

Understanding the politics of national HIV policies: the roles of institutions, interests and ideas

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- In many contexts, politics, ideology and ignorance have greater influence on HIV policy than do evidence and best practice
- Despite the political nature of HIV policy, there is surprisingly little published analysis of the political determinants of HIV policy in low- and middle-income countries
- The literature suggests that no single determinant can explain HIV policy but that it emerges from a unique interaction and configuration of institutions, ideas and interests
- Analysis which identifies the political obstacles and opportunities to evidence-informed policy should constitute a core feature of every national HIV response



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1. Introduction: politics matters

As a disease associated with sex and illegal drugs, HIV has from the outset been highly politicised. In many contexts politics, ideology and ignorance have proven more influential on policy than epidemiology or technical best practice. Despite this, there has been limited analysis of the political determinants of HIV policy formulation and implementation.

Unprecedented levels of resources have been mobilised for HIV and AIDS and significant advances have been made in treatment access, but overall the global AIDS response remains off-track – with 7000 new infections recorded daily. Prevention policies and messages in many contexts are still not targeting people most at risk, and laws and regulations continue to stand in the way of effective policies (Piot et al., 2008). Political commitment is voiced at international meetings, yet leadership to address the prejudice and stigma, particularly directed at most at risk populations, is wanting.

Why are many HIV policies out of tune with the requirements of the epidemic and why do the more appropriate policies fail to perform as expected? Answering these questions involves understanding more about the way in which problems are defined and agendas are set, the processes through which ideas and knowledge become policies, and the demands and incentives facing decision-makers. We examine the interactions among institutions, interests and ideas in HIV policies in low- and middle-income countries (LMIC) to get a better sense of what has led to particular policy outcomes. This is done through a review of 28 peer-reviewed articles reporting on empirical studies of policy change. The findings can help advocates and policy-makers take more strategic decisions about future policies and their implementation.

2. Making sense of politics in national HIV policy processes

Policy-making is not just about a particular decision made at a certain point in time but needs to be understood in the context of ongoing interactions and conflicts among **institutions** (the structures and rules which shape how decisions are made), **interests** (the groups and individuals who stand to gain or lose from change) and **ideas** (discourses, arguments and evidence) (John, 1998).

This approach to understanding policy suggests that it is inherently complex and that history, and people's often conflicting values and interests, are often the main drivers as change is contemplated (Figure 1).

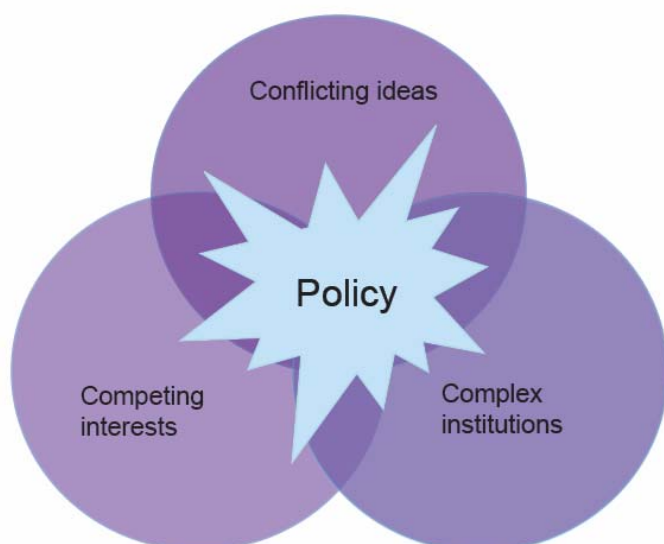


Figure 1: Influencing policy: a conceptual framework for understanding the interplay between ideas, institutions and interests in policy processes (Buse et al, 2008)

Our review considers policy at various stages (agenda setting, formulation and implementation) and uses John's conceptualisation to identify and explain the factors which account for national HIV policy responses. In reviewing the literature we attempt to answer the following questions:

- Which institutions, interests and ideas account for HIV policy change?
- Which actors are typically involved in policy development?
- What incentives underpin policy positions?
- What political strategies and tactics have been employed to drive policy change and with what effect?

