

CARING ABOUT AID:
AN ETHICS OF CARE APPROACH TO GLOBAL HEALTH AID

by

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Abstract

Taken on face value the concept of foreign aid seems to imply some level of caring on the part of donors for recipients, but in reality aid is given for all kinds of reasons, many that have nothing to do with care. This project seeks to understand what aid would look like if it was designed and delivered from a caring perspective and how that change would impact aid recipients. Using an ethics of care perspective I examine current thought on our ethical obligations to the poor, demonstrating how the relational perspective of a care approach moves the discussion away from abstract debates to focus on the concrete daily realities of people struggling with poverty and poor health. A care approach helps expose the broader social, political and economic background against which global health and development problems occur. Mainstream approaches to global health that focus on human rights, economic growth and security provide only a partial picture of that background. In contrast a care approach to global health keeps the focus sharply on the targets of aid, working to create space for them to give voice to their experiences and empowering them to create more responsive aid programs. After discussing what a care approach to health would look like at the theoretical level I apply it to the case of global aid for HIV/AIDS. By analyzing three of the largest HIV/AIDS relief efforts, the U.S., U.K. and Global Fund programs, I show both the strengths and weaknesses of these programs as well as how they could be adapted using a care approach to become more responsive to the needs of target communities. A care approach offers scholars of global aid an important critical prescriptive that brings to light aspects of poverty and poor health that can be missed by conventional perspectives and provides policy makers with a tool to build more caring and responsive aid policy, empowering aid recipients as active partners in the aid process.

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Introduction

As the images of destruction from Haiti's 2009 earthquake streamed across the globe, so too did the public response. Just as they did to the tsunami in Southeast Asia a few years before and countless other natural disasters and humanitarian emergencies before that, people responded quickly and with generosity. Although we certainly have many examples of our global failure to act, too many Rwandas and Darfurs, we also have many examples of people around the world rushing to help strangers in a time of need. We can and should debate the effectiveness of these responses, but the compassion behind them is undeniable. We may not know what to do to help and over time we may get distracted and lose focus, but when emergencies happen, many of us are driven to respond. Care is a crucial and integral component of aid.

Interestingly, while appeals to get us to give money to support relief programs often try to motivate us based on that sense of caring, when actually designing aid programs, policy makers are expected to respond based solely on rational analysis of the situation. Conventional ethical approaches teach us that the only fair way to make decisions is to emotionally distance ourselves from those we are trying to help. Care may have a key role to play in encouraging people to give, but there appears to be much less room for it in the development of aid policy and programs. It does not have to be this way.

Embracing care in aid policy does not mean leaving behind rigorous analysis and basing decisions on emotional whims, but nor does it encourage us to abstract ourselves away from the messy reality in which poverty and poor health occur. The promise of an ethics of care approach is that it can give us a theoretical perspective focused on constantly learning to care

better. Applied to foreign aid the ethics of care can help provide new insight into some of the key difficulties that have hindered conventional approaches to aid.

In the following chapters I use a critical ethics of care perspective to examine traditional ethical assumptions about aid and our obligations to others. I have two goals in taking this approach. I want to assess the contribution a critical ethics of care approach can make to our understanding of the ethics of aid by bringing to light aspects of global poverty that traditional ethical approaches have overlooked. And I want to generate a more practical understanding of what an ethics of care approach would look like applied to the problem of global poverty. I will use the case of foreign aid directed to HIV/AIDS relief to illustrate the practical contribution of an ethics of care approach. The larger motivation driving this project is my desire to contribute new knowledge and insight into the fight against poverty and poor health.

With that in mind, my project is led by four research questions, two addressing the theoretical contribution of the ethics of care and two addressing its practical contribution:

- What are the limitations of the current ethics of aid literature?
- How can an ethics of care approach address some of those limitations and help us better understand how to get from theoretical insights about poverty and aid to practical solutions?
- How are major donors currently approaching and delivering foreign aid for HIV/AIDS and how might these approaches help us get a better understanding of what a care approach to health might look like in practice?
- Finally, how would this care approach to health aid change the way aid is currently

delivered?

While the objective of my research is to assess the contribution of the ethics of care to the study and development of foreign aid policy, some might question the value of even looking at a care approach when there are already so many other approaches to the ethics of aid. The next chapter will go into more detail on the potential contribution of a care approach to the study and practice of foreign aid and global health, however I will take some time here to briefly sketch out some of the concrete contributions of an ethics of care approach that make it worth examining in this project. Ethics of care scholars have provided several valuable insights but there are three key contributions that make the ethics of care a promising approach to study foreign aid: its insight into the context in which problems occur and its ability to understand and deal both with difference and dependency.

Held (2006) argues that care is the most basic moral value, demonstrating that by focusing on understanding how care is actually delivered in concrete contexts and what motivates us to act to help others we can get better insight into many of the issues conventional approaches to ethics struggle with. She points to the example of human rights, to illustrate that the key to understanding why human rights are violated and neglected is to understand what motivates people to care about the suffering of others in specific circumstances. By emphasizing the importance of understanding the specific context of human rights violations and understanding the broader relationships and interactions that lead to those violations, a care approach is able to provide unique insight missing from conventional approaches.

The ethics of care is also better positioned for dealing with difference than conventional

ethical approaches that start from an assumption that we are all equal. Using the idea of asymmetrical reciprocity Sevenhuijsen (2003) demonstrates the limitations of approaches to empathy based on the idea of trying to imagine ourselves in someone else's place. She points out that each of us have our unique perspectives and subjectivity so it is never possible to fully see the world through the eyes of another. In practice this means that a care approach places greater emphasis on creating space for others to communicate their needs and is able to help underscore the need for greater consultation in any policy development process. This insight also forms the foundation of Sevenhuijsen's model of responsive policy making, which provides concrete guidance for policy makers in how to create a more consultative and responsive policy development process. As I will show in the next chapter, conventional ethical approaches begin from the assumption that we are all equal and seek to establish universalizable moral principles to guide action. Sevenhuijsen is able to demonstrate the limitations with this assumption when it is applied to concrete contexts where people are different and have differing perspectives. Thus a care approach is able to provide an ethical approach that is much more capable of addressing difference than conventional approaches.

Being able to deal effectively with difference is obviously crucial for foreign aid policy where so many cultural, economic and social differences come into play. Indeed, using the example of long-term care, Kittay, Jennings and Wasunna (2005) demonstrate how a care approach is able to deal specifically with the issue of cultural difference in a way that is not possible from a liberal perspective that starts from an assumption of equality and sameness. By emphasizing the importance of paying attention to others and the context in which moral decisions are made, Kittay and her colleagues show how a care perspective is ideally suited for bringing difference to the fore, where it can be addressed and alternative perspectives

voiced. If we begin by assuming that we are all equal and have similar needs and desires, we eliminate any opportunity for others to express their differences and so effectively silence them. A care perspective, by embracing and acknowledging difference helps create space for those differences to be voiced and expressed, thereby creating the opportunity to develop aid policy that meets the needs of a broader cross section of society, especially those vulnerable and marginalized groups whose perspectives may not be included in mainstream approaches.

A care perspective has also been able to provide unique insight into the issue of dependency. Kittay (2001) highlights the dilemma conventional models of justice face when dealing with people with mental disabilities, who lack both the rationality and independence that are considered key to being a fully functioning moral citizen. She draws on examples of contemporary high profile cases of abuse and neglect of persons with mental disabilities to illustrate the tension created between our sense of injustice at encountering this abuse with the failure of these people to meet the conventional liberal requirements of what is needed to be a fully moral being. Kittay powerfully exposes this gap in conventional understandings of justice, using a care approach to propose an alternative method of defining a moral person built around the ability to be in relationships with others. Without this more encompassing definition of justice Kittay argues people who fall outside liberal definitions of moral personhood are forced to rely on charity and benevolence rather than claims of justice. A care approach provides an alternative understanding of justice that acknowledges and understands dependency as a central part of human existence.

Arneil (2002) similarly brings attention to the limitations of liberal understandings of moral citizenship by using the example of the dependency of children. Arneil demonstrates how the high value liberal perspectives place on autonomy has the effect of not only

excluding children from moral citizenship, but also their caregivers because the demands placed on them in caring for a child limits their ability to pursue their own autonomous actions. Thus, by excluding care-giving as something done outside the realm of autonomous actors, liberal theory effectively ignores dependency. A care approach on the other hand acknowledges the interdependent nature of human existence and understands dependency and the need for care as a part of our everyday lives.

Dependency, just like cultural difference and the importance of understanding the context in which moral problems occur, are significant challenges in developing foreign aid policy. The few examples I have used here help illustrate how a care perspective has been able to deal with each of these in ways conventional ethical approaches have not and why it is worth studying how these contributions might translate to foreign aid policy. In this way the ethics of care offers an intriguing alternative to mainstream approaches to understanding the ethics of aid. Starting from a relational rather than a rational perspective the ethics care shifts the focus of ethics away from debates about what we should do to fight poverty to focus our attention on the moral reality of our current relationships with the poor and marginalized. The ethics of care seeks to uncover how our relationships have created the circumstances where some have better access to resources and good health outcomes than others, and it works to understand how we can improve those relationships to reduce inequalities. Ethics from a care perspective has a strong practical focus aimed at improving the daily realities of the most vulnerable members of society. For this reason it is an ideal ethical approach to take when examining foreign aid policy because not only does it help lay bare the ethical and moral motivations behind policy decisions, but it also offers concrete guidance for how to improve those policies to better meet the needs of the targets of aid interventions.

Indeed, the ethics of care has an important contribution to offer both the theory and practice of foreign aid policy. At the theoretical level I will demonstrate how a care approach helps uncover some important limitations of conventional approaches to the ethics of aid, whose narrow perspective appeals to abstract rationality and universal principles that approach people as independent actors. In contrast, the ethics of care provides a broader understanding of ethics and aid rooted in the acknowledgement that we understand the world through our interactions with others. This relational perspective pushes scholars away from abstract debates over moral principles and forces them to engage with those living through the concrete realities of specific problems. I argue that this approach lays the foundation for a more responsive and effective policy development process that works to actively include the targets of policy interventions as full partners in the process.

In practice an ethics of care approach offers policy makers a broad understanding of the context in which particular challenges occur and encourages them to work directly with vulnerable communities, empowering those communities to build policies and programs that better reflect their needs as they express them. Aid policy developed from a care perspective moves away from a heavy reliance on quantitative measurement and evaluation, embracing a more democratic needs assessment process that seeks to understand the situation as it is experienced on the ground. While it is a unique approach to developing aid policy, what is exciting about a care approach is that it can be built out of aid policies currently in use. Using examples from the aid policies of three major donors targeting HIV/AIDS (the U.S., the U.K. and the Global Fund) I show how some of their policies could be adapted to create a more responsive and caring approach to HIV/AIDS assistance.

My research uses the work of prominent care scholars like Joan Tronto (1993), Fiona

Robinson (2006 and 1999), Selma Sevenhuijsen (2003 and 1998), Virginia Held (2006) and Olena Hankivsky (2006 and 2004) to develop a critical and caring alternative approach to the ethics of aid. This approach demonstrates the applicability of the ethics of care to the study of foreign aid, building on the insights generated by the ethics of care literature in other areas of public policy to provide new insights for foreign aid. Looking specifically at the issue of health aid, I show how an ethics of care approach can overcome some of the key shortcomings of the human rights, human security and economic approaches to health identified in the literature. A care approach to health does not rely on weak and contested universal rights claims the way rights based approaches do. At the same time, unlike rights approaches, the ethics of care provides concrete guidance for how to put its ideas into practice without relying on security based language and concepts common in security approaches to health. Further, the ethics of care exposes the limitations of the instrumental understanding of health taken by economic approaches to health and demonstrates the importance of building policy driven by the needs and concerns of the poor rather than policy experts. However, more than just drawing out the shortcomings of these perspectives, the breadth of a care approach also provides the space for these perspectives to work together. A care approach can help create the conditions where rights are respected and realized, while also providing a broad perspective from which to study the important interplay between the health of individuals and their society and the security and economic prosperity of those individuals and their society. Thus, my approach demonstrates how insights from the ethics of care can be brought to the study of foreign aid to create more responsive and caring aid policy.

I take a critical approach to ethics in this research similar to that of Robinson (1999) in

that I move beyond a traditional understanding of ethics, which focuses on determining the rightness or wrongness of a particular situation, to an ethical approach that seeks to understand how a particular situation has come about, uncovering the broader social, political and economic factors behind it. Thus, I am interested in understanding more than the immediate suffering of people in need of international assistance and instead am focused on bringing to light the broader context in which poverty and poor health occur. In this way my approach also has a very strong practical focus on the concrete realities of actual aid practice and its impact on the daily lives of aid recipients. This is part of the reason why in later chapters I repeatedly emphasize the need to creating space to receive and respond to input from aid recipients. Finally it is important to mention that while my theory and approach is deeply rooted in feminist theory and literature, and would be impossible without it, I do not specifically call my research a feminist analysis. This should not be seen in any way as an attempt to devalue the crucial contribution of feminist literature to my work. Indeed, I hope that my work helps demonstrate the value of feminist approaches to global politics more broadly. However, I have purposely chosen not to label my research this way because I believe the contribution of the ethics of care goes beyond areas that have been traditionally considered the focus of gender and feminist analysis. It has an important contribution for aid theory and practice in general.

I use a two-phased process to develop an ethics of care approach to global health and assess its contribution to global health and development literature and practice. Chapter 1 begins at the theoretical level by first reviewing the major approaches taken towards the ethics of aid in the literature and comparing them to the ethics of care to establish more generally why it is worth bringing a new perspective to the study of the ethics of aid. From

there Chapter 2 moves to compare the ethics of care with three of the main theoretical approaches taken towards health in the literature: health as a human right, health as a driver of economic growth and health as a vital component of human security. Each of these perspectives are supported by substantial academic literature and have been embraced in varying degrees by key players in global development, including international organizations like the World Bank, World Health Organization and the UN, as well as major foreign aid donors like the U.S., and the U.K..

One important approach to health that I chose not to look at was the social determinants of health¹. I did this because the three approaches to health that I chose are more broadly applicable to other areas of foreign aid and global development. Human rights, human security and economic growth figure prominently across global development literature and practice, while the social determinants of health remains focused primarily on health. Indeed, one of the key impediments to the broader applicability of a social determinants of health approach is its ultimate focus on health so that with every issue it looks at, whether it is poverty or gender inequality, the essential concern is the impact on health. The problem with this health focus is that it makes it harder for non-health sectors to see the benefit of a social determinants approach because if they want to engage with a social determinants approach they are forced to prioritize health outcomes over their particular concerns. This may seem like a strange concern for me to have given that one of the principal objectives of my research project is to develop a care approach to health, but I am also interested in the

¹ For more information on the social determinants approach see: WHO (2010) Equity, Social Determinants and Public Health Programmes; WHO (2008) Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health; Galea, S. (2007) Macrosocial Determinants of Population Health; Wilkinson, R. & Marmot, M. (2005) Social Determinants of Health; Navarro, V. & Muntaner, C. (2004) Political and Economic Determinants of Population Health and Well-Being: Controversies and Developments; Combers, M. (2002) Determinants of Health: Theory, Understanding, Portrayal, Policy.

implications of the ethics of care for foreign aid and development more generally. Therefore I chose to look at three approaches that are important both for global health and the development literature more broadly. That said, I certainly believe there is real value in looking at what an ethics of care approach might be able to add to a social determinants approach and see this as an important area for future research. At the very least a care approach should be able to help a social determinants approach better demonstrate its usefulness to non-health sectors by bringing to light some of the connections between health and other development issues without giving priority to health outcomes.

I review the literature on each of these three approaches and examine how they have been operationalized in practice. My objective in this review is to synthesize the key components of each of these three perspectives and clearly draw out their contributions and shortcomings to the study of health and development. Chapter 3 compares these approaches with an ethics of care approach to health to determine how an ethics of care perspective offers an alternative understanding of global health challenges.

In order to develop this care approach I use the ethics of care literature to draw out the key components of a care approach and then work to establish what those components would mean in the context of health aid. I focus on the relational ontology of the care approach, as well as its emphasis on responsibility, attentiveness, responsiveness and competence. Each of these has been highlighted by leading care scholars as the key components of the ethics of care (e.g., Held, 2006; Robinson 1999; and Tronto, 1993).

After clearly establishing what an ethics of care approach to health aid looks like and how it helps generate new insight into how we think about aid, Chapter 4 applies this

approach to the challenge of foreign aid policy for HIV/AIDS to establish the practical contribution an ethics of care approach can make to government aid policy. I have chosen to focus on HIV/AIDS because of its high profile among donors and international aid agencies. Over the last decade no other global health issue has received more attention than HIV/AIDS. At the same time, HIV/AIDS is more than a health problem. It is also very much a political, social and economic problem, making it an ideal case for an approach like the ethics of care, which emphasizes the importance of understanding the background context in which a problem occurs.

To study this case, I use specific examples from the HIV/AIDS relief programs of the U.S. and U.K. governments and the Global Fund to Fight AIDS, Tuberculosis and Malaria. My goal is to provide a snapshot of major trends in the HIV/AIDS policies of donors so that I can then compare these policy approaches to those that would emerge from an ethics of care perspective. The U.S. government is currently in the middle of a 5 year, U.S. \$48 billion commitment to fight AIDS through its, President's Emergency Plan for Aids Relief. The British Department for International Development has also given HIV/AIDS a high profile with its 2004 Taking Action strategy and its follow up 2008 Achieving Universal Access strategy to address HIV/AIDS. I have also included the Global Fund, not only because it is a major donor for HIV/AIDS, but also because of its unique multilateral approach that brings together donor and recipient governments along with the private sector and NGOs. The Fund's approach provides a useful contrast to the two government approaches and an opportunity to look at what an ethics of care approach could add to multilateral aid initiatives as well as more traditional bilateral foreign aid programs. After examining the strengths and limitations of these three approaches, Chapter 5 uses the care approach to health I developed

earlier to draw out the lessons from the three cases and examine how a care approach would change the way the three donors deliver their aid and how it could adapt some of their practices to produce a more caring and responsive approach to HIV/AIDS. Further, this chapter will help provide a better sense of what an ethics of care perspective to aid might look like in practice.

My research is the first of its kind to apply an ethics of care perspective to the challenge of foreign health aid. It builds on the important work of ethics of care scholars in other areas of public policy to show the applicability of a care approach for international politics and global health. There is still a lot to learn about what the ethics of care means for global politics, but this work is another step in that direction. We do not have to abstract ourselves away from our emotions and relationships when building aid policy. We can embrace the notion that we care about suffering in the world and use that caring to help us create more effective policy responses. Indeed, as I will show, when we do embrace caring in policy development we open up exciting and challenging opportunities to work together with vulnerable populations to take on some of the most significant challenges of our time.

Chapter 1: Why Care About the Ethics of Aid?

Much has been written on the ethics of aid and our responsibilities to others. Leading scholars like Jeffery Sachs, Thomas Pogge, Amartya Sen, Peter Singer and Onora O’Neil have all taken on the issue and put forward thought-provoking arguments on what duties they believe we owe the poor. This leads to the question, why do we need a new ethical approach for international aid, and what new insights can an ethic of care give the discussion?

The purpose of this chapter is twofold. First, to examine the conventional literature on the ethics of aid and compare it with an ethics of care approach in order to understand how a care approach differs and what new insights it offers. Second, to begin to lay out the case for why an ethics of care approach is necessary for helping us better understand and meet the challenges of developing more effective aid policy.

The ethics of care provides an important moral orientation missing from the current literature on the ethics of aid. At the same time, an ethics of care approach to aid offers a potentially powerful tool to both critically analyze current aid policies and develop innovative new policy approaches to some of the most important problems facing the world today. I will begin this chapter by reviewing the key limitations in current ethical approaches to aid. I will then examine what a care approach is and how it helps us overcome these limitations. Finally, I will conclude the chapter by looking at the promise of a care approach as a compelling tool for aid policy analysis and development. The contribution of a care approach to the development and analysis of aid policy will be further examined in later chapters using the case of international aid for HIV/AIDS.

In order to understand the limitations of current approaches to the ethics of aid, it is

important to first get a general sense of their major arguments. A good deal has been written on the ethics of aid and my aim in this section is not to provide an exhaustive review of that literature. Rather, my goal is to provide an overall picture of the major trends and approaches in the literature in order to better understand the criticisms launched against it.

Conventional Approaches to the Ethics of Aid

Conventional approaches to the ethics of aid can be categorized by their answers to two basic questions: to whom do we have obligations, and how do we decide what is a right action? Two basic answers emerge in the literature to each of these questions. On the question of who we owe obligations to, most scholars break down between those that take a cosmopolitan position, arguing that we have obligations to all people, regardless of where they live, and those that focus more on the obligations we have to members of our own community. This latter group of scholars justifies its more limited take on our obligations by appealing to some notion of a social contract between citizens of a state that entitles those citizens to more involved obligations to each other than to non-citizens. The vast majority of those writing on the ethics of aid have tended towards a more cosmopolitan approach.

The split in the literature on the answer to the second question is less lopsided than the first question, but still tends to be more in favour of judging the rightness or wrongness of an action based on rights or principles (a deontological approach), rather than the outcome of the action (a consequentialist approach). Thus, while there is certainly some debate among conventional scholars on how to judge right action, most accept that we have some cosmopolitan responsibility to help others regardless of where they live. Of course, this does not mean the literature is unanimous in how that responsibility should be put into practice.

Much of the debate between and among consequentialist and rights-based approaches revolves around questions of how much we need to do to fulfil our responsibilities to others. The remainder of this section will examine some of the key works from the two camps, beginning with consequentialist approaches and followed by rights-based approaches.

Consequentialist approaches

Although appeals to cosmopolitan ethics have primarily been used to justify our obligations to help others, some scholars, such as Garrett Hardin, have used a cosmopolitan approach to suggest that sometimes we may have an obligation not to act in the face of crisis. Hardin (1974) believed the world had become overcrowded to the point that the planet was dangerously near its carrying capacity to support life. Thus, he argued, in order to save human life, and the planet as a whole, now and in the future, we had an obligation to stop policies that encouraged unsustainable population growth. For him, such unsustainable policies included poverty relief and open migration and he used the analogy of overcrowded lifeboats to support his controversial advice.

Hardin argued that just as letting too many people into a lifeboat would risk the lives of all survivors, so too, attempts to aid impoverished countries put the entire planet in jeopardy. For Hardin, the world was in a lifeboat situation, so providing relief for the world's poor only risked pushing the planet beyond its limit and putting all life at risk. As he put it, “every life saved this year in a poor country diminishes the quality of life for subsequent generations” (Hardin, 1974, p. 565). For Hardin, the ultimate end of saving the planet for humanity now, and in the future, justified harsh actions against particular individuals. The conclusions Hardin reaches from this consequentialist ethic stand in stark contrast to those reached by

another consequentialist scholar – Peter Singer.

Singer's "Famine, Affluence and Morality" (1972) is perhaps the most challenging article written from a consequentialist perspective on global poverty. His call for the rich to sacrifice their well-being to the point that they sacrifice something of comparable moral worth to what the poor will gain from this sacrifice is enough to make any reader feel a twinge of guilt. However, the sheer weight of this obligation, as well as his contention that we have a duty to help people suffering anywhere in the world, regardless of the distance between us, has attracted some intense criticism.

Singer himself seems to have softened his stance somewhat on the weight of our obligation to others, but he has held firm that distance has no impact on those obligations. In 2004 Singer reflected back on his earlier article and some of its common criticisms. Addressing the notion that his principle of sacrificing something of comparable moral worth is so burdensome that it would actually discourage people from helping, he argued that even if a person does not act on a principle, it does not make that principle any less right. However, when it comes to translating the comparable moral worth principle into practice, Singer was more flexible, acknowledging that

if it is true that advocating a highly demanding morality will lead to worse consequences for all those affected than advocating a less demanding morality, then indeed we ought to advocate a less demanding morality – even though at the level of critical thinking, we will know that impartialism is sound (Singer, 2004, p.28).

This flexibility does not spill over to whom he argued we have obligations to help. Singer flatly rejected any suggestion that we owe special obligations to our fellow citizens

that we do not owe to distant others. He suggested that if we acknowledge that other characteristics, like race or religion, are not acceptable grounds for discriminating who we help, than citizenship should not be either. As Singer put it, “if the strength of institutions favouring special obligations based on racial and religious affinity is not sufficient grounds of accepting them, then the strength of an institution about, say, special obligations based on fellow-citizenship, should also not be sufficient reason for accepting them” (Singer, 2004, p.14).

This lack of flexibility creates a challenge in using Singer’s approach to determine ethical obligations a state may have in delivering foreign aid because, from a public policy perspective, citizenship does provide widely and deeply accepted grounds for special obligations between a citizen and her state. Thus, as a Canadian taxpayer it is hardly controversial to expect that my government will reinvest more money back into Canada than it will give as aid to another country, regardless of the comparable moral worth between money spent here and money spent abroad.

To be fair to Singer, in his original article he distinguished between the obligations individuals have to poor people in other states and the obligations a state may have to those same poor people, only applying the principle of comparable moral worth to the situation of individual giving (Singer, 1972). However, given that national governments are the major donors of foreign aid and that citizenship does create special obligations in a public policy context it is not clear how useful Singer’s approach is if it cannot be applied to state funded aid. Modern political organization creates special obligations between citizens in a way that race or religion does not. It is certainly true that the various legal and financial obligations citizens have to one another do not get them off of the hook from having moral

responsibilities to distant non citizens, but as long as foreign aid continues to be dominated by nation states, we will need to look beyond Singer if we want a comprehensive understanding of the ethics of foreign aid. When it comes to public policy, citizenship matters, and, regardless of whether or not we have a cosmopolitan perspective on ethics, we cannot simply pretend it does not.

Indeed, Nigel Dower (1993), another consequentialist scholar, takes a similar approach as Singer on our ethical obligations to help the global poor, but he is more nuanced in how those obligations balance against our obligations to fellow citizens. He argues that we have an obligation to overcome the “serious evil” of poverty no matter where it occurs, but he is also clear that our obligations abroad do not negate our obligations at home (p.277). Dower steps even further away from Singer when it comes to the scale of our duties to distant others, arguing that Singer’s approach requires that we “care relentlessly” (p.282). Instead, Dower suggests there are limits to our obligations, arguing we have “the duty of caring as much as we can consistent with our quality of life” – clearly a much less serious duty than the one proposed by Singer (p.282).

These three examples from prominent consequentialist scholars illustrate that it is possible to end up with quite different perspectives inside a cosmopolitan consequentialist approach. However, we can also see the roots of some of the limitations of conventional approaches to ethics in each of these scholars. All three approach ethics from an abstract perspective, seeking to establish general principles or guidelines for dealing with poverty globally. This leads them to debate their arguments at a theoretical level, largely divorced from the context in which poverty occurs. At the same time, despite the appearance of offering a fairly wide range of insights, in reality they all operate within a very narrow

understanding of ethics. The narrowness of conventional approaches will be illustrated further in the next section.

Rights-based approaches

Modern rights-based approaches to poverty have their roots in the deontology of Immanuel Kant (Donaldson, 1992). Kant's ethical approach is based on the principle of the categorical imperative. This principle, which Kant saw as the highest moral principle, requires we act in such a way that our actions could be universalized and practised by everyone (Donaldson, 1992). This idea of the importance of actions and principles that everybody can accept is at the core of rights-based approaches, although, how exactly it is expressed can vary rather significantly from author to author. For example, Thomas Scanlon (1998) shifts the focus from principles that all would accept to those that rational individuals could not reasonably reject. In his words, "every rational person must be committed to the aim of finding and living by principles that others, if similarly motivated, could not reasonably reject" (p.187). Nonetheless, the basic idea remains the same: actions are judged based on principles that we imagine are universalizable, either by the fact that all would accept them, or none could reasonably reject them.

Tied to Kant's imperative are both perfect and imperfect duties to others. Perfect duties "hold for all agents in all their actions with all possible others," while imperfect duties "are necessarily selective as well as indeterminate" (O'Neill, 1991, p.178). In other words, perfect duties are those duties that can be universalized, while imperfect duties cannot. In the context of helping others, this means, because we cannot help everybody in all situations, an obligation to help cannot be universalized, and so is an imperfect duty (O'Neill, 1991).

However, Kantian scholar Onora O'Neill argues that we still have some significant obligations to help others.

The key factor in determining how significant various rights-based theorists believe those obligations are depends on how those theorists use the language of rights and duties to link into Kant's conception of perfect and imperfect duties. For example, Thomas Donaldson (1992) argues that O'Neill purposely focuses on a language of duties rather than rights in order to tie into Kant's conception of an imperfect duty and to demonstrate the strength of the obligations that flow from that duty.

O'Neill's (1975) use of duties to support our obligations to help others is exemplified in her classic paper, "Lifeboat Earth." O'Neill starts from the position that all people have the right not to be killed and demonstrates the significant duties to prevent unjustified killings that flow from this basic right. The duty to "enforce others' rights not be killed" extends even beyond our own actions to those of third parties (p.274). O'Neill is clear that, given the nature of the vastly interconnected global economy today, and the fact that she believes we must be responsible for the consequences of our actions, whether intentional or not, only a person completely independent of the economic system could claim to have no duty to help. In her words, "only if we knew that we were not part of any system of activities causing unjustifiable deaths could we have no duties to support policies which seek to avoid such deaths" (p.286).

In his examination of Rawls' Law of Peoples, Charles Beitz (2000) also suggests we have a duty to assist the global poor. However, Beitz steps further away from a strict Kantian tradition by making a distinction between Rawls' social contract based approach to justice

and a more cosmopolitan Kantian approach. Rawls argued that our duty to assist poor countries extends only to the point where they have developed decent and well ordered institutions – a duty that Rawls argued was much less burdensome than a cosmopolitan approach, which he believed would require the elimination of inequality (Beitz, 2000). Even if we accept that Rawls' approach is significantly less demanding than a cosmopolitan one, it still “almost certainly requires substantially more of the wealthy countries than they do now or are likely to do in the near future” (Beitz, 2000, p.694). I will not spend any more time here on the difference between cosmopolitan, duty-based approaches to rights and understandings of rights linked more closely to a notion of the social contract because for the purpose of this chapter they are subject to largely the same criticisms. However, this distinction becomes somewhat more important in the next chapter when I look at rights-based approaches to health because many proponents of a right to health are actually strongly critical of more individualistic, neoliberal rights while simultaneously appealing to a more general cosmopolitan notion of human rights. This move is interesting because, as I will show, it creates some space for a care approach to engage with a rights-based approach to health. I will return to this idea in subsequent chapters. For the moment I am more interested in the contributions and limitations of rights-based approaches to aid more generally.

Thomas Pogge (2005) is closer to O'Neill in his approach, but he goes even further to demonstrate the heavy duties we have to alleviate poverty. Pogge argues forcefully against the idea that we should conceive of aid in terms of helping the poor; instead, he argues that “severe poverty is an ongoing harm we inflict upon the global poor” (p.1). For Pogge, poverty is not a consequence of the rich not helping the poor, but a direct harm inflicted on the poor through “an unjust global institutional order” that benefits the rich at the expense of

the poor (p.5). Echoing O'Neill, he argues that our involvement and participation in unjust global institutions makes us responsible for the impacts of those institutions. In Pogge's (2002) words, "a human right is a moral claim on any coercive social institutions imposed upon oneself and therefore a moral claim against anyone involved in their imposition" (p.46). Therefore, he argues that overcoming global poverty does not require any special positive duty from the rich to the poor. It simply requires us to fulfil our negative duty not to cause harm.

Critics take issue with Pogge on two grounds. First, they challenge his argument that the global order harms the poor and benefits the rich. Second, they dispute his suggestion that global poverty can be addressed through a minimal duty not to harm. Mathias Risse (2005a) questions the extent to which the global order has actually harmed the poor, pointing to evidence of significant improvements that have been made in indicators of poverty as a result of economic globalization. Alan Patten (2005) raises serious doubts about Pogge's argument that poverty can be overcome through "a minimal normative injunction against causing harm," suggesting that Pogge is really talking about a positive duty that he tries to dress as a negative one (p.27). Patten contends, "in effect, what would traditionally have been regarded as positive duties of assistance and aid get relabelled as negative duties" (p.27). Finally, Norbert Anwander (2005) challenges Pogge's argument that benefiting from an unjust global system requires the same duties that actually causing that harm requires. What is instructive in these criticisms is not their specific comments, but that they are largely abstract debates over what constitutes a positive and negative duty and what should be considered harm.

There is certainly value in trying to determine what kind of obligations we have to one another and how we can balance conflicting obligations, but the problem is that conventional

ethical approaches often get stuck at this point and go no further. The overview that I have provided in this section illustrates this point. From Singer's principle of comparable moral worth to Pogge's negative duty not to harm, conventional approaches are rich in ideas about what we should be doing to help the poor, but are less effective in providing concrete suggestions to help us understand what we are actually doing and how we can do it better. This is because these approaches start by abstracting individuals away from their concrete realities, imaging them as independent, rational actors. However, people do not make decisions in the abstract, they live, work and make moral decisions in concrete contexts. Any approach that abstracts individuals out of their context will be limited in its ability to provide insight into how people actually think and respond to moral issues in practice. These criticisms are at the heart of the challenge made by critical scholars against conventional approaches to ethics.

Limitations of Conventional Approaches

Ethics of care scholars argue that conventional approaches to ethics are limited in their understanding and approach to ethics, and, as such, only provide a partial picture of ethical considerations. I will focus on four major areas of concern among care scholars: the tendency of conventional approaches to separate ethics from politics and the overall narrowness of conventional approaches; the abstract rationality used by these approaches; the way these approaches conceive of, and appeal to, universality; and the focus of these approaches on actors as independent individuals. It is important to note that by pointing out these limitations care scholars are not suggesting that conventional approaches to ethics are wrong, or have no value. Rather, care scholars argue that these limitations hinder conventional approaches from gaining a more complete understanding of the ethical

considerations involved in a given situation. Thus, the contribution of a care perspective will be to help us understand and move beyond the limitations of conventional approaches to ethics.

The separation of politics and ethics

There is a tendency in international relations to approach politics as ‘how things are’ and ethics as ‘how things should be’. Critical scholars strongly reject any attempt to make such distinctions, arguing that there are ethical considerations embedded in all aspects of global politics. In the words of Fiona Robinson (1999), one of the first scholars to bring an ethics of care approach to global politics, “ethics cannot be regarded as the opposition of ‘ought’ and ‘is’; the way that we live and organize ourselves can be understood only through reference to the historically developed and evolving ideas and beliefs that we hold – ideas and beliefs which have values that reflect our ideas about morality” (p.1). We cannot separate our actions from our beliefs because how we act is a reflection of what we believe. By attempting to separate politics from ethics, traditional approaches cover over the important ethical assumptions that are embedded in particular political actions, thereby excluding those assumptions and beliefs from debate. An ethics of care approach seeks to bring those assumptions back into the political realm. Whereas traditional perspectives on ethics have focused on determining what is right and wrong, the goal of an ethics of care approach is to broaden our thinking about ethics (Robinson, 1999).

It is not that conventional approaches never look at the interplay between ethics and politics, but that there are very big brackets put around when that can occur. For example, scholars like O’Neill (1975) and Pogge (2002) suggest that citizens of rich countries are

complicit in the suffering of the poor through our involvement in, and benefit from, the global economic system. This argument helps bring to light some of the political motivations that may be behind those that seek to portray aid as charity rather than a responsibility. If aid is viewed as charity, not only are we under no obligation to give, we are also freed from the need to scrutinize the economic system and how it unfairly benefits some at the expense of others. The problem is these scholars stop short of critically examining the powerful ethical factors embedded in the very notion of an international aid system.

