria). The philanthropic foundations will have to play an increasingly prominent role as core AIDS funders, and business community must rapidly accelerate action on AIDS. Civil society or NGOs will have to continue and fulfill their vital functions as advocate, watchdog, advisor and implementer – keeping AIDS high on the political and public agenda.

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