3. Our approach and observations on the use of policy analysis in HIV policy literature

We reviewed a set of peer-reviewed papers relating to HIV policy change and implementation which had been pre-identified through a wider literature review of health policy analysis (Gilson and Raphael, 2008). The wider review searched for health policy papers through two electronic databases (IBSS/BIDS and PubMed) using the inclusion criteria outlined in Box 1. We are aware there are limitations to this approach, particularly the exclusion of non-English and non-peer reviewed material, book chapters and reports. We are also aware that more material is available but our main interest in adopting such a circumscribed search was to pilot test the conceptual framework of institutions, ideas and interests and to ascertain its usefulness in reviewing the wider literature at a later date.

Box 1: Inclusion criteria and short listing process for selection of papers

- English language
 - Published Jan. 1994 – Dec. 2007
 - Contained an empirical component;
 - Included descriptive and analytical studies; Largely acceptable methodology (e.g. clarity of research questions, a systematic approach to data collection and analysis, adequately describing context, persuasive analytical approach, identifying and explaining limits, situating in wider literature).
- Short listing review process included studies that:
- Examined factors influencing process of HIV policy change;
 - Related to low- and middle-income countries;
 - National level or comparative national focus;

Broad results

We identified 28 papers which met our inclusion criteria, and subjected these papers to detailed analysis (the key features of each paper are detailed in an Annex.¹) A number of broad observations can be made about the set of papers reviewed:

- Studies that use policy analysis to examine HIV policies in LMICs remain limited in number in the peer-reviewed literature.
- The geographical focus for the majority of the literature is East and Southern Africa (primarily South Africa, Botswana and Uganda) though papers from Asia (India, China and Thailand) and Latin America (Brazil), and a number of multi-country studies have also been published.
- The policy areas analysed are diverse: at least three papers discuss the general socio-political environment within which policy is developed and implemented; several country and multi-country case studies trace the development and change of specific HIV policies (such as behaviour change campaigns including condom promotion, voluntary counselling and testing, breastfeeding and antiretroviral (ARV) access); at least five papers analyse specific policy implementation experience, the actors involved and the influence of social and cultural norms on those actors. A minority of the papers consider the influence of international development agencies on national policy processes.
- High profile success stories or openly contested policy issues (e.g. Uganda and South Africa) are reasonably well documented and our findings draw heavily on these cases. Overall, there is little analysis of the *de facto* making of policy in the bulk of the world's countries where risk, epidemics and poor policies persist.
- The descriptive nature of most papers – with a focus on factors or events that have converged to make a successful HIV response – limits understanding of how and why policy change occurs within countries. Very few papers identify particular research questions or are guided explicitly by theories of policy analysis or conceptual frameworks that explain policy change.
- Analysis of the role of interests and incentives in shaping national HIV policies is particularly thin.

¹ Available separately at www.hlspinstitute.org and at www.heard.org.za

4. What does the literature tell us about policy-making processes on HIV?

The literature reinforces the proposition that there is no one single determinant of policy, but rather that it emerges from the unique interaction and configuration of institutions, interests and ideas. Therefore, ongoing analysis of all three determinants in specific contexts will help identify and explain bottlenecks to developing and implementing evidence-informed policy.

Institutions

A country's institutional context is highly influential in shaping the policy environment and, therefore, in conditioning the success or failures of HIV policies. However, because every setting reveals a different story, there is limited predictive power in the case studies reviewed.

Comparable types of government do not necessarily result in comparable HIV policy responses. Countries that experience broadly similar changes in government can display contrasting patterns of politics and policy, though democratic transition in South Africa and Brazil has, in both cases, facilitated the protection of human rights for HIV positive people, and in Brazil's case, a commitment to defending the rights of those most at risk of HIV (Gauri and Lieberman, 2006). Brazil's democratic transition and the core ideas of citizenship, solidarity and human rights underpinning the democratic movement strongly influenced the development and nature of HIV policies – policies based on inclusion not exclusion (Berkman, 2005). Although South Africa's democratic transition provided an opening for the development of human rights protections, its impact on other aspects of HIV policy has not been consistent (Gauri and Lieberman, 2006).