Tomohisa Hattori (2003) argues that aid acts as a gift from a donor to a recipient country that the recipient country cannot reciprocate. Using anthropological evidence, Hattori suggests that giving creates a social obligation to reciprocate and when that cannot occur, it transforms “the powerful into the generous and the weak into the grateful” (p.156). The effect of this transformation is to reinforce the current global order, and create, what Hattori dubs, “an ethical hegemony,” where donor states appear virtuous and able to judge recipients, and recipients are made to feel responsible for their own situation. The international system that created the situation is left unchallenged. In Hattori’s words, “the institutionalization of giving creates no incentive to change the underlying material hierarchy that allows donors to give greater gifts in the first place” (p.157).

The tendency of conventional approaches to ethics to overlook some of the deeper ethical issues inside the international system that help create global poverty can be seen in the work of Loren Lomasky (2007). Lomasky argues that international justice must start from a position of reciprocal non-interference. He acknowledges that while this is a modest position it would still “force a radical revision of the control that states exercise over their citizens’ relations with foreign nationals” (p.213). Lomasky is likely correct that even such an

unassuming proposal would have a fairly significant, and potentially positive, impact on world affairs. However, the problem is that he starts from a position that excludes any critical examination of the international system. Taking Lomasky's approach, there is no way to understand how some states have been able to get into a position where they have the ability to interfere in other states. In fact, he goes even further by dismissing the role of the international system in creating global poverty by putting the major blame for current inequalities squarely on the countries themselves. He claims, "disparities in holdings are, for the most part, explicable by noting how the rich have made themselves rich and the poor have made themselves poor" (p.214).

My overview of the conventional literature shows that the majority of scholars writing on the ethics of aid do not hold Lomasky's views. Many argue passionately that rich countries do play a role in creating global poverty (e.g., Pogge, 2002; Beitz, 2000; and O'Neill, 1975), but by not really examining the ethical assumptions embedded in the international system, these scholars risk reinforcing that system. This is the issue at the heart of the concern care scholars have with the separation of ethics from politics. By bracketing off the values at play in conventional approaches, these approaches cannot help us move beyond the current political reality.

Robinson (1999) argues that the narrow focus of traditional approaches on issues like rights, obligations and justice essentially works to justify, rather than challenge, the status quo in global politics. As Joan Tronto (1993a) observes, traditional approaches take the position, "if those in the world do not act morally, so much the worse for them, but it should not be the task of philosophy to change this situation" (p.148). This attitude stems in large part from the aforementioned distinction these approaches make between ethics and politics.

As Tronto notes, “we see that the boundary between morality and politics works not only to protect morality from corruption, but also renders morality relatively powerless to change political events”(p.152). The net effect is that traditional approaches have difficulty offering alternatives to the current moral and political reality.

Traditional approaches further reinforce the status quo and inhibit moral thinking by presenting an overly narrow view of ethics, which sees ethics as choice between a cosmopolitan or a communitarian worldview and between deontological and consequentialist reasoning. Robinson (1999) contends that conventional ethics in international relations is “broadly speaking, a single tradition – one which emphasizes rights and other liberal values such as non-interference, autonomy, self-determination, fairness, reciprocity, and rationality” (p.5).

Abstract rationality

The ability of conventional approaches to provide concrete suggestions to help overcome some of the ethical dilemmas around global poverty is further hindered by their tendency to think about these dilemmas abstractly. The purpose of thinking about ethical problems abstractly is supposed to be to encourage impartiality and to develop principles that can be applied broadly across many different situations. However, the problem is, once an ethical dilemma is divorced from its context, it becomes much more difficult to provide tangible guidance for how to improve that situation. As David Campbell (1993) argues, despite the attempt by conventional ethical approaches to use abstract reasoning to build a more usable theory, it has the opposite effect. As he puts it,

while traditional perspectives on ethics and international relations have sought

to specify in the abstract what good and right conduct consists of, such accounts inevitably offer, despite their desire to be concrete, no more than intangible formulations that are always subject to interpretation concerning their applicability (p.99).

In other words, abstract reasoning may allow conventional approaches to help us understand why we should do something, but it makes it difficult for them to tell us what we need to do to actually make it happen (Wenar, 2003).

Take the example of attaching conditionality to aid to encourage reforms in an authoritarian regime. On the one hand any conditionality is a violation of sovereignty and the highly regarded liberal right of self-determination, but on the other, sending aid money into a vicious authoritarian state is clearly morally questionable. Of course, if we do decide that it is right to use conditions to pressure a repressive state to make reforms, there is still the problem of the innocent people inside the state that are already victims of a brutal state and are now cut off from any form of international aid.

Certainly this is not an easy dilemma to solve, but the abstract nature of conventional approaches provides us with little guidance on how to deal with these kinds of real life situations. We are left to try to balance competing principles. An article by Vivien Collingwood (2003) illustrates the challenges generated by an approach to ethics that requires the balancing of competing principles. Collingwood argues that from a liberal perspective some conditionality is warranted in cases of undemocratic and repressive governments. She suggests, “the moral rationale for conditionality resonates with established tradition in international liberal thought: the idea that liberal states should establish a threshold, above which the undemocratic or repressive practices of other states are not

tolerated” (p.59). She goes on to elaborate that “for moral and instrumental reasons, some form of conditionality is necessary: it can be used to punish repressive policies while giving the donor the opportunity to encourage reform” (p.60). Setting aside the strong paternalistic tone of this statement, where liberal donor states are able to decide which policies are acceptable in other states, there is a more fundamental problem. Collingwood provides no clear guidance of how or when these limits should be enacted.

Most people are likely to agree that there is a point after which donor countries become complicit in the repressive acts of an authoritarian state if the donor continues to give aid without a clear understanding of how and where that aid is being used. However, the abstract principles of conventional approaches are of little use in deciding at what point that occurs. These kinds of dilemmas need to be addressed on a case-by-case basis where broad principles must be interpreted to a specific situation. Thus, one of the key reasons for using abstract reasoning, which was to create broad and impartial principles that could serve as guides for every situation, is lost as soon as they are put into practice.

There are many examples in the conventional literature of scholars using this kind of abstract reasoning. In his attempt to develop principles to guide our obligations to others, Scanlon (1998) argues against an approach that considers each and every situation. He suggests instead that we should only focus on “representative cases” and use them to judge what principles others could not “reasonably reject” (p.171). He says “we must move away from the idea that each person’s happiness ‘matters’ to the question of an acceptable system of general principles of action” (p. 171).

Scanlon’s argument makes a lot of practical sense. It would be impossible to consider

every situation when trying to develop a system of general principles. There would simply be no way one could ever develop a system of general principles that could cover all situations, and that is precisely the problem. In attempting to establish broad guiding principles, conventional approaches have to use abstract reasoning – such an approach could not succeed if tried to take a more concrete approach. The limitation this creates for these approaches is that they are then unable to adequately address the important specific issues involved in each case. Further, as Campbell argues above, if these general principles are to have any impact on the ethical problems they seek to address, they need to be interpreted and applied to specific cases – something for which they are not equipped.

Leif Wenar (2003) argues there is an assumption in much of the conventional literature that it is relatively easy to know how to help distant others and what the impact of that help will be. However, he is clear this is not the case: “it is in fact quite difficult to determine how much the sacrifices of a rich individual will contribute to the long-term well-being of distant people in need. There is nothing clear or obvious about the relation between what a rich individual sacrifices and what the distant poor gain” (p. 291). We need research and a concrete understanding of the reality on the ground if we expect to make an impact (Wenar, 2003).

Instead, conventional approaches end up stuck in abstract debates over what we should do or what obligations we might owe to others. For example, Risse (2005b), in his response to Pogge’s (2002) call for action on global poverty, spends the bulk of his article debating whether or not the international system has harmed the poor and whether that potential harm creates obligations for rich states. These kinds of debates may be intellectually stimulating, but they do not get us any closer to dealing with the challenge of global poverty in practice.

As Robinson (1999) puts it,

an approach to ethics which is concerned only with the construction of an elegant and rigorous theoretical test for whether principles 'count' as 'moral' may deserve our intellectual respect, but it does not help us get any closer to the deeply social political problems surrounding the human suffering and deprivation brought on by world poverty (p.152).

There is another problem generated from an abstract approach to ethics – the use of analogies. Singer (1972) and Hardin (1974) are both good examples of this problem. In order to make their ideas more comprehensible and less abstract, both scholars employ powerful analogies to support their respective arguments. Singer uses the analogy of a child drowning in a puddle to support his principle of comparable worth, while Hardin uses the analogy of overcrowded lifeboats to justify his argument against aid. In both cases readers are asked to imagine themselves in fictitious situations in order to help them understand very real problems. Not only do these imagined scenarios create an obvious challenge for anyone trying to use them to come up with concrete solutions, but both are also embedded with very powerful values and assumptions about how the world works. In Singer's analogy there is an assumption that the challenge of global poverty is relatively easy and painless to overcome – as easy as pulling a child from a puddle at the minor expense of dirtying one's clothes.

The assumptions in Hardin's (1974) analogy are more ominous. First, the whole analogy of the lifeboat puts the reader in a situation of extreme emergency where some must die in order for others to survive. Next, Hardin's analogy provides three basic situations in which people find themselves: struggling to stay afloat in the water, clinging to an overcrowded lifeboat, or sitting inside a half full boat. He places the reader in the final situation, looking out from this boat at a mass of desperate people surging toward the lifeboat, certain to

overturn it and kill everyone. The message from Hardin's analogy is clear; in order to save ourselves, and others in our boat, we have an obligation to prevent anybody else from getting inside. How different the message might have been had Hardin placed the reader drowning in the waves, crying for help from a half-full lifeboat, only to be beaten back to certain death while the empty spaces sat unused.

The point is, using abstract reasoning to address ethical problems not only makes it difficult to apply these approaches in concrete situations, but it can also create the need for analogies embedded with value judgements and assumptions that further muddy the water in our attempt to develop solutions to concrete problems. As Hugo Slim (2002) put it, "it's easy to write political philosophy for a place that does not exist" (p.17). For him, "rights-talk is not enough," human rights "must be able to leave the paper on which it is written and show itself to work on the ground by protecting people better" (p.17). This is a challenge for all ethical approaches in global politics, but it is all the harder for conventional approaches because their reliance on abstract reasoning pulls them away from thinking about ethical challenges as they occur on the ground.

Universality and equality

As I mentioned earlier, one of the primary motivations for using abstract reasoning is to enable conventional scholars to develop principles that they argue can be applied universally. At the heart of the idea of universality is the fundamental belief that all people are equal and should be treated as such. Thus, as the reasoning goes, if we are all equal then it is only logical that we should be able to develop universal ethical principles that can be applied equally to all.

Care scholars have two major objections to this view of equality. First, while it may be appealing to say that we are all equal, the reality is we are not. The world is full of great inequality and to start from an assumption that we are all equal is, in Tronto's (1993a) words, "fiction." Tronto argues that by making this assumption, conventional approaches close off any discussion of how the current situation of inequality was created and how real equality can be achieved. The second objection care scholars have on the issue of equality is the way it is understood in the conventional literature.

Selma Sevenhuijsen (1998), argues that equality has come to be associated with sameness in conventional approaches. The result is, from a conventional perspective, by saying everyone is equal, what I am really saying is that we are all the same. Sevenhuijsen claims that this has the effect of marginalizing and pushing out those that are different. What is worse, difference quickly becomes negative. As she puts it, "differences, whether speculative in nature or accompanied by convincing evidence, are always considered deviant and negative in relation to a universal norm" (p.45). The effect is that anyone who is different is either marginalized or subsumed by the universal norm of equality as sameness.

Chris Brown (1992) uses examples from Todorov's study of the Spanish conquest of America to demonstrate that Western political thought has a long tradition of being unable to embrace difference. When the Spanish encountered difference in "the Other" of the Aboriginal Americans, they either saw that difference as inferior and destroyed it, or attempted to assimilate that difference by viewing the Aboriginals as potential Christians (Brown, 1992). Both approaches had the effect of eliminating difference; one did it through brute force, while the other destroyed difference by appealing to an idea of universal equality (Brown, 1992). According to Brown, what was missing was "an equality that recognizes and

celebrates difference” (p.224). It is exactly this kind of equality that care scholars embrace. An equality that moves away from ideas of sameness and universality to one that recognizes everyone’s “equality in the ability to display moral characteristics” and starts “from the assumption that each person’s aims and conceptions of what is good initially deserve respect, because they are important for determining a sense of self” (Sevenhuijsen, 1998, p.63). A care perspective emphasizes the need for equal opportunities and equality of access and voice in the public sphere.

The principles of universality and equality as sameness are prominent throughout the conventional literature stretching back to Kant. The categorical imperative requires that we act in such a way that our actions could be universalized. In the same way, Scanlon (1998) calls on people to live by principles that others “could not reasonably reject” (p.187). There is no space for difference in either of these perspectives. If I do not accept a universalized principle in Kant’s approach, then I am not rational. If I do not agree with a similar principle in Scanlon’s approach, then I am not being reasonable. In both cases, those that are different are silenced and their perspectives are excluded.

Thus, conventional ethical approaches have tended to marginalize alternative perspectives and voices by their appeal to a concept of universalism grounded in an idea of equality as sameness. This limits conventional approaches and makes them unable to incorporate different perspectives. In contrast, by understanding equality in a way that is more open to difference, the ethics of care is better able to bring in a greater diversity of views and values to the discussion of important political and ethical issues and so should be better able to address the current lack of equality in the world.

Independent actors

The final area where care scholars take issue with conventional approaches is the assumption made in the conventional literature that actors are always independent. Care scholars argue that treating individuals as independent actors ignores the important role cooperation plays in achieving autonomy (Held, 2006). By downplaying the significance of cooperation, traditional approaches obscure inequalities in power and resources that allow the privileged to obtain their position. Tronto (1993a) argues this creates a situation

where the notion, ‘I made it on my own, you should make it on your own,’ appears to have the formal quality of a morally correct and universalizable judgement, it can also serve to disguise the inequality of resources, powers and privileges that have made it possible for some to ‘make it’ while others have not (p.147)

Implicit in the assumption that we are independent individuals is the idea that if I succeed, it is a result of my own choices and abilities, and if I fail, it must also be a result of my own choices and lack of abilities. Clearly, this assumption has very important implications for how we understand poverty and our obligations to the global poor.

It is true that rights-based scholars like Pogge (2005) and O'Neill (1975) make strong and convincing arguments that global poverty is not simply the result of the bad choices of the global South, but also a direct consequence of our actions in the North. However, they still begin from what Robinson (2006a) calls an “individualist moral ontology” and ignore the “relational nature of morality” (p.7). In other words, rights-based approaches do not pay enough attention to the role social interaction plays in allowing rights to exist. As Virginia Held (2006) argues, “unless we have sufficiently strong motives to care about our fellow human beings and value this caring, we will not care whether their rights are respected or not,

especially in the case of people who are too weak to make serious trouble for us, as the history of domination, exploitation and indifference makes evident” (p.89). Thus, ethics of care scholars do not reject the idea of human rights, but they see the achievement of rights as only possible through our caring relations with others. By focusing only on rights and not understanding the underlying social conditions that help create them, rights-based approaches are unable to tell us “what is required to secure the political, economic and social conditions which make the exercise of rights possible” (Robinson, 2006b, p.329). Robinson (1999) is clear, “it is only when we begin from social relations, recognising them as both a moral and an ontological starting point, that we can think usefully about appropriate moral responses to world poverty” (p.150).

Independence is a central concept in liberal thought and figures prominently in rights-based approaches to ethics. Not all liberal scholars draw the same implications for rights and aid from the idea of independence. Some, like Lomasky (2007) take a more extreme view, arguing that the major obligation we have to distant others is simply to respect their independence. As he puts it, “to respect the rights of others is first and fundamentally to afford them noninterference. Positive provision of welfare goods is, if present at all, secondary” (p.218). However, even scholars like Pogge, who argue that rich countries have played a major role in the economic situation of poor states, still place significant importance on independence. In Pogge’s (2002) view, “I respect someone’s autonomy only insofar as I accept his measure of his flourishing as well as his way of arriving at this measure – without demanding that he must come to it on some path I approve as sufficiently reflective” (p.31). The weight Pogge puts on respecting difference is certainly much closer to a care perspective than Lomasky’s view of independence, but there is still an underlying assumption that we all

have an equal ability to both measure and achieve human flourishing.

For care scholars, who point out that we all need care at different points in our lives, the danger in making this kind of assumption is that care then becomes “a burden or ‘necessary evil’,” something to be put up with rather than valued (Sevenhuijsen, 1998, p.28). Worse still, the liberal focus on independence and self-sufficiency encourages us to see “dependency and vulnerability only in others” and “to look for needs and problems in others instead of in ourselves” (Sevenhuijsen, 1998, p.28). Part of the disdain for dependence and vulnerability in the conventional literature may come from the tendency in the literature to conflate autonomy and independence. Sevenhuijsen argues “in the liberal framework, autonomy and independency tend to be conflated, and autonomy, in the sense of autonomous judgement, is linked to an ideal of independence as self-sufficiency and to marginalization or even repression of the dependent dimensions of the self” (p.63).

Therefore, conventional approaches to ethics, especially liberal rights-based approaches, place a heavy emphasis on the independence of actors that ignores the reality that everyone is dependent on others at different times in their lives. By downplaying the importance of care, these approaches not only devalue care, but also create a tendency to only see dependency and vulnerability in others. Viewing myself as independent and only seeing dependency in others has important implications for how I understand my obligations to others. If I view my success as largely the result of my own effort and the failure of others as largely the result of their own shortcomings, I will likely be less willing to help them out and will be completely unable to see what role I may have played in their failure, or what role they may have played in my success. Indeed, from this perspective I am very likely to take a similar view to that of Lomasky’s (2007), which I quoted earlier in this chapter, “disparities in

holdings are, for the most part, explicable by noting how the rich have made themselves rich and the poor have made themselves poor” (p.214).

In this section I have outlined four key limitations care scholars argue are common across the conventional literature: the separation of politics and ethics, the use of abstract reasoning, an appeal to a concept of universalism based on a notion of equality as sameness, and an assumption that individuals are independent actors. However, while these criticisms are certainly true of the bulk of traditional approaches, there are some approaches to aid that maintain liberal language without falling victim to some of the criticisms I have discussed above. The capabilities approach developed by scholars Amartya Sen (1999) and Martha Nussbaum (1999) appears to offer an important bridge between conventional approaches to aid and more critical approaches. This potential bridge is important because it suggests that rights approaches and care approaches may be able to work together to achieve common goals. Indeed, as I will demonstrate in subsequent chapters, a care approach can help uncover why rights are not being respected and help create the conditions where the achievement of rights is possible.

The Capabilities Approach

In his book, Development as Freedom, Sen (1999) argues that the focus of development should be to enhance freedom rather than economic growth. For Sen, true human development means having more freedom and overcoming crucial “unfreedoms” like poverty, tyranny and intolerance. He argues that the goal of development should be to enhance individuals' capabilities to achieve key political, economic and social freedoms. In other words, Sen claims that progress in development should be measured by the degree to

which individuals are able to lead the kind of lives they have reason to value (p.285). Thus, from a capabilities perspective “human well-being is the fundamental good of economic development” and “the central ill economic development should be designed to address is human poverty” (Little, 2003, p.30).

Nussbaum (1999) specifies ten key capabilities for development, ranging from the most basic capability to live, all the way to the capability to play. She defines capabilities as “the functions without which (meaning, without the availability of which) we would regard a life as not, or not fully human” (p.39). Nussbaum is clear that capabilities must be about more than simply surviving, arguing that “we want to specify a life in which fully human functioning, or a kind of basic human flourishing, will be available” (p.40). Of course, from a care perspective we might challenge Nussbaum as to how she can specify these particular ten capabilities in the abstract, without at least consulting with those whose capabilities she is trying to develop. In this way, she risks falling into the same trap of other liberal scholars by eliminating difference. If I do not accept her ten capabilities as the ten most important for me, then my life cannot be considered fully human.

However, despite this weakness, by moving away from a discussion of rights to a discussion of capabilities needed to achieve rights, Nussbaum is able to address one of the key criticisms ethics of care scholars have of rights approaches, namely that pronouncing an individual has a right to something tells us little about that individual's actual ability to exercise that right. Nussbaum openly acknowledges this shortcoming among some liberal approaches, but argues that there is nothing in liberalism that requires such a narrow perspective on rights and freedoms. Indeed, she suggests any true liberal must care about the actual material conditions in which individuals operate. In her words, “if one cares about

autonomy, then one must care about the rest of the form of life that supports it and the material conditions that enable one to live that form of life” (p.50). This idea is shared by Henry Shue (1980) and his basic rights approach, which argues that it is impossible to achieve true political freedom without ensuring at least basic protection of individuals’ subsistence rights. Indeed, as I will show in the next chapter, this notion of basic rights figures prominently in the debate around a rights approach to health.

Returning to Nussbaum, she accepts that liberal approaches also have a tendency to be too abstract when thinking about freedom and rights, but she argues that this is not the case for all liberal approaches and there is nothing in liberalism that requires such a level of abstraction. She also addresses criticisms that liberalism's emphasis on individualism leads to an unrealistic view of human beings as largely self-sufficient, arguing that a belief in individualism does not require support for self-sufficiency. Thus, Nussbaum's capabilities approach suggests it is possible to take a liberal approach without necessarily falling into many of the criticisms I discussed earlier in this chapter. This means that there is potentially some important room for cooperation between rights approaches and a care approach.

Of course it is important to acknowledge that there are some fundamental distinctions between the two approaches and their ultimate goals. For the capabilities approach, the goal is to enhance freedom, while ethics of care scholars are ultimately concerned with understanding how to help us care better for one another. Clearly, trying to get people to care is a more ambitious and challenging goal than simply giving them freedom. However, it seems equally true that if people do not care for one another they are not really going to care if others have the capability to achieve freedom. In this sense, the capabilities approach is just as vulnerable as rights approaches to Held's (2006) criticism, that without care there is

little reason to expect people will be overly concerned about helping others, especially the exploited and marginalized, to build their capabilities. Thus, the ethics of care could be seen as an important first step to help achieve the kinds of freedoms Sen is striving for. As one care scholar put it “rights and interests are important aspects of a critical ethics of care” but “they must always be understood relationally and always as embedded in and realized through existing social and political arrangements” (Robinson, 2010, p.140). A care perspective helps us understand the role of these broader arrangements in the achievement, or lack of achievement, of human rights and helps us better understand the conditions needed to secure rights.

In sum, there are some important limitations in conventional approaches to aid – including the capabilities approach – that lead ethics of care scholars to question how effective these approaches can be in addressing global poverty. It is not so much that care scholars see conventional perspectives as wrong or useless, but rather that the narrowness of conventional approaches means that a care approach is able to offer an alternative method of understanding and addressing poverty that is missing from many conventional approaches. As I will show in the next section, the ethics of care offers a very different approach to ethics, which brings new insight to the issues of poverty and global health.

The Ethics of Care

The ethics of care is a feminist approach with its roots in works by scholars like Sara Ruddick (1980), Carol Gilligan (1982), and Nel Noddings (1986). It provides an excellent position from which to critically analyze the conventional literature. In the words of one care scholar, “one of the central strengths of care theory is its ability to identify gaps in traditional

accounts of ethics that may be partially caused by the social location of the theorists who have traditionally done philosophy” (Groenhout, 2003, p.6). The ethics of care has also gone through some significant developments over time and so it is difficult to talk about the ethics of care as a single, unified approach. Instead, it is more helpful to think of the ethics of care as a constellation of approaches that share some central values, namely, a relational ontology and an understanding of care as both a moral activity and social practice that is made up of four essential elements: attentiveness, responsibility, competence and responsiveness. This section will examine each of these aspects of the ethics of care and the implications that stem from them.

However, before looking at the specifics of a care approach, it is important to acknowledge a significant distinction that exists among care scholars. As Olena Hankivsky (2004) observes, care theorists can be distinguished between first generation care theorists, which tend to link care closely with gender, and second generation care theorists, which look at care as it relates to all human life. In her words, “while most of the first generation of care theorists state that their ethic is not exclusively feminine, they nevertheless assume that women are more likely and more suited for the maternal role than are men” (p.12). She contrasts this approach with that of second generation theorists who “have established the centrality of care to all human life and activities” (p.27). This distinction is important because the criticisms of the ethics of care in the conventional literature are based almost entirely on an understanding of care that is tied closely to a gendered notion of care and fail to recognize the important diversity in ethics of care approaches. Indeed, many care scholars fully acknowledge the problems with linking an ethical approach too closely to an idea of womanhood or femininity.

Sevenhuijsen (1998) argues that such approaches rely “too heavily on the mythical image of ‘Woman’, which has persisted for too long in various moral texts and which fails to do justice to the diversity of moral experiences of actual women” (p.16). Tronto (1993b) echoes these concerns, suggesting that conceiving of the ethics of care in this way robs the approach of much of its critical insight. She argues “if feminists think of the ethic of care as categorized by gender differences they are likely to become trapped trying to defend women’s morality rather than looking critically at the philosophical promises of an ethic of care” (p.241). Both scholars are clear that their approach to care does not suggest women are morally better or more caring than men. Instead the focus of these theorists is on the role of care as a moral activity and social practice across human experience, which is also the approach to care that I take in this study.

Relational ontology

Returning to the central aspects of a care approach, one of the most fundamental differences between a care approach and conventional approaches to ethics is the care approach’s use of a relational ontology. Robinson (1999) explains that a relational ontology,

starts from the premise that people live in and perceive the world within social relationships; moreover, this approach recognizes that these relationships are both a source of moral motivation and moral responsiveness and a basis for the construction and expression of power and knowledge. The moral values of an approach to international ethics based on care, then, are centred on the maintenance and promotion of good personal and social relations among concrete persons, both within and across existing communities (p.2).

Thus, a relational ontology differs from the rational ontology of traditional ethical approaches by understanding ethics as embedded in the context and social relations in which

they occur, as opposed to abstract principles that can be understood independent of those for whom they apply (Hutchings, 2000).

Essentially, a relational ontology recognizes that “humans do not begin with rational and intellectual distance from others, recognize the advantage inherent in forming some sort of social contract, and so agree, influenced by pure, self-interested reason, to create rules that apply equally to all” (Groenhout, 2003, p.17). Instead, a relational ontology argues that people “develop their moral and rational capacities in connection and interaction with others” (Sevenhuijsen, 1998, p. 62).

A relational ontology allows ethics of care scholars to step back from questions of what we should do, and focus on building a better understanding of the actual concrete conditions in which moral relations occur (Robinson, 1999). In Robinson’s (1999) words, ethics of care focuses on the “permanent background to decision-making” (p.31). Traditional approaches tend to miss this background because their approach of abstracting ethics away from their context essentially makes that context invisible. These approaches “tend to interpret moral problems as if they were conflicts between egoist individual interests on the one hand, and universal moral principles on the other. The extreme of the ‘selfish individual’ and ‘humanity’ are recognized, but what lies between these is often overlooked” (Held, 2006, p.12).

Care as a moral activity and social practice

An important implication of a relational ontology for the ethics of care is that it positions care as both a moral activity and social practice. Treating care as a moral activity means “moral problems are observed and discussed in the first instance from an attitude of caring,

that is with attentiveness, responsibility, responsiveness and the commitment to see issues from differing perspectives” (Sevenhuijsen, 1998, p.83). Thus, “care is primarily seen as an ability and willingness to ‘see’ and to ‘hear’ needs, and to take responsibility for these needs being met” (Sevenhuijsen, 1998, p.83).

Notice the sharp distinction between a care approach and a liberal rights approach. From a rights perspective our moral obligations are focused primarily on not interfering in the lives of others so that they are free to live as they choose. While it is true that in the context of international aid, not interfering may still, as Pogge argues, involve some serious obligations on our part to help others achieve their freedom, the starting point is very different from a care perspective. From a liberal perspective we only ‘care’ about poverty if that poverty is seen as being unjust. In the words of University of Montreal ethicist, Ryoa Chung (2005),

according to the liberal framework [...] not all inequalities demand a moral response. Only inequalities that we consider unnecessary, avoidable, unfair and therefore unjust properly make up the inequalities [...] that form the proper object of ethical and political reflection (p.321).

In contrast, a care perspective begins from a relational ontology that demands we pay attention and respond to the needs of others. This does not mean that we must exhaust ourselves trying to meet all the needs of others, but that we work with them to understand what their needs are and how we can work together to meet them. Perhaps more importantly, a care perspective acknowledges that caring is a moral activity in itself.

The demands that come from a care perspective may be more encompassing than those from a liberal rights perspective, but they are also more fundamental. We need to care about others if we are going to care about their rights and freedoms, or care if the international

community is doing all it should to fight global poverty. Care comes first, and by anchoring it in a relational ontology the ethics of care is able to clearly underscore the importance of care as a moral activity in itself, so that “moral problems are observed and discussed in the first instance from an attitude of caring” (Sevenhuijsen, 1998, p.83). Further, by “taking seriously the fact that care is a central aspect of human existence” the ethics of care also helps normalize care and illustrate its role as a crucial social practice (Sevenhuijsen et al, 2003, p. 314).

The concept of care as a social practice is rooted in “the recognition that others need our attention, energy and commitment” (Sevenhuijsen, 1998, p.20). Once we recognize this, it is “possible to combat the various forms of privileged irresponsibility which are still too often found in the administrative logic of the public debate” (Sevenhuijsen, 1998, p.146). From an aid perspective, it is essential that we recognize that we all need care at different points in our lives, otherwise we risk falling into a situation “whereby vulnerability and needs are located in the so-called ‘needy’, and not in ‘normal’ moral subjects” (Sevenhuijsen, 1998, p.27).

Thus, care provides us with a normative approach that allows us to observe and analyze moral problems from a perspective that highlights how others need our attention and commitment and how all of us depend upon others’ similar consideration. In this way care is more than just the actual act of caring, it is a political and ethical theory for understanding the world. As Hankivsky (2006) puts it, “ultimately an ethic of care provides a theoretical foundation from which to develop more flexible and effective practical ways to analyze and respond to a range of global inequalities and injustices” (p. 92).

This distinction is important because if we think about the ethics of care as simply about

caring for others we risk falling into two traps. First, there is a risk that the intentions of the caregiver can become idealized as always pure and altruistic. In reality of course this is not always the case, people engage in care work for all sorts of reasons, not all of which would be considered altruistic. It is also important to acknowledge that care work can be a burden on the caregiver, preventing her from becoming active in other parts of society (Bubeck, 1995). In their critical analysis of the concept of social capital, Pamela Herd and Madonna Harrington Meyer (2006) demonstrate how care work can serve as an obstacle to women's civic engagement. Many of the ethics of care scholars I have discussed in this chapter are quite open about the fact that the motives behind care are not always noble (e.g., Sevenhuijsen, 1998). We also need to acknowledge that we do not care for everyone equally. As Tronto (1993b) explains, because we care more for some people than others, there is the potential for favouritism to creep into a care approach that focuses too much on the actual act of caring for others. Her solution is to approach the ethics of care as a social and political theory.

The second risk that comes from focusing exclusively on the actual act of caring for others is the more practical challenge of how and why to care for distant others who we have never met or engaged with. By approaching the ethics of care less as a theory and more as the actual act of caring about others, we risk falling into the trap of feeling compelled to develop elaborate principles and theories justifying why we should care. Sarah Clark Miller (2005) goes as far as appealing to a Kantian notion of duty to suggest we have a duty to care for others. She suggests "there is, an oddly fundamental question that care ethicists have not often posed, one that may be necessary to answer in order to have an ethics of care at all. The question is, 'Must I care? And if I must, why must I care?'" (p.111). What Miller

is missing with this question is that the ethics of care is about more than just the act of caring for others. It is a normative political theory that begins from the understanding that we all need care at different points of our lives and recognizes that others need our attention and commitment. Thus, the real question is not why we should care, because we need care to survive. The more important question is how can we learn to care better and address gaps in caring that currently exist. The ethics of care is about helping us care better and understanding what new insights a care perspective gives us in the face global inequalities and injustices.

The elements of care

Tronto (1993a) sets out four central elements of an ethics of care approach: attentiveness, responsibility, competence, and responsiveness. These four elements are common across most approaches to the ethics of care, sometimes with minor adjustments.

The first step in caring is being attentive to the needs of others (Tronto, 1993a). It is only by paying attention to the needs of others and, the consequences of our actions on them, that we can begin to care. From an ethics of care perspective ignoring the needs of others is a form of moral evil in itself (Tronto, 1993a). However, paying attention to others' needs is not an easy task. The idea "that 'others' matter is the most difficult moral quality to establish in practice" (Tronto, 1993a, p.130). And, it is in practice where this idea is most important. It is all well and good to have a principle that all human life has value, but if this principle is not acted out in actual aid policy, it is not much use.

Overcoming the challenges of paying attention to others is only the start of a care approach. Once we are paying attention, we need to take responsibility to address the

problems and needs we observe. As Held (2006) argues, “the central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility” (p.10). The idea of taking responsibility for others may seem paternalistic, however, ethics of care scholars take a different approach to responsibility from that of traditional ethical perspectives (Tronto, 1993a). Responsibility in the context of the ethics of care is not an obligation to care for others. It is a more flexible responsibility that comes out of our relationships with others that “must be addressed collectively through cooperation” (Robinson, 1999, p.63). Robinson (2006b) describes this responsibility as “an always, already existing part of the daily lives of all people. It recognizes that we all have developed relationships that are ‘thick with commitment or expectation’” (p.333).

Once we take responsibility to care for others, it is important that care is delivered competently and those who say they will take care of a problem are held to account (Tronto, 1993a). Thus, competence is the next element of care. This phase of care helps illustrate the strong practical focus of an ethics of care approach. It is not enough to simply be aware of what is going on in the world and take some responsibility for it, a care perspective requires that we analyze each specific case, working cooperatively with all involved, to fully understand what is needed to improve the situation. As Hankivsky (2004) argues “an ethic of care is concerned expressly with the actual outcomes and practical and material effects on people’s lives of making certain choices and decisions” (p.38).

The final element of care is responsiveness. Responsiveness is a two-way process between the receiver and giver of care, each responding to the other (Tronto, 1993a). As Hankivsky (2004) explains,

what is required for this form of engagement is a commitment to provide the opportunity and a safe space for others to express their “otherness”. To be responsive requires a special form of mutual engagement in which participants are empowered to decide what aspects of their lives they want to include as part of the discussion (p.35).

Responsiveness places special emphasis on giving a voice to the marginalized and bringing to light the power relations in society (Hankivsky, 2006). It generates communication and cooperation and is thus crucial for a care approach and its need for “thoughtful knowledge of the situation and all of the actors’ situations, needs and competencies” (Tronto, 1993a, p.136).

According to Tronto each of the elements of care corresponds to one of the four phases of care: caring about, caring for, taking care of, and care receiving (Sevenhuijsen, 1998). The first phase, caring about, requires attentiveness to “the factors which determine survival and well-being” (Sevenhuijsen, 1998, p.83). Once we are paying attention to the needs of others we need to take responsibility to care for those needs. This phase requires more knowledge and more effort than the first phase because it involves “seeing what is necessary in a particular situation and which means can be brought into action” to address that situation (Sevenhuijsen, 1998, p.83). From this phase we move into the more concrete phase of actually taking care of others (Sevenhuijsen, 1998). This is the daily caregiving work that requires care be delivered competently. The final phase of care involves responding to those receiving care (Sevenhuijsen, 1998). Different actors may be involved in each phase of care, so that those who take responsibility to care for a situation may not be the same actors who actually deliver the care (Sevenhuijsen et al, 2003).

Thus, the ethics of care approach I apply in this project is based on the work of care

scholars who move away from notions of care tied to ideas of maternal thinking or women's morality. The ethics of care used in this project is based on a relational ontology and provides an important normative political theory for understanding and responding to the world. It sees care as both a moral activity and a social practice and is expressly concerned with making peoples' lives better. An ethics of care approach contrasts with conventional approaches to ethics by focusing on responsibilities and relationships rather than rules and rights, by dealing with concrete circumstances rather than debating ethics in the abstract, and by understanding care as a moral activity rather than treating ethics as a set of principles that must be followed (Tronto, 1993b).

This chapter has concentrated on the merits of an ethics of care approach at a theoretical level. Subsequent chapters will examine a care approach in the context of global health aid to understand what it can offer the analysis and development of aid policy that conventional approaches cannot. I will conclude this chapter by briefly discussing the promise of an ethics of care approach for helping us better understand and address the problems stemming from global poverty and inequality. However, before I turn to the promise of care, it is important to look at some of the critiques of care.

Critiques of care

There are three criticisms of care that are particularly relevant for the any effort to develop a care approach to aid: the risk that care could become paternalistic, that justice and care are not really that distinct, and that care theory has failed to provide real practical guidance for how it can be applied to global politics. The concern of over the potential paternalistic nature of care is important, especially when applied to foreign aid policy. With

large power imbalances between donor and recipient states it is easy to see how care language could be used to justify a situation where rich states “take care of” poorer states in a one way relationship over which the donor has complete control.

This is exactly the concern Uma Narayan (1995) has raised, drawing parallels to the contemporary language of the ethics of care and historical justifications for colonization. Narayan, drawing on the idea of “the white man’s burden” points out that there was a “colonialist care discourse” in which “the colonizing project was seen as being in the interests of, for the good of and as promoting the welfare of the colonized” (p.133). Narayan suggests that there is a risk that this same kind of paternalistic notion of care could creep into modern care discourse if not enough attention is paid to the role of power in relationships. As Narayan highlights, it is not enough to “stress that we are all essentially interdependent and in relationships”, we also need to pay attention to “the accounts that are given of these interdependencies”. She explains that the colonizers and the colonized knew there were interdependent, but “had very different accounts of what the relationship and its interdependencies amounted to, and whether they were morally justified” (p.136). Thus, according to Narayan the danger is that care discourse could be used as a tool of the powerful to pursue their own self-interest.

None of the care scholars I have used to build my theory would disagree with this concern. Robinson (2010) deals directly with Narayan’s concerns, arguing that “at the international level, an ethics of care must not be seen to translate simply into benevolent and humanitarian practices through which the strong states and organizations [...] ‘care for’ weaker, vulnerable populations” (p.139). Instead, Robinson suggests that the “focus of attention” of an ethics of care approach “is on attending to the needs, rights and interests of

people as both givers and receivers of care” (p.139). The ethics of care is not just about responsibility it is also about responsiveness to others’ needs as they define them. It is not about the powerful care giver deciding what the weaker care receiver needs. When care is delivered responsively with attention to the other’s needs there is much less risk of it being used as a tool of the powerful.

Part of Narayan’s solution to the risks of paternalistic care is to challenge the distinction made in care theory between justice and care. She is not the only scholar to take issue with this distinction. Meyers (1998) challenges what he sees as the dichotomous relationship that Carol Gilligan (1982) presents between care and justice. Far from being dichotomous, Meyers argues that care and justice are linked through their concern with power and dependence. This becomes clear, according to Meyers, when we move from a metaphysical understanding of justice, which is concerned with principles, to an understanding of justice as a political concept that is concerned with the problem of power. However, here again I do not think that the care scholars I have used to build my approach would necessarily reject Meyers’ assertions. While care scholars may distance themselves from approaches to justice that focus “on the procedures for the fair distribution of goods” (Robinson, 2010), Meyers is talking about a different view of justice. Indeed, in making the link between care and justice Meyers sounds remarkably close to Held (2006) and her argument that you need to care in order to get justice. As Meyers puts it, “care is a way of tuning in the voice of suffering, a first step in giving a practical form to the sense of injustice and making the connection to politics” (p.154). Understood this way, Meyers’ arguments seem more of a compliment to the care approach I am using than a critique.

More recently care scholars like Robinson and Tronto have been criticized for not

providing enough concrete guidance for how to apply a care approach in global politics. Engster (2007) argues “much of what it means to care for others in international relations [...] remains ambiguous” (p.161). According to Engster, the reason for this failure is that care scholars have not proposed “anything like a body of rights for institutionalizing caring relations among people world wide”. Engster is not the only scholar to see the failure of care scholars to formulate a right or duty to care as a key gap in a care approach. As I mentioned earlier, Sarah Miller Clark (2010; 2005) has drawn on Kantian ethics in her attempt to establish a duty of care.

These challenges are important because they help underline a key aspect of a care approach. If we come at the ethics of care from a more conventional perspective the way Engster does, it may seem like we need to develop some kind of framework for establishing a right or duty to care. However, Engster is missing a key component of a care approach - its relational ontology. Without rooting the ethics of care in a relational ontology there is no clear reason why we should be more concerned about care than about rights. More importantly, without a relational ontology it is difficult to see how care can be applied effectively at a global level. After all, how can I care for someone who I have never met?

From a relational perspective our relationships with others provides the foundation for care. I do not need to establish a right or duty to care because my responsibilities to others come out of my interactions with them. As Robinson (2010) argues “an international political theory of care does not prescribe a duty among states to care for one another; nor does it proclaim a universal ‘right’ to care” (p.142). Care focuses our attention on our relationships and the broader context in which those relationships occur. From this perspective “our responsibilities to help alleviate poverty and deprivation arise not out of charity or even

contemporary obligations of ‘development’ or ‘cosmopolitan justice’ but out of a common history and an interdependent future” (Robinson, 2010, p.139). Our relationships are the starting point. Thus, from a Canadian perspective I do not need to establish a duty for Canada to care for Haiti because the responsibilities Canada and Haiti have for one another come from the relationships and shared history that already exist between the two countries. In terms of foreign aid, current and past aid, trade and diplomatic agreements all help form part of the foundation of our relationships with other states. Our responsibilities to those other states and their responsibilities to us flow from those relationships, not from any attempt to establish a universal obligation or duty to care. By neglecting the relational ontology of a care approach Engster misses the importance of relationships in generating responsibilities, so he is left to try and establish rights and duties to care in the abstract.

Critiques of care have been important to help more clearly articulate what a care approach means for global politics. Concerns over the paternalistic care underscore the importance of providing care responsively with attention to the needs of care recipients as those recipients express them. There is also nothing in a care approach that precludes discussion of rights or justice, but that discussion needs to be root in a relational understanding of global politics. Without a clear appreciation of the importance of relationships for a care approach discussions of care risk getting sidetracked in efforts to establish universal duties and obligations to care. Not only are such discussions distracting, but they take our focus away from the important historical context of our relationships. As I will demonstrate in the next section, care’s relational ontology also has some unique and interesting implications for aid policy.

The promise of care

The practical application of the ethics of care to global politics is an area still being developed. Most care research has focused on the domestic policy context. However, by drawing on this research it is possible to see the potential of the ethics of care for global politics.

One interesting area of research is Sevenhuijsen's (2003) idea of responsive policymaking where "the emphasis is placed on listening, responding and reacting immediately to problems" (Sevenhuijsen, 2003, p. 193). She suggests that

social policy in accordance with the ethics of care recognizes that dealing with dependence and vulnerability on a daily basis plays an important part in human experience. From this perspective, moral concepts such as responsibility and trust assume a central place in the normative consideration of policymakers (p.185).

Thus, policymakers in an ethics of care approach are encouraged to place special emphasis on being open and responsive to the concerns of the public.

Looking more specifically at the policy development process, Sevenhuijsen and her colleagues (2003) argue that each of the elements of care has an important role to play. Attentiveness would move policy makers beyond simply analyzing data and statistics on the scale of a particular problem and force them to engage in public consultations to understand how the people on the ground are being impacted. They suggest that attentiveness would also push policy makers to engage in more democratic needs assessments to help them better understand "what is actually the problem as experienced" by those involved (p.315). Moving to responsibility, Sevenhuijsen and her colleagues argue that responsibility from a care

perspective would encourage partnership and cooperation. However, it would also involve ensuring that someone actually takes responsibility for a situation and works against “institutionalized patterns of irresponsibility” that they argue is common in the policy making process where those involved continually try to pass the buck to others (p.316). As for competence, they suggest adding it to the policy process would help those responsible get a better picture of what is needed to ensure responsibilities are met. They argue competence “gives substance to and understanding of what people need to be able to perform care work in specific situations. It places responsibility with decision makers to optimally make resources available for care to proceed ‘as well as possible’ in terms of time, money and expertise” (p.316). Finally, they emphasize that open and responsive communication between the giver and receiver of care would enable “care receivers to respond to the care received so that caregivers can ascertain that the care provided indeed meets the needs of the care receivers” (p.317).

At the same time, Hankivsky (2004) suggests social policies developed from a care perspective would move away from the heavy reliance on economic costing common in policy development. She questions the appropriateness and effectiveness of trying to place a monetary value on something like human suffering in order to accurately assess the full impact of a policy initiative. An ethics of care approach to social policy development would broaden policy analysis to include aspects of life that cannot be captured through economic analysis (Hankivsky, 2004). As Hankivsky puts it, “principles of care challenge us to *widen* our capacity to understand that the concept of value can have many meanings other than just those associated with a quantifiable measure. At the same time, the principles of care *narrow*s our view of what may be appropriate for economic quantification” (p.83).

More recently Tronto's (2010) "seven warning signs that institutions care not caring well" could provide some interesting implications if applied to foreign aid. Some of Tronto's warning signs include: "misfortune causes the need for care", "needs are taken as a given", "care receivers are excluded from making judgements because they lack expertise" and "care is narrowed to care giving, rather than understanding the full process of care, attentiveness to needs and the allocation of responsibility" (p.163-165). Tronto's focus is on institutional care in the domestic context, but substituting aid for care in her warning signs provides an interesting and potentially quite powerful standpoint to critically evaluate aid policy. If we look at the need for aid as primarily the result of misfortune we will miss the role broader political, economic and social factors have played in creating global poverty and poor health and thus could end up with programs that work primarily as a bandage fix rather than a long term solution. Sevenhuijsen's (2003) notion of responsive policy making would warn policy makers against taking the needs of aid recipients as a given and would challenge them to engage with recipients to understand what recipients feel they need. A responsive approach understands that receivers of care have important knowledge that needs to be included in the development of any aid process. Finally, similar to the problem understanding poverty as the result of misfortune, failing to understand the challenges of poverty and poor health in a broader context cuts policy makers off from important insight into these challenges, as well as potential solutions. At the same time this narrow focus risks disempowering aid recipients as having no active role in their own care.

Looking more specifically at how care theory has been applied to global politics, Robinson (1999) suggests that an ethics of care approach to development would be built on real and long-term partnerships between donors and recipients. As well, she argues a care

approach would reject making strong distinctions between economics, politics and morality. Held (2006) has a similar view, contending that a care approach would place primary importance on “fostering the kinds of economic development that actually would meet human needs and enable the care needed by all to be provided” (p.166).

An ethics of care approach also has a lot to say about the health challenges facing the global poor. Robinson (2006a) demonstrates the ability of an ethics of care approach to uncover how an unequal division in the provision of care places an extra burden on impoverished women and girls forced to care for sick relatives. This problem is particularly acute in areas ravaged by HIV/AIDS where women caregivers, as well as their children, are adversely impacted by the increased demands placed on them as a result of having to care for others (Heyman, 2003; and Kayumba, 2000). At the same time the recruitment of health professionals by Western nations and cuts to public health services further increase the burden of care on women (Zimmerman, Litt & Bose, 2006). This increased care burden prevents women from becoming more involved in society and makes them economically vulnerable, which risks exacerbating already existing gender inequalities in many HIV ravaged states (Upton, 2006).

Thus, while “government and international aid agencies recognize the growing HIV/AIDS crisis with initiatives aimed at educating people about the disease and the importance of using condoms”, they have tended to focus less on “the actual crisis of care and the role of women’s caregiving as a key element in this context” (Upton, 2006, p.281). The implication is that by not paying better attention to the serious economic, political and social burdens of care placed on women and caregivers that result from HIV/AIDS, governments and aid agencies risk working against prominent international development

goals of enhancing freedom and combating gender inequality.

Too often decision makers take an instrumental view towards health, understanding it as “a condition of the achievement of other ends” (Sevenhuijsen, 1998, p.131). However, an ethics of care approach has the potential to see the importance of health in a much broader context and thus promises more effective and inclusive solutions to serious global health challenges like HIV. It will be the task of the following chapters to determine how well it lives up to this promise.

Chapter 2: Human Rights, Security, Economic Growth and Health

Health has become a major component of development over the last several years as research has increasingly identified the important interconnection between poverty, disease and well-being. This chapter explores how health has been understood and approached in the development literature. It will focus on three prominent approaches to health: health as a key driver of economic growth, health as a human right, and health as a security issue. These three approaches have been widely embraced by key international development organizations. The theme of health as crucial to economic growth has figured prominently in major reports by both the World Bank and the World Health Organization, including the 2001 WHO Commission on the Macroeconomics of Health and the 1993 World Bank Development Report. The 2003 UN Commission on Human Security devoted an entire chapter of its report to the importance of health to human security. Finally, the notion of health as a fundamental human right has been supported by several UN agencies, including the WHO, which featured it prominently in its constitution and has published numerous reports and publications on the value of health as a right.

All three perspectives have strong support both in the theory and practice of international aid and each provides important insight into how health is understood in relation to poverty and development. All three approaches recognize health as key component to overcoming world poverty and enhancing global development. However, there are some important ethical and practical differences in how each of these approaches justifies that understanding and translates it into practice. I will explore these differences, drawing out the theoretical and practical implications for international aid. My purpose in this analysis is to help set up the next chapter, which will make the case for the value of using an ethics of care perspective to

understand and develop international health aid policy. If a care approach is to be useful in this field, it is crucial that it be able to offer something to the study of international health aid that other approaches cannot. By laying out both the strengths and limitations of the main approaches in the field, I will be able to better illustrate what a care approach has to offer and how it can help us overcome some of the limitations of other approaches.

All three approaches have some important things to say about health and its relation to poverty. Indeed, the combined work of scholars and practitioners from these approaches has done an invaluable job of securing health's place as vital component to understanding poverty and development. However, they have limitations that an ethics of care perspective can help overcome. Economic approaches to health have been by far the most criticized in the development literature, both for their narrow, instrumental approach to health, which fails to appreciate the central importance broader social and political forces play in determining health outcomes and for their heavy and uncritical reliance on neoliberal policies, which in practice have tended to erode the health of many of the most vulnerable in societies. A care approach can help expand our understanding of health beyond just its value to economic growth and development and provide policy makers with alternative methods of evaluating the success of programs other than strictly economic analysis.

Human rights approaches to health provide a broader understanding of health and its relation to poverty and are able to make use of the language of rights to draw attention to important health issues. However, rights approaches are limited by their inability to tell us how to actually translate a right to health into improved health outcomes for the poor. Further, given the tenuous nature of international rights claims, especially those related to so called "positive rights," like health, it is questionable how much power a right to health really

has to create change in the global political system. A care approach can help support the protection and achievement rights approach by providing better insight into how we can create the practical conditions to make rights a reality. As well, because a care approach is built out of our relationships it does not have to appeal to rights claims and can instead start from an examination how care is dealt with in current relationships and look for ways to improve.

Security approaches to health also have the benefit of bringing a broader perspective to the understanding of health, as well as helping create new urgency around health issues. However, by using the language of security, these approaches risk being subsumed into a more traditional understanding and approach to security that is not appropriate for addressing complex health crises and risks making health worse for the most vulnerable members of society. A care approach would support the objectives of security approaches to drawing attention to the insecurity created by poverty and poor health, but its emphasis being responsive and attentive to the needs of care recipients would prevent it from being subsumed by more traditional approaches to security.

I will begin this chapter by examining the key claims, understandings and limitations of an economic approach to health. I will then move to conduct a similar analysis of human rights approaches to health and security approaches. I will conclude with a discussion of the implications of these three approaches for global health and international health aid, setting up the next chapter of this thesis, which will develop an ethics of care approach to health.

Health as a Driver of Economic Growth

The World Bank's 1993 Development Report, Investing in Health, made a strong case for

the importance of health in stimulating economic growth and overcoming global poverty. The report was particularly interested in the possibility that health aid could be justified on purely economic grounds, with no reference to any notion of duties or obligations on the part of the international community. Investment in health made economic sense. In the report's own words, while health "is a crucial part of well-being, [...] spending on health can also be justified on purely economic grounds" (World Bank, 1993, p. 17). This is because, according to the Bank, improved health

reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrolment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent treating illness. (p. 17)

In other words, health builds human capital that in turn generates economic growth, which is not only good for aid recipients, but for the entire global economic system.

From this perspective health is a key building block to all other forms of economic development and there is strong statistical data to support this claim. A study funded by the WHO that examined the effect of health on economic growth found that "health has a positive and statistically significant effect on economic growth" (Bloom, Canning & Sevilla, 2004, p. 11). It argued that there was clear evidence to indicate that health is "a crucial aspect of human capital, and therefore a critical ingredient of economic growth" (p. 1). This work supported the earlier findings of the WHO's Commission on the Macroeconomics of Health (2001), whose massive study of the impact of health on economic growth found strong evidence of good health's positive effect on growth and the serious drag poor health places on the economy.

According to the Commission's report (2001), just as improvements in health can create an economic boost for a country, so too can illness and disease seriously inhibit a nation's ability to prosper. The impact of health is so strong because it has important spillover effects that are felt right from the level of the individual all the way to the national economy. The report describes how illness robs individuals of income when they cannot work and creates a serious financial burden through medical bills for the poor who rarely have health insurance. The impact can spread further, eroding the health and income of families as they struggle to pay for treatment and basic necessities with less income. According to the report, this increased burden also means that there is less money to pay for the education of the children in the family, creating a trap that generation after generation of poor families are unable to escape. Further, the report points out how poor health can also burden the economy as a whole, not only by creating a strain on health resources, but also in a loss in productivity and the reduced incentive for employers to invest in training for workers that are continuously sick. The problem is compounded because companies are not as productive and so there is less revenue for the government to tax at a time when it needs more resources to meet the health needs of its population. Thus, the report argues that it is crucial for developing countries make serious investments in the health of their citizens if they expect to achieve economic growth. If this investment is not made, the impact will be serious; "the devastating economic consequences of illness and death are evident at the macroeconomic level" (Wagstaff & Claeson, 2004, p.1).

Jeffery Sachs (2005), the chair of the Commission, has remained a strong advocate for the importance of health to economic growth. His book, The End of Poverty, included investment in health as one of his five key development interventions for overcoming

poverty, precisely because of its strong impact on human capital development. Therefore, the evidence supporting the importance of health to economic growth is strong and widely accepted. However, appealing to the economic merits of health has another important benefit for supporters of the growth approach: it makes them less reliant on moral arguments when trying to generate support for health aid.

The appeal of such an approach is obvious. Instead of having to pursue difficult and demanding moral arguments for why nations should invest in the health of the poor, advocates can present clear, rational calculations for why investing in health is not only good for the poor, but for the global economy as a whole. International donors no longer have to be persuaded to give out of moral obligation or duty – now they can give out of simple self-interest because improving the health of the poor has economic benefits for donors, too. Sachs (2005) consistently returns to this theme in his efforts to convince international donors to do more.

However, some proponents of the growth approach, including many of the development banks, have taken this logic even further, suggesting that decisions on health investments should be made primarily on the basis of economic calculations of cost-effectiveness. The World Bank provided exactly this kind of rationale in its 1993 report, arguing strongly that health investments should be shifted from areas where the economic return was low, such as cancer care, towards areas of high return, like primary health care and immunizations (World Bank, 1993).

More recently, the Asian Development Bank (2000) published a detailed handbook to guide policy makers in conducting economic analysis of health projects. The handbook had

chapters explaining how to calculate the cost-effectiveness of a health intervention and how to conduct cost-benefit analysis of interventions using measures like “years of life gained,” “disability adjusted life years” and “healthy years of life gained.” This process allowed what otherwise might be difficult moral decisions to be made with straightforward rational calculations. For example, the handbook uses the case of a government deciding how to spend money to fight two very serious diseases, meningitis and schistosomiasis. After reviewing the data the handbook makes this statement:

if we are only interested in lives saved and are unconcerned with reducing morbidity, then the meningitis project is far more cost-effective than the schistosomiasis project since costs per YLG [years of life gained] are more than 10 times higher for the latter due to its weak impact on mortality rates (p. 53).

The coolness of this calculation is striking. The difference in the economic costs and benefits between saving lives and reducing the frequency of disease is presented clearly and simply. Policy makers are provided a certainty and clarity of the economic pay-off of their investments in a way that would be impossible in most other approaches to health.

However, placing a precise economic value on human life and health is very controversial. The handbook acknowledges this, stating that “unlike other sectors, benefit valuation in health is both difficult and controversial since it involves placing values on changes in health outcomes” (p. 5). It goes on to admit that even if it is possible to estimate an individual’s “own subjective valuation, the full social value involved may still not be captured because of the external effects” (p. 5). However, this acknowledgement does not stop the Bank from continuing to support such an approach – no doubt in part because of the appeal of using an approach that appears to provide such clarity.

The issue of trying to place an economic value on human life is only one of the many challenges facing the economic approach to health. The widespread support for the approach has been matched with widespread criticisms and concerns about many of its key assumptions.

Limitations of the growth approach to health

Critics have three major problems with an economic approach to health: its narrow and instrumental approach to health, its tendency to rely on expert analysis at the exclusion of public consultation, and its failure to address the fact that, while health improvements may indeed boost economic growth, many neoliberal economic reforms have actually reduced health outcomes for the poor and vulnerable.

The idea that improved health generates human capital, which in turn increases economic growth, is at the heart of the economic approach to health. However, by narrowly focusing on the benefits of health to human capital development, proponents of a growth approach take a very limited view of how health both influences, and is influenced by, larger social and political forces at work in society. A recent study of health, human capital development and gender empowerment of women in the Indian state of Kerala, illustrates the importance of understanding economic policies in a broader context.

Kerala has long been held up as a positive example of how relatively poor regions can achieve great economic success through strong investment in education, health, and social supports. The state has been particularly successful in improving access to education and health services for women and girls, with some of the highest indicators of human capital development among women anywhere in India (Mitra & Singh, 2007). Yet, experts observed

that this success has been followed closely by a startling rise in both suicide rates among women and incidents of violence against women, leading them to conclude that because cultural norms of the inferiority of women have persisted in the society, the empowerment of women has created deep tensions and violent backlash (Mitra & Singh, 2007). Thus, from a narrow economic perspective, the improvement in the human capital of the women of Kerala appears to be a great success story. However, a broader perspective uncovers the serious mental and physical health challenges facing women in response to their improved human capital and underscores the importance of taking a broader perspective on health.

Nonetheless, despite the limitations of an economic approach to health, it continues to have a significant influence on the policies of major international development organizations, including the World Bank, IMF and even the WHO (Bond & Dor, 2003). The WHO's Commission on the Macroeconomic of Health is a clear example of the organizations movement towards a more economic understanding of health. Critics of the Commission's work argue that its narrow economic approach seriously constrains the policy options for dealing with health (Subramanian & Kawachi, 2002). The focus of the Commission was on the "eradication of specific diseases, rather than encouraging the development of integrated health-care systems" because disease eradication was seen as having biggest impact on health and human capital development with the smallest investment (Waitzkin, 2003, p.523). In this approach, health is valued more for its ability to boost human capital than for any intrinsic value of health itself. Proponents of an economic approach to health, like Jeffery Sachs (2005), do acknowledge that health has intrinsic value, but their clear emphasis is on the instrumental value of health. As Howard Waitzkin (2003) describes, in an economic approach, "health as a fundamental value, worthy of investment for its own sake, slips from

consciousness” (p. 526).

The narrow focus on health as a tool to generate human capital also fails to take in account how poverty and poor health were created in the first place. Given the pressing urgency of health crises in many impoverished countries, it is tempting to focus on the problem at hand, and not bother with the long history of how that problem came to be. However, as critics point out, failing to consider the larger context in which poverty and poor health occur prevents us from getting to effective solutions. Alison Katz (2004) argues that the narrow economic approach to health leads its proponents to advocate for aid rather than real structural reform to the global economic system. Katz argues, because proponents of an economic approach to health gloss over the underlying factors that have created the current situation of poverty and poor health, for them “there are no connections between the rich being rich and the poor being poor. And yet those connections are well documented” (p.764).

The instrumental approach to health as a tool for economic growth has attracted further criticism for its attempt to apply economic cost-benefit analysis to human health. As I illustrated earlier with the example from Asian Development Bank, using economic costing to determine where to make health investments may make life easier for policy makers, but it raises some serious ethical questions. Not only is the mere idea of trying to place a dollar value on human life ethically questionable, but, because economic approaches are focused on boosting economic growth, their measurements are biased to favour the most economically productive members of society. Waitzkin (2003), points to the commonly used measure of DALYs, or disability-adjusted life years, to show how such measures devalue the lives of people with disabilities. In his words, “a measure that attaches more value to life without disability, many have argued, implicitly devalues the lives of disabled people” (p.526). The

same would be true for all members of society that are not engaged in the economy, including children, the elderly and the marginalized (Katz, 2008). By making health a tool of economic growth, these approaches implicitly prioritize more economically productive lives over less economically productive lives. Thus, cost-benefit analysis of health interventions risk biasing action in favour of those interventions that do the most to improve productivity, which is likely to mean those interventions that benefit the most productive members of society.

Marginalized members of society are further excluded in an economic approach through its tendency to base policy advice on expert analysis rather than consultation with target communities (Waitzkin, 2003; Subramanian, Belli & Kawachi, 2002). Calculations of economic cost-effectiveness are not something just anybody can do. Experts are needed to assess technical data of health outcomes, costs and economic returns. The problem is, health is much more than economic calculations, and requires a much broader understanding of the local social and political context that cannot be effectively incorporated into highly technical economic models. At the same time, local populations are transformed into passive recipients of health interventions, rather important partners. As one critic noted, the irony of economic approaches to health is that they effectively marginalize “the very people they are trying to reach. Planning, implementation and monitoring, and evaluation systems typically lack the meaningful participation of the poor” (Bangser, 2002, p. 278).

Excluding and disempowering already vulnerable groups does not seem like the ideal approach for lifting the poor out of poverty, but it might be possible to justify such an approach if it was effective. However, there is growing evidence to suggest that narrow, highly technical approaches to health are not effective and a broader approach is needed

(Katz, 2004). Despite this evidence, when the WHO Commission on the Macroeconomics of Health released its recommendations, it continued to emphasize a narrow, economic approach. In one critic's words, "there appears to be no recognition that the major interventions required for improvements in population health status lie outside the health sector" (Katz, 2004, p. 761). Katz (2004) argues the strong emphasis on economic approaches to health in the international donor community is not simply the result of ignorance of evidence demonstrating their shortcomings. Rather, she suggests it is part of a

very particular world view, sometimes referred to as TINA – There Is No Alternative – as famously asserted by Margaret Thatcher. This view has come to dominate the international health community as much as it has come to dominate world politics. It is a shamelessly totalitarian justification of the status quo – unregulated, monopolistic, corporate capitalism – which has successfully stifled dissent for a decade or more (p. 755).

The idea that the world's major development and health agencies may have accepted Katz's status quo is especially troubling given the growing evidence that economic approaches to health can often erode the health of the poorest and most vulnerable members of society (Katz, 2008; Bangser, 2002). Numerous studies have found reduced health outcomes for the poor and vulnerable as a result of economic approaches to health. From Africa, (e.g. Bond & Dor, 2003; Lugall, 1995) to Latin American (e.g. Homedes & Ugalde, 2005; Armada, Muntaner & Navarro, 2001) to Asia (e.g. Janes, Chuluundor, Hilliard, Rak, & Janchiv, 2006) there is no shortage of evidence demonstrating the serious negative impact economic approaches to health can have on the most vulnerable members of society, especially poor women.

The good news is that, despite Katz's (2004) criticisms above, at least the WHO appears

to be paying attention to this evidence and has moved away from an economic approach. The 2005 World Health Report, with its focus on child and maternal health, presented clear evidence of the negative impact of economic approaches to health on the health outcomes of poor mothers and their children resulting from reduced access to key services. As the report illustrates, while there is good evidence to support the idea that poor health hinders economic growth, the reverse is not always the case (Subramanian, Belli & Kawachi, 2002). Simply improving economic growth does not guarantee that health outcomes will improve for the poor. Approaches to health that focus on improving health as a tool to increasing economic growth are at serious risk of actually damaging the health of many members of society (Subramanian, Belli & Kawachi, 2002).

Thus, economic approaches to health fall short in several key areas. They take an overly narrow view of the value of health, focusing on the benefits of health to human capital development and economic growth, while ignoring the more important broader implications of health for society as a whole. An economic approach “undervalues the direct importance of health and overvalues its indirect importance” (Subramanian, Belli & Kawachi, 2002, p. 298). When health is understood as primarily a tool for economic growth, policy makers are able to distil complex ethical question of how to allocate scarce health resources into simplistic economic calculations of cost-effectiveness. The net result of such an approach is that the most vulnerable members of society and those most in need of help to improve their health, end up further marginalized and, in some cases, find their health worse off than before. Human rights approaches to health offer a direct challenge to economic approaches, arguing that health must be conceived of as an important human right in itself, regardless of its benefit to economic growth.

Health as a Human Right

Human rights approaches to health stand somewhat in contrast to more traditional approaches to rights. Recall that in the previous chapter, I showed how human rights approaches to aid tended to be based heavily in liberal thought. Interestingly, however, many of the leading proponents of a human rights approach to health, such as Paul Farmer and Tony Evans, are sharply critical of liberal approaches to health and rights, echoing many of the criticisms against rights approaches that I covered in the previous chapter. Thus, in this section, it will be important to fully understand how a rights approach to health stands apart from more general rights approaches to aid and how advocates of a rights approach to health are able to address the shortcomings and criticisms made of traditional, liberal rights approaches.

Rights approaches to health are able to overcome some of the shortcomings of liberal approaches, but they still fall short in other important areas. First, using the language of human rights to address health problems may provide those advocating for action on health aid the ability to appeal to legal claims, but those claims are so tenuous, especially at the global level, there is little reason to expect they will have much success in compelling improvement to global health. Second, while rights approaches are able to make eloquent claims for why we should respect others' rights to health, they do not provide a lot of practical guidance for how to create the conditions where rights are respected. Finally, rights approaches come up against the dilemma pointed out by Held (2006), that we need to care about someone first before we are going to act to protect their rights. Arguing that an individual has a right to health is all well and good, but it will only create real change if we care enough about that individual to act to protect her rights. In this sense human rights are

an important step to consider once we understand the patterns of caring and neglect that lead to rights abuses. By starting from a human rights perspective, rights advocates are limited in their ability to explain why rights violations occur and how they can be eliminated. This section will begin by examining the major claims made by rights approaches to health, and then look at the limitations of those approaches.

Rights approaches to health in the development literature tend to fall into two general categories: those that use the language of rights to challenge the prevalent neoliberal approach to health and international development, advocating instead for a broader, more critical approach to health and human rights; and those that focus more on examining and establishing a legal case for a right to health in international law. I will refer to the latter group of scholars as legal rights scholars and the first group of scholars as basic rights scholars for their similarity to Henry Shue's (1980) notion of basic rights. As I described in the previous chapter, Shue suggested that there was a fundamental set of basic economic and political rights whose protection is necessary for the success of all other rights. In Shue's words, these basic rights represent "the morality of the depths. They specify the line beneath which no one is allowed to sink" (p.18). The modern rights scholars I discuss here see health as one of those basic rights, whose attainment is crucial for the attainment of all other rights.

Paul Farmer (2003), is a leading voice in what I have referred to as a basic rights approach to health. Farmer appeals to the language and logic of human rights in making his case for action against global disease and ill health, while at the same time taking a strongly critical and anti-liberal tone. He echoes the criticisms of liberal rights approaches that I discussed in the previous chapter, describing neoliberalism as

the ideology that advocates the dominance of a competition-driven market model. Within this doctrine, individuals in a society are viewed, if viewed at all, as autonomous, rational producers and consumers whose decisions are motivated primarily by economic or material concerns. But this ideology has little to say about the social and economic inequalities that distort real economies (p. 5).

Basic rights approaches to health take issue with many liberal assumptions, in particular the assumption that individuals are independent actors. As O'Neill (2002) points out, in the context of health, where people suffer from illness and other health problems that make them dependent on others, it is difficult to see how the liberal assumption of independence applies.

Basic rights scholars also find a liberal rights approach unattractive because of the heavy emphasis it places on political and civil rights, at the expense of social and economic rights (Evans, 2002). Tony Evans (2002) argues that liberalism treats socioeconomic rights, like the right to health, as second-class rights – more aspirations, than true rights. The result is that liberal approaches often actually work against the health rights of the poor and marginalized by supporting a global economic system that leaves them behind. In Evan's words, “the liberal consensus on human rights, which relegates socioeconomic rights to the status of aspirations, prioritizes the interests of those closest to the process of economic globalization rather than those in the periphery, by emphasising civil freedoms that support values associated with liberty and the free market” (p. 208). He makes it clear that “given the dominance of the liberal consensus, the prospects for promoting the cause of health as a human right may therefore be less promising than many would hope” (p. 198). Evans suggests there is a clear double standard in the liberal treatment of rights. Liberals appeal to “egalitarian values in distributing civil rights and political rights,” but they support non-egalitarian approach to the distribution of socioeconomic rights like health (p. 203).

The end result of a liberal approach to rights is that rights to health are left behind, as things that might be nice to have, but not really true rights, like civil and political rights. As a result, it marginalizes the poor. In Farmer's eyes a liberal approach “rarely included the powerless, the destitute, the truly disadvantaged. It has never concerned itself with those popularly classified as the 'undeserving' poor” (p. 6). Worse still, the heavy emphasis that liberal approaches place on individual responsibility, means that the poor and marginalized are often blamed for their situation. The solution to their problems is for the poor to “modify their own behaviour” (Freedman, 1999, p. 231). Thus, in the case of HIV/AIDS, women facing partners that may be infected with HIV, are expected to demand that their partners wear condoms, regardless of the serious risks to their physical, economic and social security that could result from such a demand (de Guerny & Sjober, 1999).

For these reasons, rights scholars like Farmer, reject a liberal approach to health, appealing instead to a more basic rights approach. An approach that understands health as a basic right, without which human functioning is not possible and “without which no other rights can be enjoyed” (Evans, 2002, p. 204). A basic rights approach to health, as understood by scholars like Evans and Farmer, takes a much broader perspective on rights than a liberal approach, seeking to draw a connection between historical, social, economic and political factors and their impact on the ability of individuals and groups to attain basic rights like a right to health. The advantage of taking a more basic approach is that “it is possible to expose the structural practices that are the cause of many violations of socioeconomic rights” (Evans, 2002, p. 205).

Farmer (2003) is critical of liberal approaches because they erase “the historical creation of poverty” and thus “places the problem of poverty with the poor themselves” by suggesting

that “development is necessarily a linear process” in which “progress will inevitably occur if the right steps are followed” (p.155). A basic rights approach seeks to move beyond the narrow legal focus of liberal rights approaches, which “tends to obscure the dynamics of human right violations” (p. 219), in order to bring to light the important role the large social and economic context plays in the achievement of health rights. As Farmer puts it, “only through careful analysis of growing transnational inequalities will we understand the complex social processes that structure not only growing disparities of risk but also what stands between us and a future which social and economic rights are guaranteed” (p. 18). Thus, the rights perspective scholars like Farmer and Evans bring to global health represents an important step away from conventional, liberal approaches to rights and brings it much closer to a care perspective. Like a care approach, this basic rights approach challenges many key liberal assumptions about human nature while stressing the importance of understanding the broader context in which poverty and poor health occur. This move is important because it creates more space for a care perspective to help a basic rights approach to achieve its objectives of reducing poverty and improving health.

The second major category of rights approaches to health focus more on the legal implication of a right to health. For scholars from this perspective, the primary concern is establishing the legal case for a right to health, understanding how health rights translate from the national to the global level, and how health rights can be balanced against other rights.

The notion that a state has some obligation to provide for the health of its citizens has developed over the last several centuries, gaining real recognition with the rise of public health in the 19th century (Toebe, 1999). These rights have developed to the point that some

scholars feel that most citizens now have fairly well established rights claims against their states for the protection of their health (Toebe, 1999). The challenge for legal rights scholars is to move those rights claims from the domestic to the global level, where the right to health is less clear (Hunt & MacNaughton, 2007).

Brigit Toebe (1999), points to the ambiguity around the notion of global health rights in international treaties, suggesting that the wording in these documents, which use terms such as “to recognize” or “to take appropriate measures,” “implies that they represent a lower rung of State obligations than clauses which simply require State parties 'to guarantee' or 'to ensure’” (p. 306). However, even if international treaties were clear about the strength of international rights to health. These rights face the additional challenge of working against the prevailing economic ideology. Even Evans (2002), the passionate advocate for global health rights, is highly sceptical about the ability to translate a domestic notion of health rights to the global level in an era of neoliberal economic policy. In his words, “the needs of the global political economy will be favoured over the obligations undertaken in international law” (p.206).

Other scholars, concerned with the legal implications and feasibility of global health rights, focus more on how to balance health rights against other rights claims. The major questions these scholars grapple with are when and how other rights can be overridden in the name of protecting public health and the health rights of a society as a whole. They look at examples of cases where an individual may be quarantined, or have her or his freedom of movement limited in order to prevent the spread of an infectious disease (e.g., O'Neill, 2002). Others examine the question of how an overly individualistic rights approach to health rights around HIV/AIDS may actually inhibit the ability to fight the disease, thereby eroding the

broader public health of society as a whole (Gruskin & Loff, 2002).

All of these different rights approaches to health offer some important advantages over economic approaches to health, providing analysts and policy makers with a broader understanding of where health fits into society and how it can both impact and be impacted by social, political and economic forces. Rights approaches bring to light the role of structural factors in inhibiting positive health outcomes and the preconditions needed in order for people to take advantage of a right to health. As well, by appealing to larger moral and legal principles, rights approaches also provide some empowerment for the poor struggling with poverty and ill health.

Several rights scholars have flagged the importance of a range of structural factors on health and health outcomes, from economic inequalities and oppression to long standing systems of gender inequality, arguing that it is crucial to understand the impact and role of these structural forces in order to achieve good health for the world's poor (e.g., MacDonald, 2006; Farmer, 2003; Evans, 2002; and Susser, 1993). Other rights approaches stress that achieving good health requires that we understand the broader preconditions for health (e.g., Beyrer et al., 2007; Gruskin, Mills & Toranotola, 2007; Farmer, 2003; Evans, 2002; Mann, 1999; Mann et al. 1999; Toebes 1999). Finally, other rights approaches have illustrated the need to focus on the marginalized and disadvantaged when using a rights approach to health, in order to empower them (e.g., Hunt & MacNaughton, 2007). Thus, rights approaches to health are able to make some significant strides overcoming the limitations of economic approaches.

Limitations of a rights approach to health

Despite the advantages that rights approaches to health have, they also have some important limitations. First, while some rights scholars argue that using a rights approach helps provide moral and legal claims for action to improve the health of the poor and marginalized (e.g., Hunt & MacNaughton; Singh, Governder & Mills, 2007), it is very unclear how well those legal claims hold up in international law. To begin with, the legal notion that there is even a right to health at the international level is much weaker than similar claims at the domestic level. Toebes (1999) points out that the language in international treaties on health and human rights tends to be less clear and less demanding than that found at the domestic level. The UN International Covenant on the Economic, Social and Cultural Rights, itself only calls on states to work for the “highest attainable standard of health” (Toebes, 1999, p. 293). Further, even if the language in international law was stronger around the notion of a right to health it is far from clear this would have much impact on the health of the global poor. A fact acknowledged by some rights scholars like Farmer (2003), who argues “passing more human rights legislation is not a sufficient response to these human rights challenges, because those in charge already disregard many of those (clearly nonbinding) instruments” (p. 235). This is where a care approach could help a rights approach, by providing more insight into the broader factors that lead to poor health and a greater understanding of the concrete actions we can take to improve health.

The other challenge rights approaches face is that they do not really tell us what we need to do to actually achieve a right to health. To say an individual has a right to health, or that the international community should recognize the right to health of the poor, is important, but it is not clear how having a right actually translates into improvements in health. Rights

approaches are quite good at providing legal and moral justifications for why a right to health should exist, but in O'Neill's (2002) words that “does not get close enough to action” (p. 42). The problem, according to O'Neill, is that rights approaches tend to focus on health problems – and other rights issues – from the perspective of what an individual is entitled to from the rest of society, instead of the concrete action needed in order to ensure that a person's rights are actually achieved. When we move away from “a focus on required action” to a discussion of “entitlements to receive,” O'Neill argues that it is much more difficult to understand what actions need to be taken and who needs to take them in order to improve the health conditions of the poor.

Thus, even if we fully embrace the idea that all people everywhere have a right to health, and if we could all agree on what that right to health entailed, it still would not be clear from a rights perspective how exactly we turn that right into reality. Finally, even if we did determine how to go about achieving a right to health, we would still be faced with Held's (2006) challenge, that we need to care about others first, in order to care if their rights are protected. If we do not care about others, it will not really matter what rights they have. Understanding care and how we can care better must come first if we ever expect to make significant progress achieving a right to health for all. Rights approaches can provide us with arguments for why we should have a right to health, but they do not give us much guidance for how to actually go about putting that right into practice, nor do they help explain why we may or may not care enough to act in the first place. A care approach can provide this insight and help lay the foundation for greater respect and protection of rights.

The final approach to health that I will cover in this chapter, a security approach, also provides some more clarity about how to go about achieving health for the world's poor, but

it too has shortcomings.

Health as a Security Concern

The concept of security has undergone a significant expansion in international politics of the last several years, both in terms of what is considered a security issue and whose security matters. Buzan (1991) described this evolution as the widening and deepening of security. He suggests that the concept of security has been widened to include new security threats, such as disease epidemics and climate change, while, at the same time, the reference point of what needs to be secured has been deepened from the state to the individual. Not all security approaches in global politics have accepted this move. Traditional, state centric approaches still focus on securing the state from military threats. However, many scholars have embraced this move. For want of a better term, I will refer to these approaches as non-traditional security approaches. Non-traditional security approaches involve one or both of the moves Buzan describes. In the context of health, some non-traditional scholars expand the concept of security to include global health challenges, but maintain a fairly state centric focus. If these scholars look at the security of individuals, it is usually with an eye to how those individual insecurities will impact the security of the state. Human security approaches on the other hand, make both moves, shifting their focus away from the state to the security of individuals and taking a broad concept of security.

Essentially, at one side of the spectrum of non-traditional security approaches are those scholars who are concerned about the security of individuals in so much as that security impacts the security of the state, while at the other end scholars are concerned about the security of the state only as much as that security impacts the security of individuals living

inside or near that state. I will examine both the more state centric non-traditional security approaches and human security approaches, evaluating the major trends in the health security literature and highlighting the contributions and limitations of these approaches.

A security approach to health helps both create urgency around health problems and mobilize action and resources to get involved. It can provide a broad perspective for thinking about health and security and underscore the important impact health has on the security of individuals and states. Human security approaches draw attention to the interdependent nature of security, making it clear that our security depends on the health and security of others. This perspective allows some scholars to use self-interest as a motive for rich states to act to protect the health of the poor, by demonstrating how health problems can quickly spread across borders. Human security can also provide an important critique of neoliberal approaches to health, uncovering the ways in which they hinder the health and prosperity of the poor.

However, health security approaches also have some key limitations. First, by bringing non-traditional problems, such as health issues, into a security context there is a risk that health concerns will become co-opted by a traditional security agenda, so that health problems are only a concern to the extent they impact the national security of the state. Second, by using the language of security to talk about health problems, there is a risk that traditional security resources and thought processes will be used to address them, generating inappropriate responses to serious health problems. I will discuss both the contributions and limitations of these approaches in more depth below.

Strengths and weaknesses of state centric non-traditional security approaches

State centric security approaches tend to consider health primarily as it relates to the risks to the security and stability of states from the spread of infectious disease and disease epidemics across borders. As mentioned above, while these approaches do examine the impact of diseases on individuals and groups, it is through a lens of how that insecurity will impact the security of the state. Take for example Peter Chalk's (2006) description of the challenges of health for security, "the 'ease' by which pathogenic organisms can transcend across the state boundaries," have seriously eroded "the erstwhile notion of local, national and even international stability" (p.114). The message is clear, "no country is completely isolated from the diseases of the poor because the effects of globalization, more mobile populations and migration patterns" (Gutlove & Thompson, 2003, p. 26).

While, the concept of security has been expanded to include concerns about health problems and diseases, the state remains the primarily object of security in this approach. The impact on the health of the individual is considered, but the real issue is what that means for the state. For these scholars "the nature of a human security threat is such that affected states do not have the capacity to resolve them by themselves but need to rely, to varying extents, on other states, international organizations and/or individuals" (Curley & Thomas, 2004, p. 19). Thus, this approach adds an element of interdependence in state security that is absent from more conventional approaches to security and includes health concerns as potential security issues, but it keeps the focus of security fixed on the state. Chalk (2006) underscores this focus as he discusses the security challenges that arise from infectious diseases, arguing that if outbreaks are not dealt with quickly, they will "weaken public confidence in a government's ability to respond," "distort productive economic growth," "destroy the

underlying fabric that holds a given polity together,” “promote tension and mistrust,” and “strategically challenge the status-quo (if not extant ordering principles) of regional and international systems through the specter of bio-warfare and bio-terrorism” (p. 117). The concern is the state and its stability.

While these approaches maintain a fairly conventional state centric approach to security, by bringing health into the realm of security they are able to raise the profile of global health issues, adding new urgency to serious health problems and mobilizing new resources. For example, although HIV/AIDS has been a major health and development challenge for decades, by drawing it into a security discussion, these approaches have helped put it “onto the international security agenda and has thus helped to draw attention to, and mobilize resources for, combating the spread of the pandemic” (Elbe, 2006a, p. 110).

Nowhere is this more evident than the way infectious disease has emerged on the U.S. foreign affairs agenda. Barbara Boxer (2003) illustrates how U.S. lawmakers have come to understand infectious diseases like HIV/AIDS as an issue of national security. In an article the Senator wrote in the Washington Quarterly, she argued passionately that the U.S. must understand infectious disease as an important security issue, stating that:

by meeting its responsibilities to lead the world against infectious disease, the United States will not only increase its national security by protecting against the further spread of disease within U.S. borders and bolstering our global financial markets, but also maintain the mission of peace and prosperity that this country has maintained since its origin (p. 206).

Thus, a security approach to health, even one that takes a fairly state centric approach, can raise the profile of health problems to the point that a senior U.S. senator talks about infectious disease as a national security issue.

However, these more state centric approaches to security are limited in two key ways. First, by maintaining their focus on the state, these approaches are unable to provide a full picture of the causes of health problems. It is crucial that health problems be understood within the larger social, economic and political contexts in which they occur (MacLean, 2005). Simply examining how states are impacted by and respond to health problems is not enough to fully understand those problems (MacLean, 2005).

In the HIV/AIDS case, Colleen O'Manique (2006), argues that the securitization of HIV/AIDS “ignores the broader contributor to human insecurity located in the current global distribution of power and resources, and their relationship to disease distribution” (p. 162). If the state stays the primary reference point for security, key aspects of serious health problems that occur beyond the state are cut off from examination. The result is a less effective approach to security, because “it is only through using a broad concept of security that the multidimensional nature of the individual and social insecurities produced by the AIDS pandemic emerges” (Elbe, 2006a, p. 109).

The second limitation of a state centric approach to health security is that states tend to view security issues through a fairly traditional national security lens, which can lead to inappropriate responses to global health concerns like HIV/AIDS. Stefan Elbe (2006b), suggests that “the language of security also brings a 'threat-defense' logic to bear on HIV/AIDS” that can lead to inappropriate responses to HIV/AIDS (p. 120). The traditional

military and intelligence tools that states normally use to respond to security threats are not well suited to responding to complex health problems (Elbe, 2006b). By maintaining a state centric understanding of security, these approaches to health and security draw on state security structures and tools that are much better suited combating military threats than serious health problems. As a result, the responses and solutions generated from these structures are often inappropriate for the situation and are concerned primarily with protecting the security of the state, rather than protecting the health of individuals (Elbe, 2006a).

Security approaches that move beyond a narrow state focus are able to escape some of these criticisms, while at the same time providing several important benefits to understanding health and poverty that state centric approaches do not.

Strengths and weaknesses of human security approaches to health

Human security approaches to health offer several important advantages. They provide a much broader understanding of health problems and how they relate to economic, social and political issues. They underscore the clear link between health and security. They draw attention to the interdependent nature of security ignored in traditional understandings of security, and they help shed light on the health problems generated from neoliberal economic policies.

Security is interpreted broadly in this context, examining “the social, psychological, economic, and political aspects of human life that in times of acute crisis or chronic deprivation protect the survival of individuals” (Leaning, Arie, Holleufer & Bruderlin, 2003, p. 14). Understood in this way, human security is “an underlying condition for sustainable

development” (Leaning, Arie, Holleufer & Bruderlin, 2003, p. 14). When it comes to health, these approaches are able to draw attention to important health issues that are missed in more conventional approaches to security, while at the same time helping generate better understanding of how those issues relate to larger political, social and economic forces (MacLean, 2005; Chen, Leaning & Narasimhan, 2003; Commission on Human Security, 2003; Gutlove & Thompson, 2003).

In the specific case of HIV/AIDS, the breadth of human security approaches helps draw attention to how the disease impacts, and is impacted by, the larger political, economic and social system in which it operates. A human security approach can help uncover the role of gender in the spread of the disease and the particular vulnerabilities women face both in the transmission and treatment of HIV/AIDS (Tiessen, 2006). At the same time, a broader approach to security can help generate a new understanding of HIV as more than just a health problem, or a security issue, but rather as an important social, political and economic problem that is influenced by “unfair international trade regimes, failing agricultural policies, collapsing public services and crippling debt” (O’Manique, 2006, p. 173). By generating understanding of how larger factors influence HIV/AIDS, human security approaches are able to ensure that “the spread of the virus is not seen as something that happens independently of these other factors” (O’Manique, 2006, p. 173).

The broader perspective of these approaches also helps illustrate the important role health plays in establishing security and stability. The United Nations Commission on Human Security (2003) argued that “health security is the vital core of human security” (p. 96). The Commission further argued that health is “both essential and instrumental to achieving human security” (p. 96). For the Commission, health and health security must be understood

in the broader context in which they occur, “imbedded in allied social, political and environmental conditions” (p. 103). More than this however, diseases like HIV/AIDS have a clear and direct impact on individual security and survival. The sheer numbers of people impacted by HIV makes it “one of the gravest threats to the survival of human beings around the world – and thus, also one of the greatest direct contemporary human security threats” (Elbe, 2006a, p. 104). The insecurity generated by serious epidemics like HIV/AIDS reaches much further than those infected, threatening “the ability of individuals to ensure their survival” as the most productive members of society are struck down (Elbe, 2006a, p. 105). By moving beyond the state, a human security approach is better able to pull out the important interplay between health and security than more conventional, state-centric approaches.

Health can also have an important impact beyond that of specific diseases, contributing to political stability and peace-building in post-conflict situations (Negin, 2007). Indeed, a human security approach not only shows the importance of health to domestic security, but to global security as well, by illustrating the interdependent nature of security.

Paula Gutlove and Gordon Thompson (2003) argue, “a human security framework recognizes humanity's global interdependence and mutual vulnerabilities to a range of old and new threats” (p. 18). From a human security perspective it is possible to gain a more complete understanding of how diseases in poverty stricken regions of the world can quickly become serious security concerns for countries around the globe. In Gutlove and Thompson's words, “epidemics are especially likely to begin in populations that suffer from poverty, social breakdown and insecurity. Richer populations therefore have a direct interest in ensuring that poorer populations enjoy basic health” (p. 19). A human security perspective

exposes the serious cracks in traditional understandings of security that view states as independent actors operating in a competitive, zero-sum international security system. Instead, human security highlights the “intrinsically relational nature of security” (Szreter, 2003, p. 46).

The final important contribution of a human security approach to health is that it helps uncover some of the shortcomings and challenges neoliberal economic policies create for global health and human security. Simon Szreter (2003) examines the impact of neoliberal development policies on the health and human security of the poor. He argues that “considerable damage to human security and health also has been wreaked in these societies by the evangelical application of New Right ideology, resulting in sharply rising inequality and deepening poverty” (p. 44). Other scholars have used a human security approach to expose similar problems. Whether it is the strong liberal bent in development initiatives like NEPAD (e.g., MacLean 2005), or the negative health consequences resulting from neoliberal policies more generally (e.g., Negin, 2007), human security scholars have been able to draw attention to the serious health problems that can result from neoliberal development initiatives, no matter how well intentioned those initiatives might be.

However, despite the many important contributions of human security approaches to the study of international health aid, they have some important limitations. First, the sheer breadth of the concept of human security, while providing flexibility to understand health problems from a broad perspective, also results in an approach that means very different things when it is used by different actors. There is no single unifying approach under the umbrella of human security. Some scholars maintain a fairly conventional state-centric approach to security, expanding from traditional approaches only slightly, while others move

much further away from traditional approaches, taking a strongly critical view of security and health. Even proponents of human security recognize that it is in danger of being applied so broadly that “it may be impossible to prioritize policies and actions” (Chen & Narasimhan, 2003, p. 5).

Human security is often broken down into two basic camps, those with their roots in the Canadian inspired Freedom from Fear approach, which maintains a strong focus on violent security threats, and those that follow the broader Japanese Freedom from Want approach that focus on access to basic necessities like food, clothing and housing (Gutlove & Thompson, 2003). However, even inside these two larger divisions there are multiple variants with no obvious commonality other than their focus on individuals and groups as the key reference point for security. Thus, the breadth of human security may provide some advantages but it can also create a confusing array of approaches that are more easily identified by what they reject of traditional security approaches, than what they share in common across human security approaches.

The second limitation of a human security approach is its potential to generate self-interested motivations for acting on global health problems, which can end up focused more on improving the security of donor countries than recipient countries. Earlier I pointed out the positive contribution human security approaches make by drawing attention to the interdependent nature of security. From an international aid perspective, the benefits of drawing out these interdependencies is obvious, providing proponents of aid with a powerful incentive to push rich states to provide more aid and pay more attention to the suffering in other countries, because that suffering could spread across borders and quickly become a very serious global problem.

In an era of SARS, HIV and swine flu, it is relatively easy to make the case to decision makers in rich states that they “have a direct interest in ensuring that poorer populations enjoy basic health security” in order to prevent the spread of diseases around the globe (Gutlove & Thompson, 2003, p. 19). The problem, however, is this approach legitimizes self-interest as a motivation for aid, which means that donors are much more likely to be giving based on what is best for them and not what is best for the aid recipients. Such motivations are clear in the statements of Boxer (2003),

as the single greatest world power, dedicating resources, technology, and diplomatic efforts to curbing the spread of infectious diseases among foreign and domestic peoples is not just the morally responsible thing to do but it also vital to U.S. national interests (p. 200).

It would certainly be naïve to think that a substantial amount of current foreign aid is not already given out of at least some donor self-interest. Nevertheless, the risk associated with human security approaches, is that making a clear case that addressing health problems in poor countries is a matter of direct national interest for donors, reinforces the use of aid as a tool for national interest, rather an act of humanitarian assistance. In other words, aid activities become “not a function of altruism but of more restrictive and narrow national interests” (Elbe, 2006b, p. 120). This problem is compounded by human security approaches use of the language of security to motivate action, which risks pushing aid further into the realm of national interests. Indeed, many public health experts have expressed concerns “about viewing public health problems in security terms, fearing that framing the issues in such a way would offer a skewed perspective on what are in actuality public health, ecological, humanitarian, and developmental issues” (Ban, 2003, p. 20).

Framing health in security language certainly helps draw attention to global health challenges and creates a heightened sense of urgency to address them. However, it is increasingly clear that using a security approach is not the most effective way of dealing with these problems. Elbe (2006b) highlights two major concerns with using a security approach to address health problems like HIV/AIDS. First, he cautions that “the securitization of HIV/AIDS could push national and international responses to the disease away from civil society toward state institutions such as the military and the intelligence community with the power to override human rights and civil liberties” (p. 120). Once an issue is framed in security language there is a serious risk that it will be taken over by the traditional security apparatus, whose tools, understanding and whole approach to problems tend to be top-down, authoritarian and largely beyond the scrutiny of the general public – not exactly the most desirable qualities for dealing with complex social, economic health problems like HIV/AIDS. Further, Elbe warns “these processes usually lead to a greater level of state mobilization, enabling the state to encroach on an increasing proportion of social life where it might not be desirable” (p. 127). Thus, not only does the securitization of health problems risk bringing to bear an inappropriate security apparatus, it can also open the door and allow that apparatus to creep further into other social areas, pushing aside civic organizations that are better suited to dealing with those issues.

The second problem Elbe (2006b) points out with using the language of security is that it “also brings a 'threat-defense' logic to bear on HIV/AIDS” (p.120). Elbe explains that the conventional security apparatus operates based on a logic of seeking out and identifying threats and then establishing ways to defend against those threats. Such an approach is not only difficult to apply to complicated and multidimensional health problems like HIV/AIDS,

but, identifying HIV/AIDS as an “overwhelming security 'threat” works against current health and development initiatives designed to reverse the marginalization and exclusion of those infected with HIV (p. 120). Traditional security tools are simply not designed to deal with complex health problems. They are designed to identify a threat and defend against that threat, but overcoming a global problem like HIV/AIDS requires a much more cooperative and nuanced understanding of the multiple factors that have contributed to its spread. Health problems like these are much better met with cooperation and partnership between national governments, international organizations, NGOs and those actually impacted by the problems.

In fairness to human security advocates, their intention is not to simply place a health problem like HIV/AIDS on the traditional security agenda, but rather to use HIV/AIDS to illustrate the limitations of conventional understandings of security and the need for a more encompassing approach to security. However, it has not been easy to expand the well established security agenda. As Elbe (2006a) describes,

in the case of HIV/AIDS, the concept of human security certainly helped, initially, to make important inroads into the international security agenda, but there was, and continues to be, immense pressure to also prove that HIV/AIDS is additionally a threat to national security, because it is only then that proper leadership and sustained resources will flow. This, in turn, has led to a greater focus not on the ways in which HIV/AIDS affects the lives of ordinary civilians, but more narrowly on the ways in which state stability and the armed forces (including peacekeepers) are undermined by HIV/AIDS [...] human security activists end up being dragged back onto the terrain of national security in order to achieve their political aims (p. 111).

Thus, security approaches to health, both the more state centric and human security approaches, are limited in several key ways in their approach to health and are vulnerable to

being hijacked by the larger and much more established traditional national security apparatus.

All three of the approaches to health I have discussed in this chapter offer some important insights into health, poverty and international aid, but all three ultimately fall short in several important areas. Economic approaches to health are able to make a strong self-interest case for international health aid by demonstrating the clear link between health and economic growth, but they offer a very narrow and instrumental understanding of health, using economic language and calculations to gloss over serious moral questions of how and what kind of aid should be delivered. As well, economic approaches tend to rely on expert analysis at the exclusion of the voices of the poor and marginalized victims of many of the world's most serious health problems. Finally, many of the economic reforms advocated by these approaches often work against the health of the poor, failing to deal with the larger systemic issues that allow health problems to flourish. Rights approaches to health are able to provide a much broader understanding of health problems, emphasizing the need to see health in a larger social, economic and political context. But, they often rely on appeals to weak international rights claims in their attempts to motivate action and fail to provide significant guidance on the concrete steps needed to actually achieve health rights. Lastly, security approaches are also able to draw attention to the importance of understanding health problems in their larger context and show the interdependent nature of global security. However, these approaches are limited by their use of the language of security, which risks undermining the very problems they seek to address.

A care approach can help address some of these shortcomings, while at the same time creating space for improved cooperation between these perspectives. The ethics of care is

able to show the important link between health and economic prosperity while also demonstrating that health has value beyond its impact on the economy. Care can help further the development and protection of global health rights, by drawing attention to broader social, political and economic context in which poverty and poor health occur while also providing practical guidance for creating the conditions that can bring about a greater respect for rights. Finally, a care approach could support human security efforts to draw attention to major insecurities created by poverty and poor health without having to worry about being subsumed by traditional security discourse. I will expand more on the potential contribution of a care approach to health in the next chapter.

Chapter 3: A Care Approach to Health

In many ways this chapter represents the start of the second part of my thesis. In earlier chapters I focused largely on critically analyzing conventional understandings of the ethics of aid and of health in development, illustrating the shortcomings of those approaches and arguing that a care approach offers an important alternative. These early chapters made the case for why it is worth considering a care approach. The rest of this thesis, beginning with this chapter, will move to building a care approach to health and then assessing it against conventional approaches to health aid to show what a care approach offers the study of global health aid. I will begin by examining the core components of a care approach, looking at what each of those would mean when applied to health aid. I will then consider the implications for both policy making and policy evaluation from a care approach to health. Finally, I will return to the analysis of conventional approaches to health in the development literature that I conducted in the previous chapter, to uncover how a care approach can address some of the shortcomings of these approaches.

In developing a care approach to health I am not suggesting that the other perspectives I have reviewed do not care about poverty and poor health. All three perspectives clearly demonstrate concern for the world's poor. However none of these approaches make that concern an overt part of their theoretical understanding of aid. These approaches all begin at some point beyond care, be it rights, human security or economic growth. I will demonstrate that by neglecting to consider how care fits into their understanding of the world, these approaches cut themselves off from some key insights into global poverty and poor health. At the same time, by failing to fully appreciate the importance of care, these approaches also miss the important relational nature of human interaction. In contrast, an ethics of care

approach makes these elements an overt and essential component of its understanding of the world, and, in so doing, brings new insight to the study of global health and new approaches for helping improve the health of the world's poor.

A Relational Understanding of Aid

The most fundamental aspect of a care approach that sets it apart from conventional approaches to health aid is its relational ontology. A care perspective “starts from the premise that people live in and perceive the world within social relations” (Robinson, 1999, p. 2). Robinson (1999) argues that in the context of international politics, a relational ontology means that “international ethics based on care, then, are centred on the maintenance and promotion of good personal and social relations among concrete persons, both within and across existing communities” (p. 2). This has some fairly significant implications for a care approach to health aid. Health aid from a care perspective would begin from an analysis of current relationships, how they came to be and what impact they have had on poverty and poor health. A care perspective would examine ways to improve and expand those relationships, creating more active partnerships between countries, communities and people. It would underscore the interdependent and interconnected nature of global politics, forcing policy makers to pay attention to the larger context in which aid occurs and the background political, economic and social factors that contribute to poverty and poor health. Finally, aid given with a relational understanding of the world requires a long-term commitment to work together to eliminate poverty and improve health. A relational approach to aid would move donor countries away from delivering aid in one off programs, based on what donors and international experts think is best for recipients, to long-term, mutually beneficial, partnerships of donors, recipients and their citizens that reach far beyond the simple transfer

of funds between one country and another.

A relational perspective on aid shines light on the multitude of relationships that exist in global politics, but more than that “the approach is committed to the promotion of healthy, caring relations among individuals and groups [...] according to the demands of the given situation where real social relations among concrete persons need to be created and restored” (Robinson, 1999, p. 132). Of course the question that comes out of this idea of building relationships between individuals and groups on a global scale is, with so much distance between individuals in donor countries and those in recipient countries are caring relationships even possible?

Key part of the answer to this question is that a care approach begins from relationships as they currently exist, examining those relationship to understand how care is, or is not, being delivered through those relationships and seeking to understand how those relationships could be made more caring. People are more connected globally than ever before and these relationships, whether they are formal diplomatic agreements, cultural exchanges, or short term NGO aid projects, all make up the foundation of a relational approach. From a foreign aid perspective our focus will likely be on understanding the relationships between particular states and the broader context in which those relationships have occurred, but the idea is the same. The objective is to understand how current relationships have developed and how they could be made more caring.

Part of a caring policy approach could also involve encouraging new relationships. Building connections and links between people and groups can help foster deeper and more caring relationships, and make the poverty and suffering real for people in donor countries.

Further, these connections may help illuminate the ways in which the poverty and suffering in recipient countries impacts us in donor countries. As Robinson (1999) explains, a care perspective works to help to make “poverty a part of the everyday lives of those who are, at present, unaware of the way they may be affected by it” (p.147). Caring relationships are also developed through aid itself. Using aid as the foundation to establishing partnerships between countries helps to make the extent of poverty and suffering in poor countries real to donor countries, while at the same time helping both sides better understand how interdependent they are. By using the language of relationships and partnership, a care perspective shifts the way we think about aid from a perspective where aid recipients are distant, helpless and in desperate need of our help, to one in which we begin to see them as real people that we can work with to overcome important problems.

This shift in thinking is further reinforced by treating relationships between aid donors and recipients as a partnership, founded on mutual respect and equality, and developed through long-term relationships between donors and recipients (Robinson, 1999). Given the significant power inequalities that often exist in a donor-recipient relationship, establishing equal partnerships will be difficult. Indeed, care scholars are critical of how the rhetoric of partnership and equality have been used in aid policy without a real attempt to address those inequalities (Robinson, 1999). However, a care approach understands equality differently and seeks to establish what Sevenhuijsen (1998) describes as equality of access and of voice, where everyone involved has an equal opportunity to be heard. Again, this means that a care approach to aid would not base decisions about how aid money should be spent solely on the interests of donor states, or on what experts suggest is the best approach. Instead a care perspective would provide space for recipients to be heard in the aid process and shape aid

decisions. Finally, because true cooperation and partnership takes time to build, a care perspective would move donor countries to focus on long-term commitments to recipient countries.

Partnership from a care perspective would extend beyond bilateral relationships of donor governments and recipient governments. If we are to strive for equality of voice in international aid, and build aid policy on a relational approach to global politics, then the goal should be to encourage all players to work more cooperatively. A care perspective would encourage donor states to work in partnership with each other to share best practices and better coordinate money and resources across the globe, ensuring that aid is not being concentrated in a few countries, while other states are overlooked. Working in partnership could also help make donor states more accountable for the aid commitments they make at international meetings like the G20, by clearly setting out what countries are responsible for what aid commitments.

At the same time, a care approach to aid policy would also encourage partnerships between recipient countries. These partnerships would not only help recipient countries exchange knowledge and best practices on how to use aid money, but they could also help balance out some of the power inequalities inherent in donor-recipient relations. By coordinating their efforts and working cooperatively it may be possible for recipients to put pressure on donor states to live up to their commitments and be responsive to the needs of recipient states.

Further, the relational focus of a care approach means that nation states would not be the only participants in aid partnerships. Civil society groups and nongovernmental organizations

would also have an important role to play, working in partnership with donor and recipient states, but also with each other. Establishing relationships and partnerships between regular citizens in donor countries and recipient countries will help build the connections and understanding that make the foundation of a care perspective. Indeed, many of these kinds of partnerships already exist across the globe. However, a care approach to aid policy would actively encourage these relationships and integrate them into bilateral and global aid agreements. Some countries have already taken steps in this direction. For example, as early as the mid 1990s Sweden's "Partnership with Africa" included an emphasis on establishing connections between Swedish and African societies, beyond strictly governmental relations (Robinson, 1999).

These kinds of partnerships will not develop on their own, or happen overnight. The nature of a care approach to aid and its emphasis on building relationships and partnerships underscores the need for long-term commitments. Care scholars are clear that building relationships takes time and is a continuous process. Thus, to build aid policy from a care perspective will require a focus on building and maintaining sustained connections between partners. This is especially important because of the unequal power relations that are so common in foreign aid arrangements. In these situations trust is likely to be much harder to establish and so the need for long-term and sustained commitment will be crucial to establishing effective and inclusive partnerships. Care scholars are realistic about this, fully acknowledging that "dealing with dependence demands, in short, time and space to develop and sustain trust" (Sevenhuijsen, 2003, p. 186).

From an aid perspective this need for long-term commitment is not without its challenges. Changing directions in foreign policy often seems to be one way new

administrations seek to differentiate themselves from their predecessors. However, a care approach cautions against rapidly switching aid priorities or target countries based on political motives. Aid, no matter what perspective one comes from, takes time to have an impact. So it may be in the interest of donor states to stay committed and have a chance to see some real improvements from their aid.

Finally, the relational focus of a care approach would also push aid policy to consider the larger systemic factors involved in aid, poverty and poor health. Aid policy from this perspective would need to be examined and developed in context with economic, trade, defence and other policies that have an impact at the international level. This is because a care approach emphasizes the importance of understanding how “the structural features of institutionalized relations combine with typical situations to enable or deform the abilities of all concerned to hear and be heard” (Robinson, 1999, p. 49). A care perspective seeks to “situate social and personal relations in their wider socio-political and structural context” (Robinson, 1999, p. 154). Thus, the only way to really understand how a group of people have come into a situation in which they need foreign aid is to understand the larger structural factors that have helped create that situation. If aid policy only considers the immediate poverty or poor health of a given situation, without considering those problems in their larger historical context, it is unlikely to create lasting change or improvement. This means that a donor country will need to consider the impact of its past foreign policy on a recipient country.

The idea of coordinating aid, trade and defence policy is certainly not new. Throughout the Cold War, both sides used aid as a tool to further their geopolitical interests and shore up their allies. Since the collapse of the U.S.S.R., Western states have regularly been accused of

using aid to push poor countries into adopting liberal economic policies and opening their borders up to Western goods. A care approach to aid would acknowledge these motivations for aid, and seek to understand how they have helped marginalize the poor and their states. It challenges donor states to consider how their trade and foreign policies are making life more difficult for the world's poor and making international aid more necessary. To be clear, I do not think that a care approach would require donor states to pursue international trade and foreign policy in such a way that benefits poor states at the expense of their own interests. However, the relational nature of a care approach to aid forces states to recognize their connection to global poverty and the ways in which their policy decisions may contribute to poverty and poor health. Further, it encourages them to look for opportunities to use trade and foreign policy, along with aid policy, as a means of building better and more equal relations between donor and recipient states. A care approach to aid policy pushes states to see the global connections of interdependence between states and helps them see that what is good for the world's poor can also be good for them.

Aid as a Moral Activity and Social Practice

Beyond its relational nature, a care approach understands care, and by extension aid, as a moral activity in itself. As Virginia Held (2006) puts it, “care seems to me to be the most basic of moral values. Without care as an empirically describable practice, we cannot have life at all since human beings cannot survive without it. Without some level of caring concern for other human beings, we cannot have any morality” (p. 71). In practice this means that “moral problems are observed and discussed in the first instance from an attitude of caring, that is, with attentiveness, responsibility, responsiveness and the commitment to see issues from differing perspectives” (Sevenhuijsen, 1998, p. 83). I will examine the implications of

each of the elements of the ethics of care – attentiveness, responsibility, responsiveness and commitment – later in this chapter. For the moment the point I am most interested in is the implication for aid from the idea of care being a moral activity in itself. Aid policy based on the ethics of care has to not only understand the social, political and economic structures that have helped create the need for global health aid, it must also work to understand how to deliver that aid more effectively.

Here again, the concrete focus of a care approach becomes clear. It is not good enough to provide aid – that aid must get results. Robinson (1999) explains that a care approach seeks to understand “how human suffering and exclusion are shaped by a series of collective social, political and economic decisions and social and economic relations,” while at the same time working to uncover “how we might learn to care” better (p. 32). Other ethical approaches to aid spend a lot of time debating the question of why we should give aid, but the ethics of care takes things one step further. If we are not giving enough aid or taking enough care for the world's poor, then a care approach wants to understand what we need to do to change that situation?

The ethics of care acknowledges the importance of the “why” question, but it also wants to know how – how things are the way they are and how we can make them better. In order to understand how, it is crucial that policy makers have a solid grasp of the context in which aid occurs, developing a “thoughtful knowledge of the situation and of all the actors' situations, needs and competencies” (Tronto, 1999, p.136). Working to “make sense of how personal and cultural attachments and social relations can lead to exclusion and domination, but also how they may be shaped and reconstructed in order to promote solidarity, strength and well-being” (Robinson, 1999, p. 139) is the foundation of this method of developing aid

policy.

Part of understanding how to do things better is critically evaluating what has, and is, being done. Therefore, a care approach to aid will also have a strong emphasis on the ongoing evaluation of aid policy and programs. Evaluation is generally part of any policy development process, however what makes a care approach unique is how that evaluation is done and who is consulted in the evaluation process. The emphasis a care approach places on giving voice to the marginalized and excluded means that policy evaluation from a care perspective will actively seek out input from all those impacted by aid and be less reliant on “expert” evaluation than more traditional policy processes. The indicators and measures a care approach uses to conduct evaluations will also look different from traditional approaches. I will go further in-depth into what policy evaluation would look like from a care perspective later in this chapter, but for the moment the key point is that a care approach to aid policy would include a heavy emphasis on evaluation with the aim of learning how to create better and more effective aid policy.

There is an additional benefit of using a care approach to develop aid policy. By focusing on the structural factors that have created the situation in which aid is necessary a care approach helps uncover the links between how rich states have become rich and poor states have become poor. At the individual level Joan Tronto (1993) describes this as the “false notion that people are entirely 'self-made' [...] that the wealthy and powerful accomplished what they have accomplished without the support and assistance of many others” (p. 177). At the global level, paying attention to the global patterns of political and economic interactions between states helps shed light on the many ways in which rich states have been able to take advantage of the global system in order to achieve wealth and prosperity and the way poor

states have been unable to make use of the same advantages. This does not mean aid policy developed from a care perspective would be focused on doling out blame for global poverty and poor health, suggesting that the rich have become rich on the backs of the poor. A care approach is much less concerned with assigning blame than it is about drawing attention to our important connections to one another, understanding how those connections have resulted in some doing better than others and uncovering how those connections can be reshaped to make us all better off.

This notion of paying attention to what is going on around us and how we are impacted by and impact others ties into the idea of seeing care as a social practice. In this sense “care begins with the recognition that others need our attention, energy and commitment” (Sevenhuijsen, 1998, p. 20). Initially this may not seem like a particularly profound insight when it comes to aid policy. If others did not need help then there would not be much need for aid. However, a care approach to aid starts not simply from the recognition that poor people in the world struggling with illness and poor health need help, but that they need *our* help. Further, we need to pay attention to those people and their needs. Global poverty and poor health need more than increased aid. A care approach clearly acknowledges that the poor require our attention, energy and commitment.

In order to give this attention, Tronto (1993) suggests that we need to overcome our position of “privileged irresponsibility” that comes about as a result of the ability of those in power to shape the system to meet their needs and ignore the needs and concerns of others. This position of privileged irresponsibility makes it difficult for us to “see what people need to maintain life and the quality of life” (Sevenhuijsen, 1998, p. 59). We can see privileged irresponsibility at play in the Washington Consensus and the heavily criticized Structural

Adjustment Policies (SAPs) of the late 1980s and early 1990s. The “expert” knowledge behind the development of the Consensus was rooted in a belief that free markets, privatization and free trade would pave the way for poorer countries to achieve sustained economic growth and lift themselves out of poverty. These concepts seemed to work well among Western states, so it was thought they would have equal success in other parts of the world. However, not only did SAPs reinforce a global economic system that benefited rich Western economies, but they also completely ignored the important social, political and economic needs of the people living in poorer countries that existed beyond neoliberal economic policies. Instead of helping, in many cases these needs were made worse by SAPs. As a result SAPs did not have the success their creators hoped they would.

A care approach to aid pushes policy makers to move beyond their position of privileged irresponsibility and be willing “to 'see' and 'hear' needs, and to take responsibility for these needs being met” (Tronto, 1993, p. 83). This is not an easy task and cannot be achieved without active engagement and communication with the targets of aid policy. Sevenhuijsen (1998) is clear that what this engagement will look like and how it will work “is dependent on social interpretations and conflicting notions of what constitutes good care” (p. 20). Thus, health aid policy developed from a care perspective cannot rely simply on the advice of policy experts. It must also engage with the communities it seeks to help, negotiating conflicting understandings of what is needed and how to best deliver aid. In other words, aid policy developed from this perspective is likely to be time consuming and require a long term commitment from everyone involved. However, it also promises to deliver a more effective product. The good news is that the ethics of care provides clear guidance for how to work through this process with attentiveness, responsibility, responsiveness and competence.

The Elements of a Care Approach to Health Aid

Attentiveness

I have already examined the importance a care approach places on paying attention to the needs of others, the context and history of their suffering and the impact of our actions and policies on the health and prosperity of the world's poor. However, there is one key aspect of attentiveness for aid policy that I have not looked at yet – the idea that attentiveness is a learned process, which is built through sustained relations with others. “Responding morally to others is a capacity which is learned” and requires “sustained and continued attention to the lives, relations, and communities of people in developing countries” (Robinson, 1999, p. 46). As Robinson explains, at the global level, learning to be attentive will require building long term, sustained partnerships with developing nations. Hankivsky (2006) further underscores the importance of relationships to attentiveness, arguing that paying attention to others and the consequences of our actions on them, means focusing on building social bonds and cooperation with those we are seeking to help.

Therefore, it seems that many of the implications for health aid from other aspects of the ethics of care that I discussed above are equally true for attentiveness. Like other aspects of care, to incorporate attentiveness into aid policy will require a focus on building long term partnerships with recipient countries that deal with all aspects of state interactions, not just aid. Attentiveness would push donor agencies to have a sustained presence of personnel on the ground in recipient countries, building relationships and connections with the communities they are seeking to help and gathering information about those communities, their insights and needs, as well as the effectiveness of current and past aid initiatives in the

region. Finally, incorporating attentiveness into aid policy would also suggest that donors consider creating opportunities for exchanges between citizens and aid workers in both countries to interact and learn from one another, while at the same time building partnerships and awareness of each others' experiences and needs.

Some clear patterns have begun to emerge from what it means to apply a care approach to health aid. A care approach encourages a focus on broad, long term and sustained partnerships that work to bring the countries involved closer together, making them more aware of each others' needs. Developing these relationships is important for care because it is through these relationships that responsibility is developed.

Responsibility

Care scholars understand responsibility somewhat differently than conventional aid scholars. Rather than see responsibility as “some kind of moral imperative that can be morally or legally enforced,” care scholars understand it “as an always, already existing part of the daily lives of all people” because “we all have developed relationships that are 'thick with commitment of expectation'”(Robinson, 2006, p. 333). Essentially this concept of responsibility pushes us to pay attention to how our actions affect others and take responsibility for the consequences of those actions. In other words it asks us to “recognize how those around us – both close and distant – are affected by our actions or conversely by our inactions” (Hankivsky, 2006, p. 105). At the international level this notion of responsibility implies that states are responsible for how their actions affect people in other states. So, for example if a rich Western state enters into a trade agreement with a poorer country in the South that trading relationship creates a responsibility for the rich state to

understand the consequences of that trading relationship for vulnerable populations in both countries and act if needed.

By the same token, if donor states make commitments to provide aid for a specific program or project, they have a responsibility to follow through on that commitment. Equally, by entering into a relationship with a donor state, recipient governments also have responsibilities to live up to their commitments to ensure that money and aid get to where they are suppose to go.

Thus, one of the key tasks of a care approach to aid is to establish who is responsible for taking action in the face of specific instances of poverty and poor health and prevent situations where no one takes responsibility (Sevenhuijsen, Bozalek, Gouws & Minnar-McDonald, 2003). The message from a care perspective is that international relations, just like interpersonal relations, create responsibilities to care for others. However, because a care perspective also stresses a relational approach, acting on these responsibilities requires partnership and collaboration. So this element suggests that a care approach to aid would call on states not only to pay attention to the impact of their actions on other states, but to take responsibility to work with that state to address those consequences. Further, to ensure that no one shirks their responsibilities to act, a care approach also suggests that donor states work together with each other and recipient states to establish who is responsible to act and how that action should best be carried out.

Finally, the relational nature of a care approach also suggests that simply having relationships with other states will create a sense of responsibility to act in times of need. The tsunami that devastated Southeast Asia in 2004 and the subsequent rapid global response

illustrates the power of relationships in creating a sense of responsibility to help. The region's popularity as a tourist destination, and thus the connection Westerns felt for the region and its people seemed to help motivate the response. Similarly, the rapid response of the Canadian government to the recent earthquake in Haiti suggests the important role relationships can play in foreign policy. Canada's large Haitian diaspora and its Haitian-Canadian Governor General both appeared to play a significant role in encouraging the government to act. By building relationships we build the connections that foster a sense of responsibility for others.

Competency

Of all the elements of a care approach, competency does perhaps the best job of underscoring the concrete focus of care. While traditional ethical approaches in international relations have tended to focus primarily on debating questions of why we should act and who we owe obligations to, a care approach goes further seeking to ensure that when we act, it actually makes things better. It is not enough to give aid that aid must be effective and once a commitment is made to provide aid that commitment must be honoured. Competency in this context seeks to understand what is needed to do the job well and to assess how well the job is being done. As Sevenhuijsen and her colleagues explain (2003), competency

gives substance to an understanding of what people need to be able to perform care work in specific situations. It places a responsibility with decision makers to optimally make resources available for care to proceed 'as well as possible' in terms of time, money and expertise. (p. 316)

Notice that from a policy perspective decision makers are not expected to provide all the care. Instead, one of their primary roles is to ensure that the resources are available so that those who are responsible for delivering care are able to do so competently. Or, more

explicitly, the authors argue that “social policies should, again, care about how competencies can be can be enhanced and persons can optimally develop their capabilities” (Sevenhuijsen, Bozalek, Gouws & Minnar-McDonald, 2003).

In an aid setting this suggests that donors should focus on providing the resources needed to allow those responsible for delivering care to be able to do their jobs well, rather than sending donor experts over to design and deliver programs. This does not mean that donors should simply become sources of money for aid projects. There is still an important place for an exchange of knowledge and expertise between donors and recipients. However, by placing the focus on building the competencies of those who are actually responsible for delivering care, the ethics of care suggests a more sustainable approach to aid – an approach where recipients are given the opportunity and resources to care for themselves.

This has some implications for NGOs. If, from this perspective, aid is suppose to be used to help build competency among those responsible for providing care, it suggests that overt time money should be shifted away from NGOs who are not directly accountable to the citizens of the states in which they operate, and focused instead more on local actors and governments who are actually responsible for providing specific services. I do not think this would necessarily mean that no money could be given to NGOs, or that they should be excluded from the aid process. It is certainly clear that in the case of health aid many states lack the capacity to provide important health services, leaving NGOs to provide crucial care that would not otherwise be available. However, it is important to acknowledge that aid NGOs are often reliant on donations – usually from the West – to provide services that are generally considered the responsibility of the state, to people to whom they have very little accountability. Again, it is certain that in the case of HIV/AIDS the work of large

international humanitarian NGOs has saved millions of lives. A care approach to aid would never support letting people suffer and die in the name of building local capacity. However, the element of competency in a care approach calls on policy makers to acknowledge that NGOs are only a temporary and last chance solution to provide care to people who have not been cared for by anybody else. Further, when NGOs are used it should be with a focus on building local capacity so that eventually aid from both foreign states and NGOs is no longer necessary.

Competency also pushes Western policy makers and citizens to see their role in aggravating the lack of health services in poorer states through policies like those that recruit health professionals from countries with desperately under resourced health systems. In addition it implies that care needs to be delivered well and, as Tronto (1993) argues, that those who commit to address a problem actually follow through on that commitment. Thus, a key part of a care approach to aid will be the evaluation of aid projects and initiatives. Projects launched from a care perspective need to get results and policy makers need to be aware of the consequences and outcomes of their initiatives. I will delve more deeply into this issue later in this chapter. The key point is that evaluation is important in a care perspective and how that evaluation is conducted will be different from a typical policy evaluation process.

Responsiveness

Part of the evaluation process of a care approach involves donors and recipients responding to each other in order to ensure that the care provided actually meets the needs of the recipient. This open and two way communication is important because it allows all

involved to better understand each other and provide better care. Often we are asked to put ourselves in the other's place and imagine how we would like to be treated in order to understand the other's perspective. However, care scholars point out that this assumes we are all the same and want the same things (Tronto, 1993). Instead, a care perspective "suggests that we consider the other's position as that other expresses it," making open dialogue and communication all the more important (Tronto, 1993, p. 136). Part of the process of considering "the other's position as that other expresses it" is empowering the marginalized and poor to express themselves as part of the policy process.

Hankivsky (2005) explains that responsiveness requires "a commitment to provide the opportunity and a safe space for others to express their 'otherness'." According to Hankivsky this means empowering participants "to decide what aspects of their lives they want to include as part of the discussion" and "what should be part of policy deliberations"(p. 35-38). This means that aid policy developed from a care perspective would be driven by the needs of recipients as they express them. So, instead of policy makers and aid workers looking at issues like HIV/AIDS and deciding based on their own expertise what needs to be done, the community would be empowered to explain how their lives are being impacted and what they feel needs to be done. By creating the opportunity for recipients to voice their experiences and have real input into what is done about it, recipients are transformed from passive victims to crucial participants in a process for change.

This does not mean that aid policy would ignore policy expertise and experience, but it would shift the priority given to these perspectives. As Hankivsky (2005) explains,

instead of prioritizing the 'voice of the market' or the 'voice of the policy expert', an ethic of care would prioritize the voice of the people, and in particular those

vulnerable and at-risk populations, who have been, and continue to be, disproportionately affected by globalization and its related policies and actions (p. 102).

In an era where aid programs regularly talk about concepts like empowerment, partnership and inclusiveness, a care approach would actively work to put those concepts into practice, “involving civil society, social movements and grassroots communities” (Hankivsky, 2005). The goal of bringing these actors to the table is to develop more responsive policy, which better meets the needs of recipients and empowers them to take an active part in the process.

Other Implications from a Care Approach to Health Aid

Bringing such a broad range of actors together to develop a coherent way forward is challenging. Fortunately care scholars have already begun to draw out what it means to build responsiveness into the policy process. Sevenhuijsen refers to this approach as responsive policy making.

Responsive policy making

Responsive policy making emphasizes “listening, responding and reacting immediately to problems” (Sevenhuijsen, 2003, p. 193). As I discussed above, it also works to empower the poor and marginalized by including them in the policy process. Thus, responsive policy making will emphasize consultation and evaluation while at the same time working to establish an environment of trust where participants are comfortable to respond openly and honestly about the level of care they have received.

Sevenhuijsen and her colleagues (2003) suggest that approaching policy development

from this perspective shifts policy makers away from a focus on data and statistics about the scale of a problem to a focus on actual on the ground knowledge of how a problem is being experienced by those involved. This would mean a shift towards what they describe as more democratic needs assessments, which rely heavily on public and community consultation throughout the policy development cycle. The overall objective of this consultation is to help policy makers get a better understanding of “what is actually the problem as experienced by those who are implied in these practices, both as givers and receivers of care in a broad sense” (p. 315). Put simply, responsive policy making “prioritizes listening to the voices of those who may be affected by policy decisions” (Hankivsky, 2005). This may seem like an obvious part of any policy development process, but as I described earlier, responsiveness not only brings the voice of recipients into the process, it prioritizes their input above typical policy tools like economic evaluation and expert analysis. The result is that responsive policy making ends up with “different objectives and different measures for evaluating the success of any given policy” based on the input of those who are actually experiencing that policy (Hankivsky, 2005).

Applied to the case of health aid, responsive policy making suggests that aid policy place a heavy emphasis on the input of the target communities of aid interventions and work to establish a climate of trust. A key component to building trust will be for donor states to fulfil their commitments and promises to provide aid and be seen to be doing more than just giving lip service to global health problems. Reacting quickly to problems would also go a long way to help build trust around aid. The international community can move incredibly quickly to respond to emerging crises as we saw with the 2004 tsunami in Southeast Asia, or it can be painfully slow to respond as we have seen far too many times in cases like Darfur and

Rwanda. Finally, the importance responsive policy making places on empowering the marginalized would suggest that aid policy needs to work to provide aid through more inclusive partnerships that value and prioritize the input of the community and create a space where they can contribute to the policy process. As I have touched on several times already in this chapter the way those policies are evaluated will also look quite different from this perspective.

Measurement and evaluation

A care approach is ultimately concerned with helping us understand how to care better. Therefore, a care approach to aid will need to place a significant emphasis on researching and evaluating what is and is not currently being done and what the impact has been on specific groups of people. This is not unique to a care approach – evaluation is a well established component of the policy development process. However, a care approach offers policy makers a new understanding of how to measure success and helps uncover some of the important limitations in common policy evaluation tools.

All policy makers are under intense pressure to demonstrate the value they get from the money they spend. Decision makers and elected officials, as well as the public at large want to know that governments are spending money well and getting good return on the money invested in a particular program or policy. One of the most effective ways of making that case is to use economic indicators to demonstrate how each dollar spent brings measurable economic value to the region. A care approach challenges policy makers to resist the temptation to try to express all the benefits of a particular policy in economic terms, by demonstrating the limitations of economic indicators. As Hankivsky (2005) explains, “the

principles of care challenge us to widen our capacity to understand that the concept of value can have many meanings other than just those associated with a quantifiable measure. At the same time the principles of care narrow our view of what may be appropriate for economic quantification” (p. 83).

Take the example I discussed in the previous chapter of the popular economic health indicator, disability-adjusted life years (DALYs). The purpose of DALYs is to help put an economic cost on the loss of human capacity caused by disability or disease. The assumption implicit in the indicator is that disability free years have more value than years of life in which an individual has to struggle with disease or disability. The problem is “a measure that attaches more value to a life without disability, many have argued, implicitly devalues the lives of disabled people (Waitzkin, 2003, p. 526). By taking the impact of a particular disease or accident and aggregating it out into a measure like DALYs we remove the impact of that disability from its context and so fail to get a full appreciation for how it is actually being experienced by an individual. According to Hankivsky (2005), the net result is that an approach to policy evaluation that relies on broad, quantifiable economic measures fails to “adequately represent the diversity of values required for social policy decision making” (p. 93). So for a care approach economic and other quantitative measures are important tools for policy evaluation, but they are not the only tools and are often not the most appropriate tool. A care approach to policy would not abandoned these kinds of measures, rather it would seek to “broaden what we consider to be effective evaluation” (Hankivsky, 2005).

The previous section discussed some of the alternative approaches to evaluating policy a care perspective offers. It shifts policy makers from relying heavily on broad quantitative and economic indicators of policy evaluation in favour of more consultation with those actually

impacted by the policy. This presents some challenges for aid policy because it will require donor countries to invest significantly in getting people on the ground in recipient communities and spending the time and money needed to get a clear understanding of how the policy or program has impacted people in the context in which they live.

A Care Approach to Health in a Nutshell

So far I have discussed a variety of implications from applying an ethics of care approach to aid policy. However, in order to get a full picture of what the ethics of care would mean for how aid policy is developed, it is worth pulling out those implications a little further. In doing this I am conscious of the fact that a care approach moves us to examine the world from a relational perspective that rejects attempts to provide universalized rules which can be applied in all circumstances. Therefore, I need to be clear that my goal here is not to present a prescriptive list of vital elements that a care approach to aid must have. Rather, I am seeking to understand the implications of applying a care approach to aid policy and how such an approach might improve the way we think of, design, deliver and evaluate aid. To fully appreciate the benefit of a care approach will require applying it to a specific case, as I will do in the following chapters. However, it is still possible to draw out some of the implications of a care approach to aid even at a more theoretical level. With that in mind, I can see six key components to a care approach to aid.

Partnership

Several of the aspects of care discussed in this chapter underscore the importance of inclusive partnership in aid. Partnership is crucial to a care approach because it is through inclusive partnership and cooperation that the other aspects of a care approach are put into

practice. Partnerships transform aid recipients from passive victims of poverty and poor health into vital partners in development. Instead of bringing already developed aid projects or objectives to recipient communities, a care perspective pushes donors to work with recipients to understand what they feel their community needs and how they feel donors can best help. A care approach would actively seek to bring in the voices of the marginalized and most impacted groups, empowering them to help create policy responses to health and poverty issues identified by the community. As much as possible then, aid partnerships developed from a care perspective would seek to create a more equal relationship between donors and recipients, working collaboratively together with the acknowledgement that all parties have an important role to play.

Civic engagement

Civic engagement stems from the broad and inclusive notion of partnership in a care approach. Further, given that the ethics of care suggests that we understand the world through our relationships with others, it is only natural that a care perspective to aid would work to develop partnerships and relationships that include everyday citizens and civil society organizations.

Many states already encourage their citizens to travel to other parts of the world and volunteer in development projects through programs like the Peace Corps in the U.S., or the Canadian International Development Agency's International Youth Internship Program. A care perspective would encourage these kinds of programs and expand them, looking for ways to make the impact of poverty and poor health real to citizens in donor countries. Donor countries might also consider matching or linking these types of volunteer programs with

their aid projects, so that donor citizens are working on projects in communities where their state is sending money. The purpose of linking the programs in this way would be to help develop relationships between recipient communities and donor communities. These programs are not the only way in which donor states could facilitate civic engagement and relationship building. States and civil society organizations could be creative in developing all sorts of initiatives to engage citizens that would meet the needs of specific communities and situations. The point is simply that a care perspective to aid would place a significant effort in fostering these kinds of relationships and would see them as an important part of the aid process.

Long-term

Part of what building civic engagement would do is help build more commitment from donor states to stay involved in a specific region or community and better live up to their aid commitments. It will be difficult for effective partnerships to develop between donors and recipients if donors are continually moving aid money and resources from one region or project to another, without making a long-term commitment to stay involved in any particular country or region. This does not mean that aid from a care perspective can only be delivered through long-term programs. There will also be a need for aid to address emergency situations or unexpected needs. However, a care approach would encourage donors to be more focused with the bulk of their aid, working with recipients to decide where they want to be involved and then making a commitment to stay involved in that region over the longer term. Not only would long-term involvement create more of an opportunity to build relationships and understanding between donor and recipient communities, but it is also likely to help encourage donor citizens to be more supportive of aid by allowing them to see

the difference their country has made over time in a specific region. The aid itself is also likely to be more effective, by providing a more sustained flow of resources to address a particular problem. Making a longer term commitment might also encourage donor states to create a more permanent presence of personnel on the ground in a particular country, giving these people greater decision making and budgetary authority so that important decisions for the local community are not being made by people on the other side of the world in the departmental headquarters of donor states.

Aid in context

A care perspective also pushes donor states to pay attention to the context in which poverty and poor health occur and how their actions have helped shape that context. This means looking at the role of broader economic and political structures in creating an unequal distribution of wealth and health around the globe. In particular, donor states would be encouraged to examine how their actions and policies at home and abroad impact the global poor and create a situation where foreign aid is necessary. For example, in the case of HIV/AIDS a care perspective would force donors to confront the fact that domestic policies, which encourage the recruitment of foreign health professionals, drain vital health resources from national health systems struggling to cope with massive epidemics of HIV/AIDS. Similarly, a care perspective would also force donor states to acknowledge that trade agreements that enforce strict patent protection can make it more difficult for poorer countries to get access to reliable and affordable supplies of vital medicines like antiretroviral treatments.

Understanding aid in context could also involve donor states making more of an effort to

keep policies in other areas of international relations from undoing the efforts of aid policies. This might mean that donor states would need to work to make their foreign policies more complementary to one another. Instead of using aid as a tool for furthering their own national interest, they might look at ways to make their trade policies less hostile and disruptive to the world's poor. I am not suggesting that a care approach to aid would require states to act as altruists, shaping their trade and even defence policies for the benefit of the global poor. However, at the very least it would force donor states to acknowledge how they often impede their own development projects through overly self-interested policies in other areas and encourage them to find ways to ensure they do not make lives harder for the global poor. Further, it would also push donor states to take responsibility for instances where their foreign policy has made life worse for the poor and work to ameliorate those problems.

Capacity building and empowerment

A care approach's emphasis on continually learning how to care better means it will need to focus on building capacity in both donor and recipient countries to deliver aid more effectively. Partnership plays an important role in this process by giving voice to the poor and marginalized, empowering them as active participants in the development process. Indeed, creating inclusive partnerships with community members and aid recipients will help build capacity in and of itself. Partnership is essentially the conduit through which aid programs work to help build capacity in recipient communities, by asking members of the community what they need to better care for themselves and empowering them with the resources and tools they need to do that work.

It is worth clarifying that despite the similarities between this idea of capacity building

and Sen's capabilities approach; the two approaches are motivated by different goals. While a capabilities approach sees freedom as the ultimate goal of development, and so seeks to build people's capabilities to be freer to lead the kind of lives they desire, the emphasis a care approach puts on capacity building has a more focused objective of improving a community's capacity to care for itself.

A democratic approach to measurement and evaluation

As I discussed earlier in this chapter, learning how to care better also suggests that evaluation will play an important role in a care approach to aid. In particular evaluation that relies more on democratic measures and less on expert analysis. By a democratic approach to evaluation I am working off of Sevenhuijsen's and her colleagues (2003) concept of democratic needs assessments, to get at the basic idea that a care approach to aid would evaluate the success of aid programs and initiatives based primarily on the input of the actual recipients and targets of those initiatives. In their words, the objective of a democratic approach to evaluation is to gain a better understanding of “what is actually the problem as experienced by those who are implied in these practices, both as givers and receivers of care in a broad sense” (p. 315). Thus, a care approach to aid would make heavy use of consultations, on the ground knowledge and more qualitative measures of program success. Broader statistics and expert analysis still has an important role in a care approach, but these tools would not be seen as the only and best option in all circumstances.

Filling the Gaps: Care, Rights, Economic Growth and Human Security

In the previous chapter I examined the strengths and weakness of three major approaches to health in the development literature: an economic approach, a rights approach and a

security approach. I will conclude this chapter by returning to those three approaches to demonstrate how a care approach to health is able to overcome some of their shortcomings.

I showed that economic approaches to health fall short in several key ways. They take a narrow and instrumental view of health, failing to appreciate the important role larger social and political factors play in shaping health outcomes. As well, economic approaches rely heavily on quantitative measures and evaluation tools that obscure important contextual information. Finally, these approaches tend to be expert driven, excluding the poor and marginalized from any serious role in shaping aid policy or its outcomes.

In contrast, a care approach stresses the importance of understanding poverty and poor health in a broader context and pushes decision makers in donor states to acknowledge how their actions and decisions in other areas can have serious consequences for health and development. At the same time, a care approach to aid shows the limitations of quantitative evaluation, demonstrating that it is not always the best tool for the job, and instead highlights the key contribution of more democratic evaluation tools. Lastly, a care approach is less reliant on expert opinion and analysis in shaping aid policy, preferring instead to focus on what those who are actually impacted by the policy feel should be done and ensuring that their voices are given at least as much weight as the experts. Essentially, a care approach would help expand the scope and understanding of economic approaches, appreciating the importance of health to economic growth, but underscoring that economic considerations are only one part of the picture global health aid.

Human rights approaches offer a broader understanding of health, but they too have their shortcomings. First, rights approaches at the international level rely on weak and not

universally recognized rights claims. Second, these approaches provide us with very little guidance about how to actually get rights enforced in practice. A care approach to aid does not need to rely on any kind of tenuous rights claim. It is simply focused on doing aid better. In fact, by making capacity building and empowerment among aid recipients a key part of it process, a care approach is likely to help lay the foundation to strengthen rights claims, giving a stronger voice for the marginalized to demand those rights. Further, a care approach provides clearer insight than a rights approach into the concrete steps required for building more effective aid policy.

Lastly, security approaches to health are criticized for using language and concepts that are not always appropriate for dealing with problems like poverty and poor health and so risk being subsumed by more mainstream approaches to security. As well, by expressing health problems as global security threats, security approaches often appeal to donor self-interest to act. While such an approach can be effective, it risks producing aid policies that are focused more on reducing threats to donors than working to actually overcome the problem. In response a care perspective uses the language of care, offering a collaborative approach that gives voice to the marginalized. Additional, by placing aid in a broad social, economic and political context, a care approach is still able to show how poor health and poverty can impact other important global issues like security, without having to rely on a language of security and its associated problems.

Therefore, a care approach is able to offer some important answers to the shortcomings of other mainstream approaches to health in the development literature. However, because a care approach places so much importance on understanding the specific context in which problems occur, the only way to really see the contribution of a care approach to aid policy is

to apply it to a case. With that in mind, the remaining chapters of this thesis will turn to the case of aid for HIV/AIDS, examining the policies of major international donors and assessing how a care approach might make these policies more effective.

Chapter 4: HIV/AIDS Assistance in Practice

Few diseases in history have so fully penetrated our culture as HIV/AIDS. It has spurred everyone, from rock stars to computer moguls, to action. Today, thanks to consumer initiatives like Project RED, I can even feel like I am helping fight HIV/AIDS by buying a pair of shoes or a MP3 player. Not surprisingly, this widespread awareness of the devastating impact of the disease has led to a proliferation of initiatives aimed at reducing and reversing its spread. National governments, international organizations, NGOs and private foundations have all developed responses and strategies to fight HIV/AIDS, sometimes working together and other times more or less working at cross purposes. And, while it would be naïve to suggest that all of this outpouring of aid is completely altruistic, it is clear something about the suffering of people infected with HIV/AIDS has provoked the world to act.

Given both the devastating impact of HIV/AIDS and the massive relief effort that has sprung up around it, it is important to understand what has motivated these responses and to uncover the assumptions they make around the causes, solutions and actions needed to address HIV/AIDS. In this chapter I examine three major assistance efforts targeted at HIV/AIDS: the American, President's Emergency Plan for AIDS Relief (PEPFAR), the British, Taking Action and Achieving Universal Access initiatives and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Fund). All three efforts have brought significant material and human resources to bear against the disease through three distinct approaches. The U.S. approach represents the most traditional approach to foreign assistance of the three. It is very much a top-down approach driven by what PEPFAR administrators and experts feel is the best method of tackling the disease, with little opportunity to be responsive to the concerns and needs of aid recipients in affected communities. The British government has

taken a more flexible approach to addressing HIV, giving a much greater priority to getting and incorporating input from a broader cross section of stakeholders. It has empowered staff on the ground in recipient countries to work with local partners to develop programs that meet local needs and it has shown itself to be willing to learn from its mistakes and make changes as needed. The British approach is certainly not perfect, much of its direction and priorities still comes from the centre; however, it is a more responsive approach than PEPFAR. The Global Fund is the most unique of the three approaches. It was designed to be a multi-stakeholder partnership of donors, recipients, NGOs, civil society and the private sector. It represents an interesting alternative approach to traditional foreign assistance.

My purpose in reviewing these approaches is not to suggest that one these approaches is the way to go, or fully encapsulates the key aspects of a care approach – all three have some important strengths and limitations. Instead, my objective is to uncover how each of these three initiatives approach and understand HIV/AIDS assistance and foreign aid more generally, which will set up the care approach I put forward in the next chapter. By pulling out these assumptions it is possible to better understand what a care approach can bring to the study of global health and poverty and how it would change the way we think about and deliver aid.

The President's Emergency Plan for AIDS Relief

It is somewhat surprising that a president known more for launching two wars in the Middle East and drastically increasing American military and security spending also oversaw “the largest commitment by any nation to combat a single disease in human history” (Gostin, 2008). American funding to fight HIV/AIDS dwarfs all other nations. When PEPFAR was

initially launched in 2003 it committed U.S. \$15 billion over five years and, in 2008, it was reauthorized to provide an additional U.S. \$48 billion for another five years. No other country has come close to providing that kind of funding for HIV/AIDS. According to UNAIDS data, in 2007 the U.S. providing U.S.\$3.65 billion in foreign aid for HIV/AIDS, more than three times what the next largest donor, the U.K., provided and more than ten times as much as any other nation (Kates, Izazola & Lief, 2007). The significant monetary commitment seems to have been motivated by a strong moral belief on behalf of President Bush that American should act on HIV. Bush argued that through PEPFAR “we have a chance to achieve a more compassionate world for every citizen. America believes deeply that everybody matters, everybody was created by the Almighty, and we're going to act on that belief and we'll act on that passion” (Dietrich, 2007).

However, part of the reason critics have been so concerned about PEPFAR is because it has provided such a massive investment. Critics worry that the U.S. has been able to use the power of its HIV/AIDS investment to exert undue influence on how aid recipient countries respond to HIV/AIDS. This concern is amplified by the fact that 60% of PEPFAR funding is concentrated in just 15 countries (Ingram, 2007), giving the U.S. an incredible amount of influence on how HIV/AIDS is approached in those countries. Indeed, despite the scale of its investment and its ability to achieve some pretty significant results, PEPFAR has been heavily criticized for its rigid, top-down and conservative approach to HIV/AIDS. This is why PEPFAR is such an interesting case to study. Not only is it the most significant investment in HIV/AIDS made by any nation, but it also typifies what might be called a traditional approach to foreign aid. Virtually all significant decisions about the plan are made in the U.S. based on what American policy makers and American experts feel is best for

recipient countries. All the money, power, knowledge and expertise flow from Washington out. Real consultation with target communities is extremely limited in PEPFAR.

Before further examining the shortcomings of the U.S. approach, it is important to acknowledge what it has achieved. Several studies have found that PEPFAR has significantly increased access to antiretroviral drugs (ARVs) in many recipient countries (e.g., Bendavid & Bhattacharya, 2009; Wools-Kaloustian et al., 2009; and El-Sadr & Hoos, 2008). In some cases PEPFAR has been credited with increasing ARV access by a factor of ten in just four years (El-Sadr & Hoos, 2008). Some critics have suggested that most of the improvements in access to ARVs were actually achieved through the Global Fund rather than through PEPFAR itself (e.g., Dietrich, 2007). However, there does seem to be nearly universal agreement that the U.S. plan has been able to reduce death rates associated with HIV/AIDS. A study published in the *Annals of Internal Medicine* in 2009 found that when compared to countries not receiving PEPFAR funding, HIV death rates in PEPFAR funded countries dropped more than 10% faster (Bendavid & Bhattacharya, 2009). And, while that same study acknowledged that some of that improvement was likely the result of other programs also operating in those countries, like the Global Fund, it concluded that approximately 1.2 million lives were saved as a result of PEPFAR. Another study in Kenya reported similar improvements in access to HIV treatment resulting through PEPFAR (Wools-Kaloustian et al., 2009).

In fact it appears that PEPFAR may be a victim of its own partial success, because while it has been able to reduce the number of people dying from HIV/AIDS it has not had much success in preventing new infectious, resulting in a growing population needing expensive ARV treatment (Bendavid & Bhattacharya, 2009; and Ingram, 2007). The one area of

prevention where PEPFAR does appear to have been able to make some gains has been in improving blood safety in recipient countries (Dybul, 2008). However, seeing as tainted blood has so far not been a major source of infection in recipient countries, this improvement is not likely to be much help in addressing the potentially very serious challenge PEPFAR faces if it is not able make similar improvements in HIV prevention as it has in treatment. Unfortunately PEPFAR's failure in preventing new infectious is not all that surprising given the serious criticisms it has faced for its narrow, top-down and ridged approach to prevention that has been heavily influenced by conservative moral values.

Critics argue that these conservative values have trumped public health evidence and best practice in the design and development of PEPFAR's approach (Dietrich, 2007). Looking at some of PEPFAR's decisions, it is hard to argue conservative values have not had a tremendous influence on the aid program. PEPFAR has blocked funding to NGOs that provide or even promote abortions, refused to allow its money to be used for needle exchange programs, refused to fund any group that does not have an explicit policy opposing prostitution and sex trafficking, heavily restricted the promotion of condoms and requires that one-third of all funding spent on prevention go towards promoting abstinence (Gostin, 2008; El-Sadr & Hoos, 2008; and Dietrich, 2007). From a care perspective we can see that many of these decisions are likely to further marginalize and exclude some of the most vulnerable populations to HIV/AIDS – women and intravenous drug users. Indeed, these restrictions have actually led some governments to refuse U.S. help. For example, in 2005 the government of Brazil refused U.S. \$40 million in PEPFAR support because it felt that the heavy restrictions that came with the U.S. money would seriously hamper its ability to effectively respond to HIV/AIDS (Phillips & Moffett, 2005). Of course while a country like

Brazil might be able to afford such a stand, most low income nations struggling with HIV do not have that luxury and so are forced to accept U.S. requirements.

The U.S. government has also unabashedly used PEPFAR and its influence in the Global Fund to encourage the funding of faith based organizations operating in recipient countries. A 2008 report to Congress by the Office of the U.S. Global AIDS Coordinator outlined how the U.S. government is actively working with faith based organizations to help them navigate the funding process and ensure they have better access to money coming from the Global Fund, while at the same time working within the Global Fund to make changes that make it easier for faith based organizations to access money. According to the report, “U.S. government participation in the Global Fund has been instrumental in promoting changes to Global Fund policies and procedures to expand the participation of FBOs [faith based organizations].” The improved access to funding that faith based organizations received through the Fund is on top of the significant access to money the report notes that they are already getting through PEPFAR. This is not to suggest that faith based organizations should be excluded from HIV funding, on the contrary, in many cases faith based organizations are ideally situated in local communities and have the support and knowledge of the local community necessary for effective interventions. However, when we take into consideration the conservative restrictions PEPFAR puts on groups accepting its money that I outlined above, it is fairly safe to assume that the faith based organizations that U.S. is supporting are those that support the conservative moral values espoused in PEPFAR. This is exactly what the research shows has happened (Ingram, 2007).

Interestingly, PEPFAR does not seem to have restricted itself to helping only Christian faith based organizations. A study of U.S. HIV/AIDS policy in Nigeria found that PEPFAR's

restrictions have created a situation where conservative Christian faith based organizations in the U.S. have partnered with Islamic and Christian faith based organizations in Nigeria to help spread prevention messages around abstinence (Ingram, 2007). According to this study, “these strategies have been heavily criticized for their ineffectiveness and irrelevance in the context of unequal gender relations, yet chime with the norms of many faith-based partner organizations privileged by PEPFAR.” The net impact has been that while PEPFAR only requires that 33% of prevention funding be targeted at abstinence programs, in Nigeria these programs take 70% of PEPFAR prevention funding (Ingram, 2007).

Of all of PEPFAR’s policies, it is the one-third prevention requirements that have been particularly troubling for critics. Under this requirement one-third of all prevention funding flowing from PEPFAR must go to abstinence and fidelity programming. Individual countries can apply for exceptions, but the overall target remains, so if one country gets an exception to provide less funding than other countries will have make up that shortfall by using more than 33% of their funding on abstinence programming (Ingram, 2007). Part of the U.S. government's justification for this requirement seems to be based on the perceived success the Uganda government had fighting HIV/AIDS with the so-called ABC (abstinence, be faithful, use a condom) approach to prevention. U.S. government documents regularly refer to Uganda and the effectiveness of its ABC approach. The U.S. Congress Act, United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, which, among other things, set up PEPFAR, refers in glowing terms to the “remarkable” success of the Uganda approach. The Act claims that “Uganda brought about a fundamental change in sexual behaviour by developing a low-cost program with the message: 'Stop having multiple partners. Be faithful. Teenagers, wait until you are married before you being sex'” (p. 4).

Notice how little prominence is given to condoms, or the “C” in the ABC program. Indeed, by PEPFAR's 2009 Operational Plan, the “C” is gone altogether and the document only refers to AB programming.

Leaving aside any debate about how effective the ABC approach actually was in Uganda, the evidence is clear that PEPFAR's requirements to target one-third of prevention funding on similar initiatives has seriously hampered its effectiveness. Even the U.S. government's own documents confirm the failure of this approach. One review conducted by the U.S. Government Accountability Office (GAO) found that in 17 of 20 countries reviewed the 33% funding requirements created serious challenges to developing programs that were responsive to local needs (Dietrich, 2007). Similar findings have come up in other GAO reports. In 2006 the GAO reported that local PEPFAR staff found the 33% requirements not only made it difficult to create programs that responded to local needs, but also actually prevented them from meeting their larger PEPFAR goals. The GAO was clear, “meeting the 33% abstinence-until-marriage spending requirement can challenge country teams' ability to allocate prevention resources in a manner consistent with PEPFAR sexual transmission prevention strategy” (p. 21). The same report also found that in many cases recipient countries have spent more than 33% on abstinence programming in order to ensure they make the requirement, forcing them to cut money from other, more comprehensive prevention programs.

A follow up GAO report in 2008 found that little had changed. The report cited concerns from public health experts that the 33% requirement “posed obstacles to the development of country-based and evidence-based programming” and “hindered the development of integrated prevention programs that appropriately balanced AB prevention activities with

other prevention activities” (p. 4). In both reports the GAO called on PEPFAR to address these concerns and to give recipient countries more flexibility to create programs that better meet their needs and circumstances. Frustratingly however, both reports also found the Office of the U.S. Global AIDS Coordinator to be unresponsive and resistant to making any real improvements to address these shortcomings.

PEPFAR's narrow approach to prevention is matched by an overall narrow approach to addressing HIV/AIDS that largely ignores the broader social, economic and political factors that help create the conditions in which HIV/AIDS can thrive (El-Sadr & Hoos, 2008; and Gostin, 2008) and which a care perspective argues are crucial to developing effective policy. For example, one of PEPFAR's priorities is to address the role of gender inequality in HIV/AIDS, which is an important acknowledgement of the role broader factors play in the spread of the disease. However, the programs PEPFAR has rolled out to address gender inequality have focused on improving women's access to treatment services rather than actually trying to tackle larger, systemic factors that create gender inequality. As a 2006 report by the Office of the U.S. Global AIDS Coordinator demonstrates, PEPFAR acknowledges the importance of these broader factors, it just does not do much to remedy them. The report points out that “women and girls often have limited ability to determine if, when and with whom they engage in sexual relations” and that “young women's relative lack of power and financial independence increases the risk that they will [...] be unable to negotiate whether they have sex at all”(p. 2). Yet, instead of providing initiatives to help address these power imbalances, the report tries to show how an ABC approach can help keep women safe, suggesting that “interventions aimed at reducing vulnerability to HIV by communicating the merits of positive behaviours such as abstinence, faithfulness, and partner

reduction are well-suited to provide education on the hazards of sexual coercion and the links between gender-based violence and HIV” (p. 9). The report fails to explain how choosing to have fewer partners is supposed to help protect women and girls from being forced to have sex, when only a few pages earlier the report acknowledges that many women are coerced into sexual relations.

All of this leads the report into the ludicrous position of actually suggesting that increasing women's access to female condoms and microbicides helps increase their physical autonomy when they are raped. As the report puts it, “while women-controlled methods to prevent transmission of HIV, such as microbicides and female condoms, do not reduce acts of gender-based violence, they could offer women who anticipate exposure to such violence a degree of physical autonomy which enable them to protect themselves from HIV” (p. 10). Apparently the young woman, who anticipates that, when her uncle comes home drunk he will rape her again, can feel some sense of autonomy when her horrible prediction comes true because, by wearing a female condom, at least now she does not have to worry about HIV. Setting aside the complete impracticality of wearing a contraceptive device in anticipation of a rape and what it would do to the perceived legitimacy of any woman trying to prosecute her attacker after the rape, this kind of logic underscores how completely futile it is to try to tackle a complex problem like HIV/AIDS without addressing the broader factors that contribute to an individual's vulnerability. When the only remedy a multibillion dollar aid initiative can provide a rape victim is to anticipate her attack and use contraceptives, there is clearly a very serious problem with that initiative.

The problems with PEPFAR's narrow approach extend beyond gender based violence. PEPFAR was slow to acknowledge the importance of access to cheap generic drugs for

treating HIV and initially forced all recipients to buy name-brand drugs (Dietrich, 2008). PEPFAR has now relented, but by 2007 generic drugs still made up less than 30% of drugs purchased through the program (Dietrich, 2008). Further, PEPFAR's narrow view of prevention has meant that it has failed to address the lack of local health capacity in recipient countries (Gostin, 2008), despite the fact the GAO (2004) has flagged weak health infrastructure and lack of local capacity as key factors reducing the effectiveness and inhibiting the success of PEPFAR programs. The GAO (2008) recommended that PEPFAR provide more opportunity to get input from recipient governments and local stakeholders in setting policies and targets as way of improving the responsiveness of PEPFAR and helping get a better appreciation of how broader factors impact HIV in a particular context. However, in another indication of the lack of openness and responsiveness of PEPFAR, when provided with this suggestion PEPFAR officials expressed concern that if recipient governments were given more input, "the host country government might in some cases push for its own health priorities such as investments in infrastructure" (United States Government Accountability Office, 2008). Given that a lack of health infrastructure has been identified as a serious impediment to the effectiveness of efforts to fight HIV/AIDS, it is likely that host governments have good reason to want more investment in health infrastructure instead of dubious ABC programming. Finally, both the GAO (2008) and independent experts (e.g., Gross & Bisson, 2009) have expressed concern over the lack of consistent program evaluation in PEPFAR something that might have helped PEPFAR reduce some of the shortcomings discussed in this section.

Thus, to sum up the impact of PEPFAR, the U.S. government should be commended for the sheer scale of its response to HIV/AIDS. PEPFAR has been able to achieve some

important success and has saved lives. However, its rigid, top-down approach, which has been dominated by conservative moral values, drastically reduced its effectiveness and has made it largely unresponsive to the concerns of experts and its own staff, not to mention those actually living with HIV. The American approach to foreign assistance for HIV/AIDS reflects a more traditional approach to foreign aid that is driven primarily by what donors feel is best.

From a care perspective there is not a lot positive to take from PEPFAR, as its narrow and unresponsive approach risks further marginalizing the vulnerable populations that a care perspective encourages us to pay special attention to. While it does emphasize the particular vulnerability of women and girls to HIV/AIDS, a care perspective would push U.S. policy makers to understand that vulnerability within the larger context of gender inequality, social exclusion and poverty that help create it and work to address those broader contributing factors. Finally, its unresponsiveness to the concerns of aid targets and even its own staff on the ground is a far cry from the responsive approach to policy making encouraged by a care perspective. As I will show in the next section, the British government has taken a different approach HIV/AIDS – one that is more open and responsive to local concerns and much closer to an ethics of care approach than PEPFAR.

U.K. Foreign Assistance for HIV/AIDS

On the whole the U.K. government approach to HIV/AIDS has been more flexible and has made greater efforts to get input from a broader cross-section of stakeholders than PEPFAR. Not to say that the British approach is perfect, but the U.K. government has shown itself to be more willing to learn from its mistakes and adapt its approach accordingly. This is

perhaps most obvious in the fact that U.K. strategy has undergone a major independent review and amendments since it first launched its “Taking Action” strategy in 2004.

Taking Action provided £1.5 billion in funding between 2005 and 2008 for HIV/AIDS intervention in impoverished countries (Department for International Development, 2004). After a major interim evaluation in 2007, the U.K. Department for International Development (DFID) introduced the second phase of its strategy entitled, Achieving Universal Access, which built on the work of Taking Action with the objective to “halt and reverse the spread of HIV in the developing world by 2015” (Department for International Development, 2008). The strategy committed an additional £6 billion through to 2015 to help make this happen. It placed a strong emphasis on helping build and support health systems and services in target countries and centred on four key priorities: increasing efforts on prevention, treatment and care, responding to the needs of those most affected, supporting more effective and integrated program delivery, and ensuring a more coordinated response overall. The strategy is clear that to be effective in achieving its goals it must have “strong, inclusive planning and budgeting – with the involvement of PLWH [people living with HIV] and other vulnerable groups” (p. 2). It goes on to state that “this strategy reflects the emerging evidence that long term funding for health systems and services is the surest foundation for the achievement of the global effort to secure universal access” (p. 3) to HIV prevention, treatment and care programs.

In 2003 the U.K. government launched a “Call for Action” on HIV that highlighted four key areas, arguing that the international community needed to do better in providing aid for HIV. These areas were: improving donor coordination, increasing funding, generating stronger political direction, and improving national responses to HIV (Department for

International Development, 2004). The following year, after extensive consultation with NGOs, the private sector, recipient countries and international partners, it launched Taking Action (Department for International Development, 2004).

In Taking Action DFID (2004) placed a heavy emphasis on improving coordination both within government and internationally, demonstrating the kind of partnership I suggested was important to a care approach to aid in the previous chapter. It established a cross government working group of major departments involved in foreign assistance for HIV/AIDS to help coordinate their various HIV programs and ensure better coordination and coherence in U.K. policy. At the international level, the strategy laid out the importance of improving aid coordination inside recipient countries, citing examples of countries like Russia, Uganda and the Dominican Republic all with 20 or more separate AIDS missions operating inside their borders and highlighting the immense burden this puts on recipient governments. As the strategy states, “some countries are spending a year simply completing the necessary forms to apply for funding while funds already allocated sit unspent.” To address these problems the strategy committed the U.K. government to work with other donor countries, as well as international organizations like UNAIDS and the WHO and the recipient countries themselves, to improve coordination, planning and monitoring of assistance. It also promised to support and advocate for the use of the so-called “Thee Ones” approach for HIV assistance, which would essentially establish one agreed upon action framework to coordinate all partners, one national coordinating body and one agreed country level monitoring and evaluation system. Finally, DFID committed to help recipient countries that want to limit the number of donors operating in their country, possibly by working with them to establish a minimum amount of assistance donors have to give in order to be involved.

The 2004 DFID strategy also took a more comprehensive and flexible approach to HIV than PEPFAR, which again is more inline with a care approach. The document stressed the need to go beyond medical interventions and address the causes of vulnerability by strengthening not only the health systems of recipient countries, but the education and legal systems as well. DFID argued that these activities were “essential for a comprehensive response to AIDS.” Further, as part of this comprehensive approach, the strategy emphasized the need to help vulnerable and marginalized groups like women, migrants, drug users and the poor, and to provide more predictable and long-term funding for HIV programs. In several places DFID talked about the need to “involve individuals and communities affected by HIV in decision making.” Further, the strategy regularly stressed the importance of monitoring and evaluating progress as well as working with and supporting national governments. Obviously it is one thing to commit to this kind of an approach in a strategy document, but quite another to actually put those commitments in place. Evidence from two independent reviews of Taking Action suggest that it did a fairly good job of living up to most of these promises, but it could still be improved.

The Auditor General's (2004) review of the strategy found that DFID was doing a good job of working to build local capacity by providing technical assistance and budget support to recipient governments, while at the same time providing support to NGOs to ensure programs were delivered effectively in the meantime. The Auditor General also noted that the large amount of autonomy that DFID provided to its country teams gave the strategy flexibility and the ability to respond quickly to local needs, making it more responsive than the approaches of other donor governments. Finally, the report also applauded DFID for its multilateral efforts, which the Auditor General suggested had helped focus more international

aid for HIV in poor countries.

However, there were also some problems with the strategy. To begin with the Auditor was concerned that while DFID had done a good job of providing the country teams with a lot of autonomy, it was not giving them enough support and that “there is a continuing demand from country teams for guidance on the most difficult and sensitive issues.” The report criticized DFID for its failure to disseminate key knowledge and research to local staff and not establishing regular communication with country teams so that they could make better use of this information. At the time of the review the Auditor found that current research and best practice “had little influence on DFID's country-level HIV/AIDS programmes” because that information was not getting to country teams (p. 6). From a care perspective we can see this as a failure to competently deliver aid. While a care approach encourages working to empower recipients that does not mean giving them money and leaving them to figure out what to do with it without any support. A care approach emphasizes the need to work in partnership, and would encourage donors to help support recipients to ensure that aid is effective.

The report also cautioned DFID that providing budget support directly to recipient governments made it hard to track the money and ensure it was actually being used where it was supposed to be used. Of course from a care perspective the challenge with this caution for DFID is that it has to balance the need to ensure British assistance is spent where it is suppose to be spent, while at the same time helping build capacity in recipient governments and providing them with the flexibility to respond to local issues related to HIV/AIDS. The Auditor General's report did not address this challenge or how DFID might be able to balance the competing needs of building local capacity while monitoring where funds are going.

DFID was also criticized in the report for not setting up adequate measures in the strategy to monitor how well it had achieved its objectives. The Auditor acknowledged that part of the challenge for DFID was that its broad approach to HIV made it harder to isolate the impacts of specific interventions. However, it still recommended that DFID work to significantly improve its monitoring and evaluation capacity.

The breadth of DFID's approach to HIV/AIDS created another problem. As part of its effort to reduce vulnerabilities to HIV, DFID linked the HIV response of recipient countries into their Poverty Reduction Strategy Papers (PRSP). The problem with this approach, as the Auditor General noted, is that PRSPs do not specifically address HIV and do not include initiatives aimed at HIV/AIDS. To deal with this, the Auditor General recommended that DFID work with recipient countries to ensure that HIV was better reflected in recipient countries' PRSPs.

These same criticisms over the lack of evaluation and monitoring in the strategy also came up in the independent interim review of the strategy conducted by Social & Scientific Systems Inc. (2007). The interim review recommended that the U.K. “find more effective ways to challenge political leadership that is not based on evidence, e.g., the focus on abstinence-only in HIV prevention programs for young people.” This is a very interesting recommendation because it would put the U.K. in direction conflict with PEPFAR and its heavy emphasis on abstinence as a key prevention method. The review did not address this potential conflict with PEPFAR, but it is difficult to believe that the reviewers were not aware of it. The challenge for DFID would be to balance its objective to better coordinate donors, with its objective to have evidence based and effective programs in place, when that would mean directly challenging the policies of the world’s largest HIV/AIDS donor. The

U.K. has been silent on this very clear conflict.

The interim review was supportive of the cross government working group established out of the Taking Action strategy, but challenged the government to better define the roles and responsibilities of the various departments involved. It also called on the government to establish closer links between “domestic HIV and sexual health strategies and issues of relevance to other government departments, such as TRIPS [Trade Related aspects of Intellectual Property Rights], access to medicines and asylum seekers.” This criticism is key because it suggests that despite DFID’s best efforts it has not been completely successful in establishing a coherent approach to HIV across the U.K. government. Indeed, the U.K. treatment of HIV positive asylum seekers is further evidence of that failure. The British decision to block HIV positive immigrants from entering the country and restricting their access to treatment in the U.K. stands in stark contrast to its international HIV/AIDS efforts. In the words of one expert, “while global HIV/AIDS relief aims to secure life in global borderlands, the exclusion of some categories of people within the U.K. from access to free treatment is a revealing exception to the new geographies of salvations” (Ingram, 2008, p. 889). By the same token, it is easy to see how quickly DFID’s effort to improve access to treatment and affordable drugs could be sidelined if it is not able to ensure other government departments are not being overly stringent in enforcing patent protection laws.

Like the 2004 Auditor General's report, the interim review also found some key strengths in Taking Action, including its comprehensive approach to HIV treatment and prevention, and the important flexibility it provided to allow countries to develop their own responses to HIV. The review applauded DFID as “as strong advocate for country-led approaches,” pointing to DFID's efforts to support national HIV programs that respond to the needs of the

most vulnerable. In another, not so subtle reference to PEPFAR, the review highlighted that the “U.K. has championed the needs of those most vulnerable to HIV infection, providing an essential counter-weight to the perspective of others who fail to recognize the importance of these groups.” While the U.S. approach is not mentioned, the interim report talks about countries that marginalize the most vulnerable members of society by blocking harm reduction efforts and advocating abstinence programs that are not backed up by good evidence. Thus, both the Auditor General's report and the interim review found that Taking Action was doing some important things right, but that it could also do better. Interestingly both reports seemed to want to push DFID towards an approach to HIV that would directly challenge the kind of approach embraced in PEPFAR. Of course, given the significant shortcomings with the American approach I have already discussed, it really is not surprising that others would recommend that the U.K. take an alternative approach.

When the U.K. launched the next phase of its HIV strategy, Achieving Universal Access, it made a significant effort to address the criticisms of Taking Action while building on its strengths. The new strategy kept the emphasis on understanding the local context and tailoring responses to meet the unique factors that influence the spread of, and vulnerability to, HIV/AIDS in each country. It also continued to push for a comprehensive approach to HIV that built local capacity, especially in the health system, and tied HIV efforts into broader public health initiatives. The strategy continued to focus on giving voice to those impacted by HIV, and committed to include community members and those living with HIV “in setting priorities, designing programs as well as monitoring the quality of services and their access to them” (p. 37). According to the strategy the objective is to use this input to “promote comprehensive approaches to HIV prevention based on the realities of people's

lives” (p. 21).

Achieving Universal Access also acknowledges an important criticism of the recent international focus on HIV/AIDS, namely that “concentrating so many resources only on tackling AIDS can weaken a country's ability to provide other health services that are just as important” (p. 12). Several critics have pointed out that this intense push to address HIV can actually prevent a recipient country from addressing its larger health concerns by drawing away scarce health resources to focus on HIV (e.g., England, de Lay, Greener & Izazola, 2007). This is precisely why DFID has made such an effort to link its HIV programs into broader public health initiatives and emphasized the need to build the capacity of local health systems as part of any approach to HIV.

The strategy also maintains its focus on targeting vulnerable groups and improving the coherence and coordination of the U.K. government's response to HIV, while directly answering earlier criticisms by laying out clear roles for the various departments involved in addressing HIV/AIDS. DFID further improved on its early strategy with a significant emphasis on evaluation and monitoring, committing itself to another independent review in 2011 to ensure it has lived up to its commitments. To underscore the seriousness with which DFID took the criticisms of the lack of evaluation in Taking Action, it released a separate document outlining how it would monitor and evaluate its performance (2008b). As one might expect, this document has a lot of emphasis on establishing quantitative performance measures, but it also talks about including members of civil society in the evaluation teams and the need to include “input from relevant partners.” The annex to this document lays out the key priorities of the strategy. The first priority is to ensure all programs and activities that come out of the strategy are relevant to the local context. The second priority is “supporting

the empowerment of people living with HIV and vulnerable groups to act on their own behalf and in their own interest, and participate in all aspects of the AIDS response” (p. 12). DFID is not clear exactly how it will measure the success of either of these two priorities and given the prominence it has placed on them, it is something DFID needs to consider. These are not the kinds of objectives that lend themselves well to quantitative evaluations and will require a much more qualitative approach, suggesting that DFID still has some work to do when it comes to monitoring and evaluation. A care could help here because, while it supports the use of quantitative evaluation in some circumstances, it also helps demonstrate the value of more qualitative measures in policy evaluation.

Achieving Universal Access has not yet been as extensively evaluated as earlier British strategies. However, it was highlighted in a report by the Auditor General in 2009 which praised DFID for how effectively it had worked to respond to the criticisms of Taking Action in developing Achieving Universal Access. In fact, the Auditor General used DFID as a model for how government can learn to respond more effectively to its stakeholders. In the report the Auditor General traced the criticisms of Taking Action to show how DFID conducted a major consultation with stakeholders both in the U.K. and in recipient countries, including representatives of NGOs, academia, the private sector and multilateral agencies to come up with ways to address these shortcomings. DFID then used the same group that conducted the interim evaluation of Taking Action to help it build the new strategy. According to the Auditor General, the net result of this process was a much more effective strategy that addressed all the major shortcomings of the first strategy.

The academic literature has not had as much to say about the U.K. government's approach to HIV as it has about PEPFAR's approach. This is likely in part due to the smaller

size of the British effort and the fact that it has not been associated with more controversial programs like the ABC program the way the American approach has. That said, while the U.K. has been praised for taking a comprehensive approach to HIV that emphasizes the empowerment of vulnerable groups (Bovill, 2009; Armon, 2007; and Zhang & Locke, 2004), it has come under fire for not doing more to address its role in recruiting health professionals from AIDS ravaged countries and for its policy restricting the immigration of HIV positive immigrants into the U.K. (Ingram, 2008; Eastwood et al, 2005; and Buchan & Dovlo, 2004). Both of these criticisms highlight the importance of having a coherent and coordinated approach across government. On its own, DFID is likely to have little control over either British immigration policies or the recruitment of foreign health professional by the National Health Service. However, policy decisions in both of these areas, especially the recruitment of health professionals could have a significant impact on the effectiveness of DFID's HIV/AIDS programs. Evidence from Achieving Universal Access suggests that DFID is aware of these problems and is at least acting to address the health professional issue. The strategy has nothing to say about immigration requirements, nor is it explicit that the recruitment of health professionals to the U.K. has directly reduced the capacity of some countries to respond to HIV/AIDS. However, it does highlight how it has worked with the Department of Health to strengthen codes of practice around the recruitment of health professional from overseas, which have deterred some recruitment of health professional from poor countries.

Thus, the U.K.'s approach to HIV/AIDS offers a useful counterpoint to PEPFAR. With both British strategies we see an approach much more in line with a care approach than PEPFAR. The British strategies off a more comprehensive approach to HIV treatment and

prevention that better understands the need to build responses to HIV based on the local context and needs. DFID employs a much more flexible approach than PEPFAR that is driven by the needs of recipients rather than the values of the donor. And, while DFID has been criticized for its lack of evaluation it is important to note that the U.S. government has not subjected PEPFAR to the kind of independent scrutiny that the U.K. has done to its HIV/AIDS strategies. This is not to say that the British approach is perfect or that exemplifies a care approach in action. It still has some things to work on from a care perspective. It remains unclear just how much input those who are actually impacted by HIV/AIDS in recipient countries really have into the policies and programs developed out of the U.K. approach. DFID's approach still seems to be driven largely by “expert” opinion, whether it is an expert from a government, an NGO or an international organization, the input that seems to count most is not the voices of the community. DFID has made an effort to consult with those impacted by the disease, but it is not clear how much influence those consultations really have. While it has shown itself to be responsive to feedback about its approach, DFID needs to do more to ensure that it is as responsive to the people actually impacted by the disease as it is to the technical experts that advise it.

The final approach to HIV/AIDS that I will review in this chapter is quite different from the first two. The Global Fund represents a new approach to foreign aid that attempts to establish broad and inclusive partnerships, which brings donor and recipient states together with NGOs, civil society and the private sector to create a funding body that is beyond the control of any one state. It is a unique approach and one that has many interesting implications for health aid and foreign assistance in general.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund was established in 2002 in an attempt to create a performance-based funding body that could provide money to address HIV/AIDS, Tuberculosis and Malaria. According to the Fund (2007) its purpose is “to fill unmet needs and achieve substantial, measurable impact on the burden of disease in countries it funds.” According to its website (globalfund.org), as of 2009 the Fund attracted over U.S. \$18 billion in funds. It is governed by a board of 20 voting members and four non-voting members. Board membership includes eight representatives from donor countries, seven representatives from recipient countries, a NGO representative from both a developed country and a developing country, as well as a NGO representing communities living with the three diseases, and finally, a representative from a private foundation and one from the private sector. The non-voting members include UNAIDS, WHO and the World Bank. The board is aided in its funding decisions by the Technical Review Panel, an “independent panel of health development experts” that reviews all the proposals and makes recommendations for funding (Global Fund, 2007).

Each recipient country sets up a Country Coordinating Mechanism (CCM) to develop a national strategy to address each of the three diseases and submit proposals to the board for funding to implement that strategy (Global Fund, 2007). CCMs are supposed to be cross-sector representatives of all key stakeholders in the country and include representatives from the government, NGOs, academic institutions, the private sector, affected communities, faith based organizations and donors working in the country (Global Fund, 2007). As I will show in the next chapter, from a care perspective these CCMs offer an interesting avenue for building capacity and responsiveness into aid programs. Each CCM nominates a public or private organization to act as the principle recipient of each grant and be legally responsible

for the money. As an oversight mechanism the Fund uses a local funding agent to assess the capacity of the principle recipient, administer grants and verify that all the funds are properly disbursed (Global Fund, 2007).

Grants are provided for up to five years, but once a grant has been approved only the first two years of funds are released. The local funding agent works with the CCM to establish performance measures that are used to determine the success of the grant (Global Fund, 2007). After 18 months the CCM submits a request for the rest of the grant and only those with satisfactory performance measures get the additional money (Global Fund, 2007).

Interestingly, despite the importance the Fund places on being open and transparent, it appears the process by which it was negotiated was anything but. The former director of research on HIV/AIDS for the U.N. Secretary General, Nana Poku (2002), described it as an “opaque and ad hoc process” (p. 294). While the Fund has certainly made efforts to be more open, many stakeholders continue to complain they have not been given enough voice and input into the process. A recent study of the Fund by Garrett Brown (2009), found that many CCMs were not living up to the Fund’s recommendation to have NGOs make up at least 40% of CCM membership. According to Brown this has “resulted in programs and CCM processes that have systematically excluded, or failed to include, various stakeholders and NGOs affected by the diseases” (p. 173). He argues that the Fund’s failure to do more to ensure broader representation in CCMs has reinforced the perception by many that the Fund is really only accountable to major donor countries. The danger for the Fund is that despite an intense effort to portray itself as a new kind of inclusive partnership, it will be perceived as just more of the same.

The Fund has also faced questions about its ability to attract the money it needs to live up to its commitments. By 2004 the Fund had committed U.S. \$1.5 billion, but had only been able to disburse U.S. \$113 million (Okuozni, 2004). Several scholars have raised concerns over the Funds ability to get enough money (e.g., Ooms, Van Damme, Baker, Zeitz & Schrecker, 2008; Doyle, 2006; Okuonzi, 2004; Poore, 2004; and Poku, 2002) and these concerns were reinforced by the recently completed five-year review of the Fund (Sherry, Mookherji & Ryan, 2009), which suggested that the Fund's long term sustainability is at risk if it is not able to mobilize new resources.

It is difficult to see a solution. Part of the Fund's uniqueness is its ability to attract new sources of money that are typically beyond the reach of government donors. For example, through Project RED, an initiative spearheaded by a group of private actors, including Bono, companies make donations to the Fund when consumers buy certain products (Youde, 2009). Several major international corporations have embraced the project including Nike and Apple (Youde, 2009). So far the money generated by this initiative has been relatively minor – especially given the needs of the Fund (Youde, 2009), but it is an example of the kind of unique funding project that is open to the Fund. The Fund could work to expand these kinds of initiatives, and that certainly seems to be what the five-year review of the Fund had in mind, however it will need to do more to ensure it has the money to meet its objectives. The problem is that no matter how successful these kinds of initiatives are, the Fund will remain dependent on money from national governments for the foreseeable future and if governments are not willing to do more, the Fund will continue to struggle. The advantage the Fund has over more traditional approaches to foreign aid is that it can look to private sources for money, it just is not clear how much help private sources will be. Thus, operating

beyond the control of any one state gives the Fund more flexibility to find other sources of money, but because it remains dependent on money from states, it is still vulnerable to the possibility that states will lose interest in providing money to an organization over which they do not have direct control.

Securing sustainable investment is not the only challenge for the Fund. It has also been criticized for the long and burdensome application and approval process required to get a grant. Sam Okuonzi (2004), the former head of policy analysis for the Uganda Ministry of Health, reported that it took nearly two years for Uganda to get money through the Fund because of the Fund's rigorous and burdensome application and screening process. The Fund's own review found that its approach had "evolved into a complex and burdensome system that has thus far focused more on project inputs and outputs than on development outcomes" (Sherry, Mookerji & Ryan, 2009, p. 32). The same review also uncovered a concerning lack of effective monitoring and evaluation of projects conducted with these grants, noting that the focus of evaluation has been more on "narrow performance measures than on a more systemic approach." Further, the report also raised concerns about the lack of monitoring going on inside CCMs to ensure that the money is being spent appropriately. It is a concern that is also shared by donors, who "have often expressed concerns about accountability, effectiveness, and the possibility of governmental corruption within CCMs" (Brown, 2009, p. 175).

One of the key principles of the Fund is what it dubs "additionality," the idea that all the money provided through grants be used in addition to already existing government health spending, and not used to offset health spending so governments can spend money elsewhere. The objective is to ensure that more resources are going into the health system to

help fight the target diseases. However, because of a lack of monitoring, the Fund's five-year review could only be sure that the principle of additionality was being upheld in four of the over 100 countries receiving grants through the Fund (Sherry, Mookherji & Ryan, 2009).

Unfortunately, the shortcomings of the Fund do not end there. On top of these important specific criticisms, the Fund has also been challenged at a more fundamental level. Critics argue that the Fund's disease specific focus has led it to a short term approach that does not build local capacity and is not tailored to local needs. Further, instead of linking into or building up local health structures, the Fund has tended to create parallel health systems inside states that pull much needed resources away from other parts of the health system. These criticisms represent the most significant challenge to the effectiveness of the Fund. Recall that in the previous chapter I identified capacity building, responsiveness and a longer term focus as important components of a care approach to aid. In order to be effective it is crucial that the Fund works to help strengthen local health systems and build local capacity (Ooms, Van Damme, Baker, Zeitz & Schrecker, 2008; and Drager, Gedik & Dal Poz, 2006). There is no way any action on HIV/AIDS can be effective in the long term if there are not the facilities or professionals to deliver care. The Fund's five-year review makes it clear that there are "major gaps in basic health service availability" in recipient countries which act as a significant barrier to the success of the Fund and "going forward, the weakness of existing health systems critically limit the performance potential of the Global Fund" (Sherry, Mookherji & Ryan, 2009, p. 21). The review found little evidence that the Fund's current approach was having any significant spill over benefits for the health system at large and it made it clear that it was crucial for the Fund to do more. It argued that "grants should focus more on investing in long term capacity-building, or demonstrating partner contributions to

capacity-building” (p. 24). Further, it specified that “grants for health systems strengthening should support overall country health sector strategic plans” (p. 22). It is not as if the Fund is unaware of the importance of these broader factors, but it appears that initially it felt that its disease specific investments would encourage other broader, investments in the health system and this has not happened (Poore, 2004).

The Fund’s granting process is at least partially to blame for the failure of its grants to address longer term issues. In the words of the five-year review, the Fund lacks “a considered longer term strategy” (Sherry, Mookherji & Ryan, 2009, p. 57). It “has drifted from longer term and strategic issues toward ad hoc and incremental decision making and to operational details” (p. 57). As I mentioned early, recipients only get two years of funding to start and have to show success in the first 18 months in order to get the rest of the money. Faced with this kind of system, there is no incentive for recipients to make longer term investments in the health system. Instead, they end up creating parallel systems inside recipient countries, often duplicating structures and programs already in place (Druce & Nolan, 2007; and Bruce & Harmer, 2006). Not only do these parallel systems fail to build local capacity, but they can also create serious distortions in the existing health system, sucking away much needed resources from other areas and actually weakening the recipient country's capacity to address other health concerns (Druce & Nola, 2007). In Haiti, for example, the influx of resources to combat HIV crowded out other health programs and actually resulted in Haiti moving backwards on nearly all indicators of health except HIV (Farmer & Garrett, 2007).

This result really should not be all that surprising given how stretched governments often are in recipient countries. In these circumstances a sudden dump of funds that have to be targeted to specific programs and initiatives can quickly overburden local staff (Farmer &

Garrett, 2007). Couple this with the wide range of actors recipient governments are required to work with in order to get the money and it is not hard to see how governments can quickly get overwhelmed. As one expert argues, government institutions are often “too weak to manage the wide variety of public and private players linked to the Fund” (Okunzi, 2004, p. 56). When these challenges are taken with the distortion aid money can have on local salaries, it is easy to see how well meaning efforts to improve one disease can ironically damage overall health indicators. The Fund's five-year review found that money from the Fund created “discordant salary scales” for staff working on its projects and “contributed to an internal 'brain drain',” in recipient countries, drawing staff away from other important tasks (Sherry, Mookherji & Ryan, 2009, p. 17). Not only does this kind of impact look bad for the Fund, it also works against its ability to be effective over the long term by creating an unhealthy population that will be more vulnerable to HIV infections.

Hand in hand with the Fund's tendency to create a parallel health structure in recipient countries is its failure to tailor its approach to meet local needs and build local capacity. There is a tendency among many donors, not just the Fund, to fall into the trap of assuming recipients have common interests, missing the fact that many stakeholders inside a country may have conflicting and competing priorities (Mogedal, 2004). The Fund has attempted to address this through the broad composition of CCMs, but this has not been enough. The five-year review of the Fund found that it needed to do a better job of taking into consideration the unique circumstances inside each recipient country and it encouraged the Fund to better tailor its approach to meet local needs and circumstances (Sherry, Mookherji & Ryan, 2009). A care perspective, with its emphasis on understanding the context in which problems occur, would encourage the Fund to make better use of the CCMs to provide a more tailored

approach.

To be fair to the Fund it has faced some significant pressure from the World Bank to not get involved in encouraging investments to build local health capacity, which the World Bank feels is its territory (Ooms, Van Damme & Temmerman, 2007). The World Bank has proposed a “division of labour” with the Fund focusing on the three specific diseases, while the Bank deals with the broader system (Ooms, Van Damme & Temmerman, 2007). It is not clear if the Fund will continue to accept this approach, or if it will give into the pressure from staff on the ground and international health experts and move to greatly increase the amount of money it directs to building local health systems. As it stands now CCMs can apply for grants that focus more on addressing broader health system issues (Drager, Gedik, & Dal Poz, 2006), but there has been recent indication from the Fund that it might discourage these kinds of proposals, leaving “the strengthening of health systems and support for the health workforce to others” (Ooms, Van Damme & Temmerman, 2007, p. 605).

Although there has been a significant push to get the Fund to do more to build health systems, some experts caution that such a move could bring the Fund into conflict with the IMF. Ironically the IMF has been a major barrier to improving local health systems because of the tight macroeconomic restrictions it places on recipient countries, enforcing wage restrictions, which make it hard to attract and retain health professionals and pushing recipient countries to use most of their aid to pay down debt (Ooms, Van Damme, Baker, Zeitz & Schrecker, 2009). For example “in 20 sub-Saharan countries between 1999-2005, the IMF permitted, on average, just 27 cents on every incremental dollar in foreign assistance to be used for program expenditures, with the balance used for paying down domestic debt and accumulating foreign exchange reserves” (Ooms, Van Damme, Baker, Zeitz & Schrecker,

2009, p. 4). Currently the Fund is not subject to this restriction because of its disease specific focus, but there is concern that if it starts to expand beyond its specific focus, it may face a challenge from the IMF (Ooms, Van Damme, Baker, Zeitz & Schrecker, 2009). Thus, for the moment at least, the Fund's unique position provides it with the potential to help build local health capacity in a way that would be difficult for most donor governments. It remains to be seen if the Fund will take advantage of this unique position.

Indeed, many scholars point out that the unique position of the Fund is one of its most important advantages and it is important to acknowledge that despite the many shortcomings I have mentioned so far in this chapter, there is a lot of potential in the approach the Fund takes to international aid. Because the Fund brings together a broad cross-section of stakeholders and is not under the control of any one state, or group of states, it is able to do things that national aid agencies cannot. I already discussed the example of Project RED and how private actors took it upon themselves to create an initiative that helps provide money for the Fund. It is difficult to imagine any circumstances where those actors would have done the same for a donor government aid agency. Generating access to new funding sources is only one of the advantages of the Fund's position. The Fund is not as susceptible to the same kind of domestic pressures and self interest that national agencies are, and so, some scholars argue, is able to pursue more evidenced based policies (Doyle, 2006). Looking at the example of PEPFAR and the significant influence of conservative moral thought in its approach, it is easy to see how domestic pressure can derail the effectiveness of an aid initiative. Some observers also argue that because the Fund provides money based on the proposals of recipient countries, its aid is based more on the needs of recipients than on the interests of donors (Doyle, 2006; and Nantulya, 2004). Of course what these observers miss

is that while the Fund may provide money based on recipient proposals, the criteria against which those proposals are judged are still decided by the Fund, so it is not completely driven by recipient needs, but also by the Fund's evaluation of these needs. Where the Fund differs from national aid agencies is that representatives from both donors and recipients make up the Fund's board, so recipient states have potentially much more influence on the Fund than they would on a donor aid agency.

Earlier I mentioned that the Fund has been criticized for not doing enough to include NGOs in the CCMs, but it is important to acknowledge the fact that Fund has CCMs at all, which bring together a broad cross-section of stakeholders, including NGOs and representatives of those living with the diseases, make it far more inclusive than most national aid agencies, including the two I have examined in this chapter. It has to be acknowledged that the Fund has made some significant efforts to give all stakeholders a voice (Drager, Gedik & Dal Poz, 2006; and Nantulya, 2004). Further, the Fund's inclusiveness appears to have had some spill over effect by creating new space and opportunity for a broad range of stakeholders to have a voice in the aid process more generally (Sherry, Mookherji & Ryan, 2009).

The Fund's unique position also allows it to change the way sustainability is understood in the aid process. Traditionally, when donors have talked about the sustainability of aid they were referring to the idea that once programs or initiatives were set up recipients would be able take them over and eventually replace aid money with their own money (Ooms, Van Damme & Temmerman, 2009). The problem that a growing number of aid experts point out with this understanding of sustainability is that it is completely unrealistic for the majority of low income countries whose budgets are already overstretched trying to fund basic services

for their citizens (Ooms, Van Damme & Temmerman, 2009). However, because the Fund is a global funding body, it has been able to shift the concept of sustainable aid to a global level. Instead of looking at aid as sustainable at the individual recipient level, aid is sustainable as long as the Fund can continue to attract donors (Ooms, Van Damme & Temmerman, 2009). This is an important difference because it allows individual recipient governments to use their national budgets to cover the basic provision of services, while being able to take advantage of money from the Fund to combat the threat of specific diseases. It creates the potential for recipient states to have access to much longer term aid investments. Of course, as I mentioned early, so far the Fund has not taken full advantage of its ability to specifically target grants for longer term projects, but its very existence makes those kinds of investments more likely than they would have been under a national aid agency that is measuring the sustainability of aid from an individual recipient's perspective.

The Fund has been also credited with helping raise the profile of HIV, tuberculosis and malaria, and the immense burden these diseases put on many low income countries. Farmer (2007), acknowledges that the Fund certainly has not been perfect, but he argues that whatever its shortcomings, the Fund has helped raise a global focus on the seriousness of the threat of these diseases that simply was not present even a few years ago.

Finally, there is good reason to believe that the Fund can overcome many of the shortcomings that I have mentioned in this chapter because it has already shown itself to be responsive to its limitations and willing to make changes to address them. The Fund has made efforts to be more inclusive, increase the input of recipient countries in its planning processes, and make its funding more predictable for recipients (Buse & Hammer, 2006). In April of 2007, it agreed to do more to encourage proposals that focus on comprehensive

approaches to recipient country health programs and work to help build local capacity (Ooms, Van Damme, Baker, Zeitz & Schrecker, 2008). Clearly, as its five-year review shows, the Fund still has some work to do in this area, but it is making efforts to improve. In the words of one observer, “what has always been impressive about the Global Fund is its ability to learn from critical evaluation and to rethink its institutional practice, [...] the Global Fund has been a self-learning and reflective organization” (Brown, 2009, p. 174). This ability to learn from its mistakes and be responsive to the concerns of its stakeholders is one the Fund's most important strengths. It does not erase the significant challenges I discussed early in the chapter, but it does show that the Fund is willing to work to overcome them.

The Fund is an important departure from traditional approaches to foreign aid, which tend to be driven largely by the interests and concerns of donor states. It is not an approach that will replace donor government aid programs any time soon, but it does offer an important example of how aid can be done differently. The Fund is far from perfect. It has struggled to attract the money it needs to operate. Its disease specific focus has led to the creation of parallel programs instead of building local capacity and its failure to adequately monitor and evaluate the impact of its grants has meant that it has been unable to ensure its money is actually creating the changes it is suppose to be creating. However, the Fund's unique position allows it to attract money that other donors cannot and its responsiveness to the concerns of its stakeholders and its own shortcomings make it an important example to consider when studying how to create a more caring approach to aid.

This chapter has provided an analysis of three of the most significant international aid initiatives currently targeting HIV/AIDS. The three cases run the spectrum from the very

conventional approach of the American PEPFAR, to the interesting multisectoral approach of the Global Fund. All three have had some strengths and some shortcomings. The U.S. government has provided a staggering amount of money to address HIV/AIDS, but, despite this generosity, it has done little to empower aid recipients or provide them any real input into how aid money should be used and delivered. Recipients are understood as just that, recipients, receiving money and guidance from PEPFAR experts, with little opportunity to do much else. PEPFAR shows some superficial elements of both attentiveness and responsiveness by paying attention to the devastation and suffering caused by HIV/AIDS and acting to address some of that suffering. However, by failing to actively engage with recipients as partners and not providing them with any significant space to express their needs and concerns, PEPFAR cannot really be considered responsible, attentive or responsive from a care perspective. Further, with its narrow, disease specific focus and failure to consider the important role poverty and social inequality play in facilitating an environment where HIV/AIDS can thrive, PEPFAR cannot be considered competent from this perspective either.

The British government has certainly done a better job of recognising the broader social factors that influence the impact of HIV/AIDS and has given staff on the ground significant flexibility to create programs that respond to local needs. As well, it has been quite responsive to criticisms and has made efforts to address these criticisms. However, it is still unclear how much input those actually impacted by HIV/AIDS have on policy and program decisions. DFID's approach still seems to be driven more by expert opinion than grassroots inclusion. While it has listened to opinions from outside government, this input seems to have been largely restricted to NGOs, academia and international aid organizations. It needs

to do more to empower those affected by HIV/AIDS to decide what kinds of interventions they need and how they feel aid money should be used in their communities.

On paper the Fund seems like it is the most open and responsive of the three approaches. It has made strong efforts to include all stakeholders in its processes and has created space through the CCMs for affected communities to directly contribute to the development of HIV/AIDS plans and programs. However, as I have shown, in practice it seems that most CCMs have struggled with inclusiveness and donor countries continue to be seen as having undue influence on the Fund. In addition, the Fund's narrow approach has not helped build local capacity and may have actually eroded it in some cases. Like the U.K. approach, the Fund has shown that it is willing to learn from its shortcomings, but it remains to be seen if it will evolve into an attentive and responsive approach.

My purpose in this analysis is not so much to specifically critique these three approaches, but rather to examine three different approaches to delivering health aid in order to understand their benefits and limitations and uncover how an ethics of care approach to health aid might be able to change the way we deliver aid. The next chapter will further this purpose, tying together the lessons of these three approaches with the theoretical approach I developed in the previous chapter to draw out the full implications of an ethics of care approach to aid.

Chapter 5: Putting Care into Action

To truly understand an ethics of care approach to foreign aid I need to move beyond a theoretical argument to demonstrate how a care approach would change the way we actually deliver aid. By returning to the lessons from the three HIV/AIDS strategies that I reviewed in the previous chapter it is possible to get a better understanding of what a care approach would mean for aid in practice. Interestingly, as I will show in this chapter, there are actually a lot of aspects of three aid approaches that could be adapted to help create a more caring approach to foreign aid. This is not to say that the U.S., the U.K. or the Global Fund are already using a care approach to aid, but that by drawing on aspects of all of them we can see the foundations for a care approach. This is important because it suggests that creating foreign policy that helps us care better for each other is not as idealistic or naïve as it may initially seem.

Before turning to the lessons from last chapter, it is helpful to briefly recap what I have said so far about aid from a care perspective. In earlier chapters I argued that a care approach to health aid would have six key components. First, it would be based on inclusive partnerships between donor and recipient states that work cooperatively to develop and deliver aid projects that meet the needs and desires of target communities. Second, a care perspective would encourage a broad and inclusive approach to aid that works to build civic engagement in both donor and recipient states. Third, growing out of the first two components, a care perspective would push donor states to follow through on their aid commitments and work over the long term with a recipient country until aid objectives are met. Fourth, aid from this perspective would consider health issues in their broader context, looking at the role social, economic and political factors play in contributing to a particular

health problem. Fifth, aid would be focused on building local capacity and empowering those most impacted by poverty and poor health to help create solutions to their problems. Finally, evaluations of aid initiatives delivered from a care perspective would rely on more democratic approaches to measurement and evaluation, seeking to understand the situation as it is experienced by those most impacted by a problem or program. A care perspective would encourage policy makers to take a more critical approach to measurement and evaluation, encouraging them to be less reliant on broad quantitative measures and more focused on understanding how a project has impacted the daily lives of those most affected.

Thus aid policy developed from a care approach would understand health issues broadly, considering not only how HIV/AIDS fits within the larger health situation in a community, but also how that health situation both impacts and is impacted by the larger social, political and economic environment. It would move policy makers away from understanding the targets of aid as passive recipients and victims to see them as important partners in the aid process, emphasizing the need to build local capacity. However, beyond this a care approach would also bring an important critical perspective that is often lacking in conventional policy discourse. Rather than simply working to understand how to make the current global system work better for the poor and vulnerable, a care perspective encourages us to critically engage with that system and understand how it has led to a situation where so much of the world's health and wealth has been concentrated in the hands of so few.

As Robinson (1999) explains, the critical lens provided by a care perspective challenges us to “try to make sense of how personal and cultural and social relations can lead to exclusion and domination, but also how they may be shaped and reconstructed in order to promote solidarity, strength and well-being” (p.139). In order to do this Robinson argues that

we need to focus on the “permanent background to decisions rather than simply on the moral criteria for making decisions” (p.142). From a policy perspective we can think of this as going beyond the normal policy analysis of the pros and cons of a particular action to get a deeper understanding of the context in which a particular problem can occur. In practical terms this means a care approach to aid policy will strive “to make this poverty a part of the everyday lives of those who are, at present unaware of the way they may be affected by it” (Robinson, 1999, p.148). In many ways this creates a much more challenging task for policy makers. It is no longer enough for them to develop policies and programs that meet their stated objectives. They need to work to try and improve understanding among their citizens of how distant poverty and illness impacts them. The trade off of this extra work is the opportunity to reconstruct our social relations to promote the solidarity, strength and well-being that Robinson describes above and generate lasting solutions to these important problems.

At a more general level the critical aspect of a care approach to aid draws attention to how the very nature of foreign aid can help reinforce a global economic system where some countries are vastly wealthier than others. I discussed Hattori's (2003) ideas on foreign aid in an early chapter. He describes how the foreign aid system, where donors are seen to be giving to needy recipients, transforms the “powerful into the generous and the weak into the grateful” (p. 156). The net effect is that instead of eliminating inequalities, foreign aid actually reinforces those inequalities by “allowing donors to judge recipients and compelling recipients to shoulder responsibility for their own plight” (p. 155). Hattori argues that aid acts essentially as an unreciprocated gift, which reinforces the power imbalance between rich and poor states by morally indebting recipient states to generous donor states. Further he argues

that “the institutionalization of giving creates no incentive to change the underlying material hierarchy that allows donors to give greater gifts in the first place” (p. 157). Indeed, even the language of donor and recipient implies a one way process where the donor is the only one giving and the recipient only receives. Rather than acknowledging the systemic factors that have made foreign aid necessary and looking at ways to change the global economic system in order to reduce the need for aid, foreign assistance has tended to focus our attention on how much aid we give.

A care approach would certainly not do away with foreign assistance, but it would situate any flow of money or assistance in the context of a global system that accumulates wealth in the hands of a few and it would work to understand how that system could be reformed to more evenly distribute benefits and risks. It would also encourage policy makers to pay better attention to the connotations of the language they use in talking about global poverty and poor health. This may seem like a minor point, but language plays a powerful role in policy making. As Cornwall and Brock explain (2005), the use of buzzwords like participation and empowerment play a key role in shaping international development policy.

Cornwall and Brock (2005) examine how these words have been used in mainstream development policy, and in particular how they have been operationalized by both the World Bank and the UN to create very specific meanings and approaches to understanding and delivering development assistance. Cornwall and Brock describe how these words “do more than provide a sense of direction: they lend the legitimacy that development actors need to justify their interventions” (p.1044). Further, they argue that the fuzziness of words like participation and empowerment allow the World Bank to appeal to a broad audience, essentially creating a one-size-fits-all approach to poverty that “becomes the medium through

which diverse understandings of development are translated into targets, instruments and plans” (p. 1049). A critical perspective pushes us to pay better attention to how development buzzwords are used and how they are linked with other words to create very specific meanings that lead to very specific policy interventions, which Cornwall and Brock argue have been used in mainstream development policy to further a neoliberal agenda. From a practical perspective one way to counter this tendency to gloss over difference and bring more diversity to the policy development process is to make that process as inclusive as possible, taking special effort to include the voices of the vulnerable and marginalized.

Thus, the critical aspect of a care approach leads to a more encompassing approach to policy development that forces policy makers to consider specific interventions within their broader context, seeking to both understand how we got into a particular situation and how social, economic and political interactions can be restructured to reduce poverty and illness. Initially it may seem unrealistic to expect donor states to take on such an approach. However, as I move to look at some concrete examples from aid policy I will show how this kind of approach may not require as radical of a change to foreign aid as it may seem.

This starts to become clear by examining how the six elements of a care approach to aid that I discussed at the opening of this chapter might be operationalized in practice. The relational nature of a care approach would increase the need for openness and dialogue throughout the aid process. This is further underscored with the importance a care approach puts on examining issues in their broader context. It suggests a need to improve the dialogue and cooperation inside the governments of donor states between the various actors involved in global politics and an effort to provide a better balance between donor countries' aid, trade and defence objectives. This improved internal government dialogue should also help policy

makers be better aware of the consequences of policy decisions in one area on the policy outcomes in another, whether it is a trade agreement that increases unemployment or a national health system that relies on the recruitment of international health professionals. A care perspective would encourage interdepartmental collaboration inside donor states so that policy makers can have a better understanding of the larger context in which they are operating and be more aware of the consequences of their actions.

Inclusive partnerships in development would also make aid policy less reliant on expert analysis and more focused on working cooperatively with the targets of aid policies to develop the kind of programs they feel they need. Experts would still have a role to play, but it would be balanced with an emphasis on creating space for marginalized populations to express their needs and work with policy makers and program administrators to decide what they need to determine that an intervention has been a success. It would not be left up to the donor alone to determine if a project has been successful. There are aspects of these ideas in the three approaches to HIV/AIDS assistance I analysed in the previous chapter.

Translating Care into Practice

So far I have been talking about a care approach at a fairly theoretical level. However, by using the elements of a care approach to aid that I have already discussed as a lens through which to analyze the three aid approaches I examined in the previous chapter it will be possible to more clearly draw out what a care approach to aid could look like in practice.

A broad perspective

One of the components of a care approach that I have emphasized repeatedly in this and

previous chapters is its broad perspective, which seeks to understand issues in their larger context. Both versions of the British HIV/AIDS strategy emphasize the importance of understanding the disease broadly. Taking Action talks about the need to address the vulnerabilities of populations to HIV/AIDS and commits the government to “invest in social, cultural and economic research to understand how to best tackle the epidemic” (DFID, 2004). In this strategy DFID commits itself to link country level HIV responses to their Poverty Reduction Strategy Papers (PRSPs). While I did point out in the last chapter that the U.K. Auditor General cautioned DFID on this move because of the lack of HIV focus in these PRSPs, it does show that DFID clearly understands that HIV cannot be addressed on its own and needs to include action on broader social issues. Indeed, Taking Action clearly states that “dealing with AIDS will be ineffectual unless the underlying causes and impacts are tackled. Politics, the law, culture and social attitudes can all increase vulnerability” (DFID, 2004, p. 50).

Achieving Universal Access continued the British emphasis on understanding and addressing HIV broadly, talking about the need to take broad action that included education, justice and social welfare (DFID, 2008). Of course it is one thing to talk about the importance of these broader issues in a policy document, but quite another to actually translate that talk into practice. One of the concrete steps the U.K. Government has taken to help ensure a broad perspective in its HIV/AIDS policy is its use of an informal cross-Whitehall working group that brings together representatives of all departments whose work impacts HIV/AIDS assistance in order to keep all key government players informed of what each other is doing in this area. DFID points to the Department of Health’s adoption of a code of practice for the recruitment of international healthcare workers, which limits its heavy reliance on foreign

health professionals, as evidence of the importance of this collaboration (DFID, 2008, p. 60). As I discussed in the previous chapter, the U.K. has been widely criticized for its role in actively recruiting health professionals from countries already struggling with limited health resources and serious HIV/AIDS rates (e.g., Ingram, 2008; Eastwood et al, 2005; and Buchan & Dovlo, 2004), so any effort to reduce the nthis recruitment is welcomed.

From a care perspective this kind of collaboration is key to ensuring that those developing aid policy are better informed and can have some opportunity to influence and inform other parts of the government that might be impacting the success of HIV programs. Further, as I mentioned above, intergovernmental collaboration has the potential to provide a more critical perspective to aid policy, by bringing in voices that are not normally part of the policy development process.

Indeed, the U.K. government could make better use of its intergovernmental group than it is currently. The 2007 external review by Social & Scientific Inc. recommended the group be formalized with better defined roles and responsibilities for collaboration. These concerns were echoed in March of this year in a report by the House of Commons International Development Committee (2010). The Commons Committee was concerned that the working group lacked “sufficient authority or capacity to act as the main mechanism for monitoring the implementation of the U.K.’s Strategy,” recommending that the terms of reference for the group be clarified and suggesting that the group be headed by ministers rather than officials. These specific recommendations aside, a care perspective would certainly support doing everything possible to ensure that this kind of working group has the support needed to be as effective and collaborative as possible.

Interestingly, an element that would also help keep a broad perspective on aid that did not come up in any of the three HIV/AIDS initiatives is addressing what Robinson (1999) describes as the “permanent background to decision-making.” I know from my own experience of working over a decade in policy with several government departments that it is these important background questions that often get lost in the pressure for quick decisions. And, as we enter another phase of government downsizing and a significant retirement of experienced bureaucrats, it seems certain that more and more of the background to decisions will get lost in government policy. Of course Robinson is not just talking about understanding the actual history of decisions and choices in a particular policy area. She is also talking about critically engaging with the moral and ethical factors behind those decisions. While I can attest that this kind of engagement does occur inside government departments, it is not part of regular policy training and is not always encouraged by senior decision makers. Indeed, while bureaucrats may be able to include some of this type of critical analysis in their internal reports it certainly would not be considered appropriate to do it publically. This means that if a government is really going to embrace the kind of critical engagement of its own decision making that Robinson is talking about, it will need to cooperate with external government sources, most likely academia and policy think tanks to get it. The challenge is that in an era where governments seem to be moving more to close themselves off from public scrutiny it is not clear how willing they will be to open themselves up in this way. However, given that two of the three aid approaches I have examined here have subjected themselves to external reviews, there is hope.

Partnership

Creating inclusive partnership in aid agreements would also help broaden the perspective

of donor governments. Partnership is a word that tends to figure prominently in a lot of development policy but can be difficult to really put into practice. However, both the British approach to HIV/AIDS and the Global Fund have incorporated some interesting approaches to partnership that are useful for a care perspective. I have already discussed the British cross-government working group, but the British have embraced partnership in other ways. Taking Action lays out plans for the U.K. government to work with aid recipients and aid donors to help streamline the aid process of recipients and reduce the number of donor organizations and planning missions that recipient countries have to deal with. The strategy also commits the government to work with international organizations to help improve the coordination of donors and reduce the heavy administrative burden this places on recipient countries. It is not clear from either the Taking Action strategy or the follow up, Achieving Universal Access, how successful the U.K. has been in improving coordination and reducing the burden, but the simple fact that it is raising it as an issue is further evidence of its efforts to understand the challenges of delivering aid in a broader context.

Both U.K. strategy documents also talk about the need to include people living with HIV in their planning. Achieving Universal Access calls for “strong, inclusive planning and budgeting – with the involvement of PLWH [People Living With HIV] and other vulnerable groups” (DFID, 2008, p. 2). However, it is not clear if the government has been able to live up to this commitment in a meaningful way. It has emphasized the need to consult and be inclusive and has made several attempts to get feedback and input from key stakeholders, but vulnerable populations are not usually on that list. In 2009 the British Auditor General held up the major consultation DFID did with stakeholders in between Taking Action and the launch of Achieving Access as a government best practice for learning and being responsive

to the concerns of stakeholders. These consultations included representatives of domestic and international NGOs working on HIV/AIDS, academia, multilateral agencies and the private sector, but they do not appear to have included any representatives of those actually living with the effects of HIV/AIDS. While it is important to hear from NGOs working in the area, they cannot be a substitute for hearing the actual voices of the people.

As I discussed early in this dissertation, empowerment of vulnerable populations is a crucial component of a care perspective. Thus, it is essential that aid policy, “provide the opportunity and a safe space for others to express their 'otherness'” and “decide what aspects of their lives they want to include as part of the discussion” (Hankivsky, 2005, p. 35). A key first step of empowerment is creating a space to actually hear the needs and concerns of target populations and allowing them to decide what elements of the problem are important to them. If impacted populations are not included, or if it is assumed that their views can be expressed through local NGOs, an important opportunity to empower those people is lost and so is the chance to create truly responsive policy. As the value placed on creating good public policy has increased so has the reliance on technical experts in the policy development process. An ethics of care approach does value the insights of experts in the policy process, but it balances this with input from those actually living the reality of those policies, understanding them as experts in their own right.

The Global Fund's approach to partnership through its Country Coordinating Mechanisms (CCMs) provides a useful example of how it might be possible to better balance both of these important inputs. The CCMs are suppose to include representatives of all key stakeholders in the recipient country, including representatives from both recipient and donor governments, NGOs, affected communities, faith based organizations, the private sector and

academic institutions (Global Fund, 2007). I already talked about some of the criticisms of the CCMs in the last chapter such as a lack of monitoring inside some CCMs and their failure to meet representation guidelines suggested by the Fund (Brown, 2009; and Sherry, Mookerji & Ryan, 2009). However, these are not criticisms of the concept itself, but of its failure to live up to its promise. The idea of bringing together such a broad cross section of stakeholders to have direct input on the development and delivery of aid programs is intriguing and offers some important insights for putting a care model into practice. The CCM example demonstrates the challenges of bringing together a range of actors with differing levels of political clout and ensuring they all still have a voice in the process. Brown's 2009 study of the Fund's use of CCMs found that groups representing those affected by the diseases were the most likely to be excluded from local CCMs. Brown argued that these groups had been systematically excluded from CCMs and this exclusion reinforced the perception that the Global Fund is driven primarily by donor interests.

Even in cases where the CCMs have better representation they do not have final say over which projects get money. All final decisions are made by the Fund's board with the advice of a technical review panel. Thus, the CCMs influence is restricted to the parameters approved by the Fund, which does not really create the kind of space Hankivsky (2005) suggests is needed to allow marginalized groups to decide what aspects of their lives they want to include in the Fund's work, but it is a step in the right direction.

It is fairly easy to see how this idea could be adapted to help achieve a more caring approach to aid. Donor countries and recipient countries could cooperate to set up similar kinds of committees in recipient countries to direct and coordinate donor aid. Further, by building on the lessons of the Fund's use of CCMs they could ensure the representativeness

of the committees and avoid some of the challenges the Fund has faced. Ideally donor countries would respond directly to the desires of these committees to determine where to focus their aid and what kinds of projects to operate. However, if this was initially too big of a step for a donor country it could stick closer to the approach of the Fund, by suggesting the area where they would like to provide money, for example prevention programs for HIV/AIDS, and then getting the committee to develop and implement project proposals to be approved by the donor government. There would still be a lot of room for a donor country using this later approach to improve its responsiveness, but the ethics of care is about learning to care better, and even directed use of these kinds of committees would be a significant improvement over PEPFAR's rigid 33 % abstinence funding requirements. In using a care approach policy makers are not expected to get everything perfect the first time because "responding morally to others is a capacity which is learned" (Robinson, 1999, p. 46). What is important is that policy makers work to learn from their previous decisions and continually strive to be more responsive to the communities they are trying to serve. Inclusive coordinating committees based on a similar model to the Fund's CCMs could help in this process.

To help ensure the responsiveness of donor countries the composition of these committees would need to ensure, in Hankivsky's (2005) words, that "the voices of those who may be affected by policy decisions" are included. Further, while these committees should include a broad cross section of voices, from a care perspective it is essential that they "prioritize the voice of the people and in particular those vulnerable and at-risk populations, who have been and continue to be, disproportionately affected by globalization and its related policies and actions" (Hankivsky, 2005, p, 102). Therefore, we can imagine a donor country

seeking to embrace an ethic of care approach in its aid policy, setting up these kinds of committees to develop and coordinate programs in every country where it provides assistance. The committees would be made up of representatives from a broad cross section of stakeholders, but would be weighted to ensure that priority is given to those representing the groups most likely to be impacted by any decision. This larger national committee could be fed into by several local committees.

While this kind of weighting would certainly help ensure that those most impacted have a clear voice in these committees, it does not address the more fundamental challenge of the significant power imbalance that will continue to exist between the donor and aid targets. It seems like this would be especially true in cases of bilateral aid agreements where the donor is the only source of money. It seems unrealistic to imagine that donor states will surrender all control of how their aid money is spent to these types of committees and instead will want final say. Thus, these committees could help donors make more responsive and informed aid decisions, but the underlying power imbalance would remain. Part of the solution for this challenge could be to encourage donor states to flow more money through multilateral aid structures, like the Fund, where it might be possible to balance out the power relationships somewhat. However, making broader use of multilateral agreements may make it more challenging to help foster relationships between individual donor and recipient states.

There does not really seem to be an easy or perfect solution to this issue. As I discussed in earlier chapters, negotiating power and dependence is a central aspect of any care approach (Meyers, 1998). A care approach seeks to bring power imbalances and dependencies and the impacts of them to light. Thus, one way to help address this situation would be to push for maximum transparency around aid decisions, so if a government

chooses to ignore the recommendations of a CCM type committee, it is clear about why it has chosen to do something different. This might at least help hold donor government accountable and could generate public pressure for them to stick to their agreements. Really, as I have already said, the ethics of care is about learning to care better, so any move to create more responsive aid policy is a good thing. The key will be to keep pressure on donors to work to continually make their policies more responsive.

Returning to the early challenge I discussed that governments might have in critically engaging the moral background of their policy decisions, this challenge might be improved by setting up a similar committee inside the donor country to provide the government with overall advice on the direction of its aid policy and critically analyze its decisions to ensure it lives up to its commitments and continues to strive to become ever more responsive.

Flexible and built from the ground up

Recipient country coordinating committees would also help address the emphasis a care approach places on being flexible to the unique circumstances in a particular country and working to build aid programs from the ground up. The British approach has been credited with working closely with recipient governments to develop aid programs and giving a significant amount of autonomy to country level teams. However, as I mentioned in the previous chapter, this approach has also received some criticism both for not providing enough support and guidance to country level teams and for not being able to adequately track funds once they are given to recipient governments (Auditor General, 2004).

The first criticism is important from a care perspective because it helps illustrate that empowerment requires more than delegating decision making. A care perspective is

“concerned expressly with the actual outcomes and practical and material effects on people’s lives of making certain choices and decisions” (Hankivsky, 2004). Care must be provided competently, ensuring that those who make a commitment to take responsibility for a problem deliver on that commitment. Therefore, when the U.K. Auditor General found that key information on the latest research and best practice related to HIV/AIDS was not getting passed to country teams, it was a sign that DFID had failed to competently fulfill its responsibilities in providing aid. Remember that from a care perspective responsibility is supposed to be “addressed collectively through cooperation” (Robinson, 1999), which means that for a donor country to provide funds to a recipient and then stand back is a failure on the part of the donor to fully live up to its responsibilities. Aid needs to be delivered in true partnership and cooperation between both donor and recipient. Donors need to provide more than money, they need to work with recipients to ensure they have the support and resources required to meet local needs. Indeed, since the 2004 report, DFID has made efforts to provide more support and guidance to its country level teams, including setting up the AIDSPortal, an on-line discussion group to share knowledge and best practices and encourage opportunities for collaboration among country teams (Auditor General, 2009).

The Auditor General’s second concern, that providing budget support to recipient governments made it difficult to ensure that aid money was being used where it was supposed to be used, is more challenging. Donors have responsibilities both to their own citizens and the recipient country citizens to ensure aid money gets to where it is supposed to, but part of a care approach is also about helping others care better. Therefore providing budget support to recipient governments and allowing them the autonomy to use that funding to support HIV/AIDS and other health programs as they see fit, is important. One way to

balance these two issues might be to again use the Fund-style CCMs that I discussed above. Providing that these committees have strong representation from those most impacted by programs, they could help ensure accountability in aid funding while also allowing recipients the flexibility to build the programs they need.

The U.K. approach does not limit itself to providing funds only to governments, acknowledging that in some cases governments lack the capacity to effectively provide services to all their citizens. In these situations the British plan provides funding to NGOs to ensure that services are delivered effectively while it simultaneously works to build the capacity of the state (DFID, 2004). This approach is in-line with a care perspective.

I have touched on the issue of funding NGOs a couple of times in previous chapters. A care perspective is a broad and inclusive approach that would encourage the inclusion of many voices in the policy process. Hankivsky (2005) stresses the importance of “involving civil society, social movements and grassroots communities” to ensure the creation of responsive public policy. From a consultation and input perspective there is no question that a care approach would push for the inclusion of all relevant NGOs. However, when it comes to the actual delivery of services like healthcare, which would typically be the responsibility of the state, the role of NGOs in a care approach is not as straightforward. In the short term, if a state lacks the capacity to provide essential health services and a NGO is available to fill the gap, then a care approach to aid would encourage the funding of that NGO. A care perspective “places a responsibility with decision makers to optimally make resources available for care to proceed ‘as well as possible’ in terms of time, money and expertise” (Sevenhuijsen, Bozalek, Gouws & Minnar-McDonald, 2003, p. 316). In other words, decision makers need to ensure the best care possible in the circumstances, so if a NGO is

best placed to provide care then decision makers have a responsibility to fund it. Funding NGOs to provide services that are the responsibility of the state becomes an issue from a care perspective when it continues over the long term without efforts being made to improve the capacity of the state to provide those services because the ethics of care is also about enhancing the capacities of those responsible for providing care (Sevenhuijsen, Bozalek, Gouws & Minnar-McDonald, 2003). From this perspective the U.K. approach provides a good model by both working to build recipient government capacity to provide services, while also funding NGOs to ensure that services are delivered in the meantime.

Capacity building

Building local capacity is another key component of a care perspective. Recall that in the last chapter one of the major shortcomings of the Fund that I discussed was its failure to build local health system capacity in recipient countries by only investing resources to address very disease specific programs, which often resulted in an overall erosion of the local health system (Druce & Nolan, 2007; Farmer & Garrett, 2007; and Buse & Harmer, 2006). The Fund's own five year review found that its failure to address “the weakness of existing health systems critically limit the performance potential of the Global Fund” (Sherry, Mookherji, & Ryan, 2009). Once again the U.K. strategy provides a useful example for a care approach. As I mentioned above, it has provided direct budget support to recipient states, but has also made the support of local health systems and services one of the key priorities of its HIV/AIDS strategy, committing £6 billion to these investments between 2008 and 2015 (DFID, 2008).

For an ethics of care based health aid policy these types of long term investments are all

part of understanding health issues in their broader context. The success of HIV/AIDS, or any other disease specific intervention, is dependent on support for the health system at large. Otherwise policy makers could end up in the situation described by Ooms, Van Damme and Temmerman (2007), where there are no staff or facilities to deliver the disease specific programs. However, even more generally a care perspective would encourage a balance between specific targeted interventions and broader investments in the health and social system at large to build capacity and empower vulnerable populations to better address their needs.

Other examples from the HIV/AIDS strategies that I discussed in previous chapter which help illustrate what a care approach to health aid could look like in practice include the Global Fund's use of performance based funding. The Fund's approach may be limited in its narrow disease specific focus, but its efforts to ensure aid gets results does mesh with a care approach. From a care approach it is not enough just to take notice of a community in need and act to help them, that action must get results (Tronto, 1993). Once a funding proposal has been approved by the Fund it works with the local CCM to establish performance measures for the project. The CCM then gets the first half of the grant, only getting the second half if it has been able to successfully meet its performance targets for the first 18 months.

There is a lot in the model that is useful for a care approach. First, the Fund works with the CCM to establish performance measures. Of course for a care approach it would be essential to ensure that this be more than token cooperation and that the target population had real input in establishing the performance measures. A care perspective “would prioritize the voice of the people, and in particular those vulnerable and at-risk populations” (Hankivsky, 2005). It would not be enough for the donor just to consult the target population on the

performance measure it wants to put in place, a care perspective would use a democratic needs assessment to give the target population the lead in determining what it would need to consider the project a success. This democratic process would involve ongoing consultations with the target community throughout the process (Sevenhuijsen, Bozalek, Gouws & Minnar-McDonald, 2003).

The second part of the Fund's approach that is useful from a care perspective is that funding is contingent on actually achieving results. A care approach would not support just halting funding if performance measures were not being met, but would want to understand why the project is not getting results and would work with the target population to fix the problem. Where the Fund got into trouble with its performance based approach was the burdensome and complex process that evolved over time around it, losing focus on actual outcomes (Sherry, Mookherji & Ryan, 2009). This is why a care perspective places so much emphasis on working in partnership with recipients. Remember that responsibility is a cooperative process in a care perspective, so if something is not working then all partners involved need to work together to find a solution.

Responsive

Once the donor has information on what needs to be done it needs to respond to that information and make changes as necessary. Both the Fund and the British strategy provide good examples of how donor governments can be responsive to the needs of recipients and learn from their past mistakes. Even critics of the Fund have acknowledged that “what has always been impressive about the Global Fund is its ability to learn from critical evaluation and rethink its institutional practice” (Brown, 2009, p. 174). In the face of criticism that it

lacked representative governance at the local level and was not doing enough to get input from the local community, the Fund made changes to try to improve its representativeness and get more input (Buse & Harmer, 2006). It is still too early to tell how the Fund will respond to its recent external five year review, but even before the review was complete the Fund had already showed signs that it was moving to take a more comprehensive approach to funding health projects (Ooms, Van Damme, Baker, Zeitz & Schrecker, 2008).

The British approach provides even more concrete example of how donors can be responsive and learn to work better. As I mentioned in the previous chapter, the British Auditor General (2009) held up DFID's work around HIV/AIDS as a best practice for the rest of government on how to learn and respond better to the needs of stakeholders. The U.K. government went through an extensive review and consultation process between its first HIV/AIDS strategy, Taking Action, and the current strategy, Achieving Universal Access (Auditor General, 2009). In addition, the government set up the AIDSPortal that I discussed earlier, which provides an avenue for ongoing consultation and input from stakeholders both in the U.K. and internationally (Auditor General, 2009).

The limitation in both the Fund's and the U.K.'s efforts to be responsive is that neither of them have placed particular emphasis on input from actual target communities. Both strategies have made good use of external experts to conduct reviews of their strategies and have consulted with NGOs and other traditional experts on HIV/AIDS. However, a care approach would encourage a central part of any effort to learn from past initiatives include explicit consultation and input from the people actually being impacted by the programs. There is certainly some opportunity for target populations to give feedback to the Fund through the CCMs and the U.K. strategy through its review process, but neither has made

feedback from affected communities a clear priority in their review processes. Instead, both donors rely heavily on technical experts to guide their progress and decision making, through bodies like the Fund's technical review panel and DFID's regular use of external experts. As I mentioned earlier, the ethics of care does not exclude the use of experts, but the priority is put on the voice of target populations.

At various points in early chapters I have discussed some other approaches that come from a care perspective, which could be used to help increase input from target populations and improve the overall responsiveness of aid policy. In the domestic context Sevenhuijsen (2003) talks about the role of government as both a steward and supervisor of care “attuned to the various aspects of a policy of care on a macro level and actively advancing the attuning of caring processes on a micro level”. These two roles do not have to change significantly at an international level, except that a donor government would need to work cooperatively with a recipient government and a variety of local stakeholders to fulfil them. Here again the CCM model of the Global Fund could be adapted to enhance aid policy more generally, so that the local CCM would take on these steward and supervisor roles. Sevenhuijsen describes both a macro and micro role for the government, requiring it to be intimately aware and actively involved in both high level policy and actual care processes on the ground. Thus, a CCM will need to have very specific knowledge of how aid is actually being delivered and the impact it is having on local communities, which means CCMs will need to be in regular consultation with local communities. The broad and general policy expertise that experts can provide will be important, but in order to understand how the day to day realities of aid interventions are experienced by target communities the input of those communities is essential.

Civic engagement

The CCM model would also help achieve another aspect of a care approach, civic engagement. In the care approach to health aid I discussed in Chapter 3 I talked about the importance of building connections between donor and recipients states beyond the traditional intergovernmental relations. Linking back to Robinson's (1999) description of the relational ontology of the ethics of care and the emphasis it places on "the maintenance and promotion of good personal and social relations among concrete persons, both within, and across existing communities," I suggested that a care approach to aid would actively encourage the development of relations between citizens in donor and recipient countries, taking advantage of the many exchanges and Peace Corps type programs that already exist. These programs could help build important connections between donors and recipients and help make the suffering experienced in impoverished countries a part of daily reality of citizens in donor countries, while at the same time potentially building capacity on both sides to better understand and cooperate with one another.

None of the three aid programs I have discussed here addressed any specific role for civic engagement, although I think the Fund's CCM model could be a potential avenue for building engagement. While I have expressed reservations about funding NGOs to provide services normally considered the responsibility of the state, NGOs do have a key role to play in helping build civic engagement between rich and poor states and creating space to explore new kinds of cooperation and exchange. CCMs type bodies could be an important avenue to include NGOs and other civil society organizations in the aid process, as well as opening up new avenues for interaction between these civic organizations and other stakeholders in the aid process. Further, if CCMs are set up in such a way as to ensure strong representation of

target populations, they could also help create space for direct exchange between vulnerable groups and donor and recipient government representatives, thereby improving civic engagement on the recipient side. Finally, if CCMs were set up in donor states to help guide overall national aid policy, they could also help build civic engagement in donor states by giving regular citizens the opportunity to directly engage with aid policy and the potential to interact with citizens in recipient states, all of which would enhance the development of concrete social relations both within and between donor and recipient states.

Long term

Building civic engagement in the aid process and helping create concrete bonds between people in both states could also help ensure that donor states stay committed to recipients over the long term. Long term commitment was also something I talked about in chapter 3 when I laid out my care approach to health aid at the theoretical level. There I outlined the importance of establishing long term commitments to provide aid funding in order to have time to build effective partnerships between all key stakeholders involved. As Sevenhuijsen (2003) explains “dealing with dependence demands, in short, time and space to develop and sustain trust.” If donors are constantly shifting funding and focus around from program to program and country to country to meet changing political whims, it will be impossible to create any real trust or partnership in recipient countries. Trying to fight poverty and disease is difficult and hard work, all the more so when it involves partnerships that cross cultures and countries. Therefore, in order to be effective and create a climate where vulnerable populations feel safe to express their concerns, it is essential that when donors become involved they make a commitment to stay until all major objectives are complete.

Interestingly, different aspects of the Fund's approach provide useful examples of both the problems that can arise in not taking a longer term approach and the benefits of a longer term perspective. As I mentioned above, part of the Fund's performance based funding involved requiring grant recipients to meet specific performance targets in the first 18 months of the grant in order to get the rest of the money. Critics point out that this short timeframe means that there is little incentive for grant recipients to make longer term investments in the health system that will not show evidence of significant improvements for a few years (Druce & Nolan, 2007; and Bruce & Harmer, 2006). In order to show the value of their programs, grant recipients have focused on getting quick wins, which, in some cases, has actually resulted in decisions that have worked against the longer term effectiveness of their programs (Druce & Nolan, 2007). On the other hand, the Fund has been applauded for its approach to aid sustainability, which has the potential to allow recipient countries predictable access to money over a much longer term than aid programs that rely on a more conventional approach to sustainability.

There is nothing preventing national donors from taking a similar approach to aid sustainability, by understanding that aid requires a long term effort and providing recipients with longer term commitments to predictable funding. Pairing this commitment with a CCM type body to monitor and administer the funding could help donor countries ensure that aid money is used where it is supposed to be used. At the same time, the Fund example also shows the potential dangers in creating incentives for recipients to focus on and getting short term results. Being able to quickly show that aid money is having an impact is important to maintain commitment from all stakeholders, but these quick wins need to be balanced with longer term objectives and measures.

I have used a lot of examples from the Fund in this chapter, some showing what not to do, but many as examples of the kind of policies that could be used from a care perspective. The majority of the Fund's shortcomings have come more from a failure to fully apply the principles of the Fund, rather than an inherent problem with the approach itself, which is why I think the basic premise of the Fund could be adapted into a global health fund, similar to what Ooms and his colleagues (2008) describe. This global health fund, provided it addressed the limitations of the Fund I have already discussed, could help support a more caring approach to global health aid. Moving away from the disease specific focus of the current fund, a health fund would be able to take a broader approach to aid and make the necessary investments to help reduce vulnerabilities to HIV/AIDS. Further, if the new fund ensured a stronger voice for target populations in local CCMs, it could help both build local capacity and create more responsive aid programs. This is not to say that the Fund's approach is a care approach, but there are aspects of it that could help create more caring aid policy. Of course the major challenge that any health fund would face is the same one the current Fund faces, which is ensuring continued funding from donors. Indeed, even in their suggestion to expand the role of the Fund, Ooms and his colleagues warn that it will need to attract a lot more money than it currently does to make this happen. Thus, while a global health fund, which improves on the format of the current Fund, could be part of care approach to aid, it is not clear it will be able generate enough support from donor governments to make it happen. A government using a care approach to aid may want to advocate expanding the role of the Fund, but if it really wants to help ensure a more caring approach to aid, that government will have to start with its own aid policy.

Special focus on the vulnerabilities of women and girls

The final element of a care approach that comes out of my review in the previous chapter is a particular focus on the impact of HIV/AIDS on women and girls. HIV/AIDS is now the leading cause of death and disease among women of reproductive age worldwide, and recent report by UNAIDS (2010) paints a frighteningly clear picture of how women's marginalization in many societies around the world makes them especially vulnerable to the disease and its many negative social, political and economic side effects. According to UNAIDS "up to 70% of women experience violence in their lifetime," making their ability to negotiate sex, let alone protected sex, next to impossible in many circumstances.

Feminist scholarship refers to this idea of overlapping and interacting levels of discrimination and subordination as intersectionality (Norris, Zajicek & Murphy-Erby, 2010; Ravnbol, 2010; White, 2007; Yuval-Davis, Anthias & Kofman, 2005). They suggest that we all have multifaceted identities and that various aspects of our identities can attract discrimination on their own as well as when they intersect with other facets of our identities, which creates another layer of discrimination (Norris, Zajicek & Murphy-Erby, 2010). Put simply, "intersectionality can be defined as the meeting point and overlap of roads of racial, gender, class and other forms of discrimination" and describes "the situation where several grounds of discrimination operate at the same time and cause a violation of the human rights of minority women" (Ravnbol, 2010, p.38). In the case of HIV/AIDS, we can see how women face multiple, intersecting streams of discrimination based on poverty, gender and often ethnicity. For example, their poverty can push them into a situation where they may need to use sex to secure enough income or resources to survive, while at the same time their gender and low social status makes it difficult, if not impossible, for them to negotiate safe

sexual practices in those interactions, risking their exposure to HIV/AIDS, which can in turn subject them to another level of discrimination. If we try to address any of these challenges on their own without understanding how they intersect we risk not only failing to prevent one form of discrimination, but we could actually put the women into a more dangerous situation, such as provoking violence from an intimate partner when trying to negotiate safe sex practice because the partner interprets this request as a sign the woman is cheating.

Of the three approaches I reviewed PEPFAR places the most focus on the vulnerability of women and girls to HIV/AIDS. However, as I showed in the previous chapter, its rigid adherence to an ABC approach to prevention and its failure to tackle the broader economic and social factors that create vulnerabilities to HIV/AIDS make it incompatible with a care approach. Essentially, the U.S. approach fails to address the intersectional reality of discrimination that women face in many recipient countries. These women face challenges from being poor, they may face challenges from being part of a minority group and they face challenges from a patriarchal system that disempowers them, does not give them option to negotiate many of their interactions in life and expects them to shoulder the burden of care.

A care perspective would support the American focus on the vulnerability of women to HIV/AIDS, but it would go much further to understand how broader social, economic and political factors contribute to their vulnerability to the disease and its consequences. A care perspective would engage with vulnerable women and work with them to develop policy responses to HIV/AIDS that meet their needs, instead of trying to impose prevention strategies on them as PEPFAR has done. Further, a care perspective would look at how women's roles as primary caregivers puts them at risk of being further marginalized as a result of HIV/AIDS outbreaks. In early chapters I discussed research that shows how

government budget cuts to health and social services, the migration of health professionals and increased demand for care as a result of HIV/AIDS have combined to put immense care burdens on women (e.g., O'Manique, 2006; Tiessen, 2006; Upton, 2006; and Zimmerman, Litt & Bose, 2006). These burdens exacerbate gender hierarchies, pushing vulnerable women further into the margins of society (Upton, 2006). Aid policy from a care perspective would bring these issues to the fore and work with those women to develop effective policy responses.

Summing Up

As I have demonstrated in this chapter, the British, American and Global Fund responses to HIV/AIDS provide a lot of useful examples of the kinds of policies that could be used to create a more caring approach to health aid and aid in general. The Fund's use of CCMs, its efforts to ensure aid interventions get results and its efforts to create more predictability around aid money are components that could be made to work from a care approach, as could the attention PEPFAR gives to the vulnerability of women and girls. There is also a lot from the U.K. approach that is helpful, including its broad perspective and efforts to build local capacity, cross government cooperation and learn from its past. Taken together all of these examples give us a better picture of what an ethics of care approach adds to aid policy and practice.

If a donor country were to put all of the elements into place that I have discussed in this chapter it would have an aid policy that included aspects of the three major strategies I have discussed here, but these components would be put together in way that would create a more responsive and caring policy than any single foreign policy currently in use. Internally, the

donor government would have a formally established cross government working group, similar to the British example but with more clearly defined roles and responsibilities and more authority to make decisions. This interdepartmental group would bring together representatives from all departments involved in or impacting foreign aid. It would facilitate internal collaboration and cooperation as well as provide decision makers with a broader perspective on how their decisions impact aid outcomes and vulnerable populations. The donor government's decisions would be informed by local coordinating committees inside aid recipient countries, modeled after the CCMs used by the Fund, but with measures in place to ensure that these committees have a strong voice from the vulnerable populations most heavily impacted by aid programs. These CCMs would be empowered to develop and deliver aid programs funded by and supported by the donor country. The donor government would also have a similar CCM body at home to help guide the donor's overall aid policy and ensure it meets its commitments. The donor country would work with the local CCM and the target community to establish performance measures and outcomes based on what the target population deems is necessary for the intervention to be considered successful. Once in place, all three parties would work together to actively track the success of programs and make adjustments as required.

This decision making process would be a departure from conventional models of public policy decision making like rationalism and incrementalism. These models present internal approaches to government decision making, either through a very rational evaluation of alternatives, or more of a bargaining and compromise between various players and options (Howlett & Ramesh, 1995). In contrast the process I have described is much more open and public, with a significant effort to actively include target communities throughout the

decision making process. There will still certainly be bargaining and compromise involved in the care model I have presented, in fact there would likely be a good deal more negotiating because of the much broader spectrum of people included in the decisions making process. At the same time, policy makers could still evaluate alternatives in an effort to find the optimal policy outcome. However, these results would be balanced against input from target communities. The key difference in the decisions making process using a care approach versus conventional models is that a care model is much more collaborative than conventional models. The trade off from this more inclusive and collaborative process is that it is likely to take longer and require more effort than conventional models. Thus, decisions made using the model I have suggested here would likely be slower than those made by a more conventional approach. However, they should also be more responsive to the needs of target communities, which means in the long run they will hopefully result in better policy outcomes.

Returning to the specific policy interventions a donor country would employ if it followed the approach I have presented here, the donor country would work to establish longer term commitments to recipient countries based on what the donor, the CCM and the target community decide together needs to be achieved. Once in place, the donor government would use this commitment to help establish funding predictability for recipients. While aid would be directed by local CCMs, it would work to help build local capacity and create the space and opportunity to empower local communities to address their concerns in the ways they want. The donor government would also work with all of its partners to maintain a broad perspective on the issues it is seeking to address, looking to understand how larger social, political and economic factors contribute to more specific problems of poverty and

poor health. At the same time, the donor government would also work with local CCMs to keep abreast of the particular challenges faced by women and girls as a result of HIV/AIDS. Finally, the donor country would follow the lead of the British and commit itself to regular independent reviews of its aid programs and policy, and take action to address any shortcomings.

Thus, if donor governments were to use all of these examples they would end up with a responsive policy for HIV/AIDS assistance based on the needs and desires of target populations. This is not the only way aid could be approached from a care perspective, or even necessarily the only way to adapt current aid practices to make them more caring, but it does give us a better picture of what a care approach to aid could look like in practice. What is encouraging from these examples is that the roots of these policies are already in place in the HIV/AIDS interventions currently in use, making it clear that a more caring approach to HIV/AIDS is possible and achievable. As I have already said several times, the ethics of care is about learning to care better. Policy makers are not expected to get everything right the first time but they do need to work to continue to care better and continue to create more and more responsive aid policy. In fact, it is only through learning and working together that we can expect to make improvements. This is why I have chosen to use examples of policies already in place in current aid practice to show what is currently being done and how it can be changed to be more responsive and effective. It will take some work and reorientation of current practices, but the fact that aspects of this approach are already being practiced shows what can be done.

Much of the care approach I have described has been based on bilateral arrangements between a donor and a recipient state. A single donor country using a care approach to

develop its aid policy could have an important impact, but obviously a care approach would have more impact if it was employed more generally across multiple donor and recipient countries. Certainly if donor countries were to focus more on longer term aid arrangements, it would be important for there to be some coordination between donor states to ensure aid from multiple countries does not get concentrated in the hands of a few states. Similarly, the way the U.K. model suggested trying to coordinate donors in a particular country so that recipient governments are not overburden trying to administer aid agreements with multiple providers, also suggests a need to coordinate at a more local level. These arrangements could be done informally through groups like the G8 or G20, but they would be more open and likely have a more balanced perspective if they were done through the UN with recipient countries able to provide input. I do not think that these kinds of new supranational institutions or agreements are necessary for a care approach to be effective, but if a care approach were eventually to be used more widely in foreign aid policy, it is something to consider.

Conclusion

Throughout this dissertation I have worked to demonstrate the value of applying an ethics of care approach to the study of global health and development. At the theoretical level I showed that an ethics of care approach uncovers the limitations of conventional ethical perspectives on aid, which rely on abstract rationality and treat people as independent actors. In contrast, the relational perspective of a care approach brings to light the important interactions and relationships that help explain the broader context in which poverty and poor health occur. It also pushes scholars away from abstract discussions about duties and obligation to focus on the concrete reality of vulnerable populations struggling with disease and inequality. This focus on the concrete leads to a better appreciation of the value of responsive policy making and creating real, inclusive partnerships with target populations. Dealing specifically with the example of health aid, I demonstrated how a care perspective is able to highlight the intrinsic value of health and its important interconnection to other development issues without relying on contested rights claims or vague and potentially misleading security language.

At a more practical level, an ethics of care perspective gives policy makers and practitioners a broad understanding of the political, economic and social context in which specific aid challenges occur. It helps create the space and opportunity for vulnerable populations to engage with donors as integral partners in the development process and thus results in programs and policies that respond directly to the needs of the community. Further, my review of current HIV/AIDS policies used by major donors showed that implementing ethics of care based programs and policies would not require as significant of a shift as one might have initially thought.

In my first chapter I made the case for why we need a care approach in the study of the ethics of aid by both highlighting the limits of conventional approaches to the ethics of aid and the promise of an ethics of care approach. In particular I focused on the limitations of the abstract rationality of conventional approaches that divorce ethical problems from their context. I further discussed how the attempt by conventional approaches to separate ethics from politics ignores the ethical assumptions embedded in politics, cutting them off from analysis and leading to a narrow understanding of both politics and ethics. This chapter also exposed how the appeal that conventional approaches make to universal principles and a notion of equality based on sameness leaves no room for difference and thus excludes those that are different, who are often the most vulnerable and marginalized members of a society. Finally, I discussed how a conventional understanding of individuals as independent actors neglects all the support and caring required for individuals to act autonomously and creates the impression that individuals are completely responsible for their own lot in life. In contrast to the limitations of conventional approaches I showed the promise of an ethics of care approach, demonstrating how its relational ontology and its emphasis on responsibility, responsiveness, attentiveness and competence leads to more responsive policy that better meets the needs of target populations.

The dissertation tightened its focus on global health in Chapter 2 by reviewing three of the most common approaches to health in the global health and development literature: health as a driver of economic growth, health as a human right, and health as a security issue. Economic approaches help garner support for investing in health by demonstrating the link between good health outcomes and economic growth. However, they take a very instrumental view of health that risks creating support for health interventions only as long as

they improve economic growth. And, while there is good evidence to support the idea that better health outcomes can improve economic growth, these economic approaches have tended to ignore that in many cases neoliberal economic reforms have actually eroded the health of the most vulnerable members of society. In addition they rely heavily on expert analysis, leaving little room for community input.

Human rights approaches to health help expose the limits of an instrumental view of health in economic approaches, but by appealing to weak and contested global rights, these approaches have a tendency to get stuck trying to justify why we have rights to health rather than actually getting down to the work of making these rights a reality. In Chapter 2 I also looked at the value of security approaches to health and some of the important contributions they have made to our understanding of the broader impact of health on a country's stability and development. However, the power these approaches gain by framing health as a security issue also works against them because of the highly contested nature of the concept of security in global politics. Indeed, as I showed in that chapter, even among security approaches to health there is a lot of debate over what constitutes a security issue and whose security matters. As well, security justifications for health, much like economic justifications, risk creating policy interventions that only work to improve health to the extent it protects national security. Lastly, I showed how the language of security and the state resources it mobilizes are often not appropriate for addressing many health problems.

In contrast to these three approaches I used Chapter 3 to build an alternative, ethics of care approach to health aid, which analysed health issues in their broader political, economic and social context, emphasizing the importance of real and inclusive partnerships with recipient communities that build local capacity and are based on democratic methods of

evaluation. This care approach leads to more community driven policy responses than economic approaches to health and better demonstrates the value of analyzing the broader context of health problems. Further, by focusing on making concrete improvements to the lives of target communities it can help lay the groundwork for the better achievement of health rights. In addition, a care approach is able to show the broader value of health without using a contested security language.

Chapter 4 examined three of the most significant aid initiatives currently under way to address HIV/AIDS: the American President's Emergency Plan for AIDS Relief, the British government's HIV/AIDS strategies and the HIV/AIDS aid delivered through the Global Fund. The purpose of this chapter was to understand how these three initiatives have approached HIV/AIDS relief in order to examine what an ethics of care approach could bring to HIV/AIDS policy. While the U.S. effort has mobilized a massive amount of resources to address HIV/AIDS, its rigid, top-down and morally conservative approach has reduced its effectiveness and responsiveness to local needs. The British government has taken a more comprehensive approach to HIV/AIDS relief than the Americans that is flexible and has made a genuine effort to get local input, while at the same time opening itself up to external evaluation. However, despite these efforts, it is still largely expert driven and it remains unclear how much real input those most impacted by HIV/AIDS have had in the process. The Global Fund's multilateral approach is the most unique approach to HIV/AIDS of the three, bringing together donor and recipient governments with members of the private and non-governmental sectors and affected communities. This approach has the potential to create very responsive aid programs, but is hampered by its disease specific focus, which failed to build long term capacity in target communities.

By examining these three approaches through an ethics of care lens I was able to show how aspects of each of them could be adapted to create a more caring policy response. Chapter 5 used the care approach to health I developed in Chapter 3 to demonstrate how the large response of the Americans and their emphasis on targeting programs at women and girls, could be combined with the broad and coordinated policy response of the U.K. approach and the inclusive approach of the Global Fund to create the foundation for an ethics of care approach to HIV/AIDS relief. What is encouraging about this finding is that it shows that a more caring approach to aid does not necessarily require a drastic and immediate departure from some of the practices already in use by major donors. The move to developing more caring and responsive aid policy can start by building from these practices.

Before beginning this research I was uncertain about how easy it would be to apply an ethics of care approach to the actual practice of foreign aid. Work by scholars like Robinson (1999) and Held (2006) clearly demonstrated the value of a care perspective as a theoretical lens for understanding global politics and hinted at its potential contribution for development and aid, but it remained unclear what exactly a care approach to aid might look like and how significantly it would change aid policies. By building on their work, as well as work by care scholars at the domestic level (e.g., Hankivsky, 2004; and Sevehuijsen, 1998) my study was able to address part of this gap and illustrate how a care approach could change the way specific aid programs are delivered. In this regard my work has been able to contribute to global politics by expanding its understanding of the importance of the ethics of care both as a tool for analyzing aid policy and developing new policies. This study is the first to apply an ethics of care approach to the study of global health aid and the first to look at the concrete way it could change the way HIV/AIDS relief programs and policies are developed and

delivered.

I also believe I have been able to contribute to the global health and development literature by analyzing and comparing approaches to health as a rights issue, a security issue and an economic issue and demonstrating the value of using the ethics of care to create an alternative approach to health. Similarly, my analysis and comparison of the U.S., U.K. and Global Fund's approaches to HIV/AIDS has not only been able to shed new light on their policies, but also how their policies could be improved by adopting a more caring approach.

Finally, by using examples from current aid policy I have been able to demonstrate that aid policy developed from an ethics of care perspective is possible and can be achieved by adapting existing aid policies. This may seem like a relatively minor point, but demonstrating that a care approach to aid could be enacted without creating major changes to aid policies already being used in the world is crucial to helping expand the use of the ethics of care. Policy makers can make more responsive aid policy and can create the space to empower vulnerable populations to build the kind of aid policies they feel they need by building from examples already in place. The ethics of care is not an approach that only looks nice in theory but is too hard or too demanding to actually put into practice. It provides policy makers with the opportunity to make some important changes in the way they approach aid and aid recipients by working from policies already in practice.

Of course, one of the limitations of my research is that it assumes that policy makers want to make more caring aid policy and give recipients more say in the development process, when the reality is that aid is given for all sorts of reasons, not all of them altruistic. In situations where aid is given for ulterior motives an ethics of care approach to developing

aid policy seems less relevant. However, while this is an important limitation to my research it does not devalue the usefulness of a care approach as a tool for analyzing policy. In fact the broad and critical perspective of the ethics of care is likely to be quite helpful in exposing the true motivations behind some aid programs. Further, just because policy makers may not always be driven by humanitarian motives when they are giving aid, does not mean a care approach is not useful for building aid policy. Even if initially it were only applied in situations where the objective of aid was clearly humanitarian the very nature of the policy tools a care approach uses to empower local communities and create an open and responsive policy environment, could help spread the demand for more care based aid policies into other areas of aid, both by helping expose the various motivations behind foreign aid and empowering recipients to demand increasing input into how aid money is spent.

Another potential limitation of the care approach to aid I have described here is that it requires donor countries to give up some control over how their aid money is delivered. This would be particularly true if donors established Fund-style CCMs as I recommend in Chapter 5, which would require donors to share their decision making power with a broad cross section of stakeholders. Donors may not be particularly comfortable with this idea as it may limit some of the usefulness of aid as a foreign policy tool because they are no longer able to exert direct control over how aid money is spent and where it is directed. While this could limit the attractiveness of a care approach as a method of developing and delivering aid policy and programs there are ways to work around this potential challenge. First, an ethics of care approach is about learning to care better and creating ever more responsive public policy, so donors would not be expected to immediately leap to the CCM model, where a multistakeholder committee makes all of the decisions about how aid money is spent. A

donor could stick more closely to the Fund's actual model and use CCMs to develop proposals and deliver aid programs that the donor approves. Over time, as all sides get more used to the process and build more trust the donor could gradually shift more and more control over to the committee. Second, the promise of care is that by engaging and empowering recipients to create the kind of aid programs they feel they need, donors will get more support among the community and can expect more effective aid policy, which over the long run will hopefully lead to less need for aid. Thus, while a donor may have to be more inclusive in developing aid policy and so sacrifice some of their control over the process they can do this gradually with the promise of more effective outcomes as a result.

The importance of learning to care better is one of the key implications from my research because it means that donors do not have to get it all right from the start. By embracing a more responsive policy process donors and recipients can learn from each other how to improve the aid process. This means that donors taking on a care approach do not necessarily have to immediately make radical changes to the way they deliver aid. Instead they need to continually work to make aid policy more responsive, which should make a care approach less intimidating for policy makers. At the same time the emphasis on learning means that ongoing evaluation based on democratic assessment methods will be a vital component of any aid initiative.

The emphasis on learning also has the potential to significantly change the traditional donor-recipient relationship. Instead of the relationship always being about the donor needing to give more money and resources to the recipient, all players would have a responsibility to work together to see how they can help improve the process. A care approach creates the space to allow recipients and donors to take responsibility for their roles in the process in an

inclusive partnership. The ability of Western donors to create inclusive and effective partnerships with recipients could also become important as China's influence starts to grow in the area of foreign aid.

Many commentators have raised concerns about China's approach to foreign aid, which has tended to be much less concerned about the human rights records of recipient states than Western donors. While I suspect that much of this concern is driven more by worries about loss of Western influence and access to important natural resources than true humanitarian motives, a care approach to aid might be able to help encourage more of a caring approach across all donors. Just as there have been concerns that China's approach to aid could put pressure on other donors to loosen up their restrictions on aid in order to maintain or get access to natural resources, I believe it is also possible that if one donor adapts a more caring approach to aid it could create pressure on other donors to do likewise. As recipients get used to having more influence in the decision making process and the aid programs delivered become more responsive to target communities, it seems likely that recipients will expect other donors to do likewise. There are obviously limits to how much pressure recipients can put on donors seeing as donors are the ones with the money, but if a care approach is seen as a more fair approach to aid, it could create broader public pressure on donors from NGOs and their own citizens to move in that direction.

The impact of an ethics of care approach to aid on the larger foreign aid system is one of several interesting questions that require further research. There is a lot still to understand about how the ethics of care could change the way foreign policy is developed and delivered. I have only been able to begin to look at how an ethics of care approach would impact aid policy, but it would be equally intriguing to look at how it would impact other areas of

foreign policy, like trade or security. In many ways aid policy was a logical place to start when looking at a care approach because it deals with some of the similar topics that other care scholars have looked at in a domestic setting, including poverty and health, but care has implications for global politics beyond aid. How would a care approach change trade policies? What impact would it have on the way we think about security and what would it add to other critical approaches to security?

These are all important and interesting questions that were beyond the scope of my current research, but would make worthwhile future research. It is my hope that my research, while only looking at one aspect of global politics, has helped show the value of looking at the ethics of care in global politics and will inspire others to continue to expand the study of the ethics of care into more and more areas of global politics.

Beyond the use of the ethics of care in global politics another important research question that I think needs more attention is how an ethics of care approach changes traditional understandings of bureaucratic accountability. This may not sound like all that interesting of a question, but it does have some important implications for how Western democratic governments are organized. The whole notion of responsive policy making encourages policy makers to become increasingly responsive to their target communities, which implies a very grass roots or bottom-up approach to policy and program development. However, at the same time public servants are expected to follow the direction of the democratically elected government, which means public servants working to create responsive public policy could get caught between the input they get from the community and the direction coming from the government of the day.

In practice there is little choice for a public servant in this situation: if she wants to keep her job, she follows the direction of the government, but it does raise some interesting questions about how to balance government priorities with community priorities in order to create responsive public policy. In situations where the pressure from the community is significant or the community has significant political power, it is likely that the government will bend to the community's will so that it does not appear unresponsive. However, if the community in question is not very politically powerful, which is the case for most vulnerable populations, the government is unlikely to change its priorities. This is not a problem unique to the ethics of care. There is growing pressure on governments to be more consultative and collaborative when they develop public policy. However, given the high priority a care approach puts on responsive policy making and the special concern it has for vulnerable groups, it is an issue that care scholars in particular need to examine.

There is still a lot to understand about the implications of an ethics of care approach for global politics. Through my research I have shown the important insights it offers to the study of foreign aid policy. An ethics of care approach to building aid policy has the potential to improve the way aid programs are developed and delivered. It promises to create more responsive policies through a process that gives space for vulnerable populations to express their needs and empowers them to create programs that meet those needs. As I have shown with the case of HIV/AIDS relief, a care approach does not always require the development of completely new approaches to aid policy. A care approach can be built from policies already in use. It is achievable. It will be a continual learning process, but by working together a care approach can help donors and recipients make more caring aid policy that responds to the needs of vulnerable populations.

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