A strong centralised democratic government with significant policy-making capacity and financial resources doesn't necessarily translate into the development or implementation of effective HIV policies. Botswana's HIV policies, for example, have faltered partly due to the nature of its modern government apparatus and democratic constitution, which sit uncomfortably with the customary sources of authority, creating a hybrid regime working at cross purposes. Increasing centralisation of government has disempowered local councils and village chiefs, significantly curtailing their powers of independent action, including local action on the formulation and implementation of HIV policies (Allen and Heald, 2004).

There is, however, evidence that some countries exhibiting democratic tendencies set the conditions for effective policies. For example, Uganda's centralist regime was pivotal in initially mobilising the non-state sector around HIV in the mid to late 1980s and in creating the space and environment for them to grow and take action (Putzel, 2004). There is, however, a tension between the principles of democracy and the respect of human rights on the one hand, and the imperatives of public health on the other. The absence of political competition in Uganda and Senegal in the late 1980s enabled leaders to spearhead national AIDS campaigns very rapidly. Programmes such as the compulsory testing of army recruits in Uganda and the compulsory registration and regular testing of commercial sex workers in Senegal may have played critical roles in containing the epidemic in high risk groups, often to the objection of human rights groups.

The institutional context shapes the organisation of health systems and influences the content and implementation of HIV policy. For example, South Africa inherited a functioning health system after apartheid and this set the stage for its HIV prevention policy (focusing on syndromic management of sexually transmitted infections). This policy lent itself to national government-led approaches based on standardised international guidelines, but not to wider community prevention and treatment programmes. In contrast, Uganda's President Museveni inherited an extremely weak health system which could not easily support standardised interventions, and instead facilitated independent service provision and a range of approaches delivered by NGOs (Butler, 2005; Lush and Parkhurst, 2004).

HIV policies, guidelines and models cannot be transferred from one institutional context to another and be expected to work in the same way, without a greater appreciation of the institutions, interests and ideas shaping that country's policy environment. For example, the World Bank's Multi-Country HIV/AIDS Program for Africa required countries to set up multi-sectoral commissions to oversee national HIV programmes under presidential or prime ministerial leadership, with representation of key stakeholders from all sectors including people living with HIV. These requirements supposedly grew out of an assessment of successful experience drawing heavily on the programmes of Uganda and Senegal. However, a political analysis of the Ugandan response suggests that the experience diverged

considerably from these prescriptions. The use of an organisational template for coordinating national AIDS programmes has proved to be a problematic model in the majority of the case studies we reviewed, and is widely reported to be the case elsewhere (HLSP, 2007). According to Putzel (2004):

“The establishment of supra-ministerial bodies ends up in inadequate attempts to reinvent government and to replace what is essentially a political challenge of prioritising HIV/AIDS in government and non-government sectors with an organisational fix.”

Ideas

Ideas, arguments and evidence, and the way they emerge, are discussed and communicated, significantly influence the content of HIV policy, and the manner in which it is implemented.

Botswana’s history of HIV policy has been strongly influenced by western ideas and approaches in dealing with HIV, and local Tswana ideas about morality and sickness. Botswana’s behaviour change policy (1987-2001) adopted a Western inspired model, with condom use as its central plank. Significant resistance from churches, parents and citizens on moral grounds, and from spiritual leaders who argued condoms were a vector of ill health, fuelled the development of an alternative parallel discourse on AIDS, based on traditional Tswana beliefs and understandings. Two discourses co-existed – the official “top down” western model and the non-official discourse which linked HIV, condoms and immorality, leading to silence and stigma around the disease (Heald, 2006). The ARV policy (2003 onwards) promoted by the government and backed by the president held little sway with the public, partly because international guidelines, which promoted the idea of HIV as a special disease demanding confidentiality, interacted with traditional values in such a way as to undermine its own goals.

“We are all in a hall of mirrors and it is important to ask how far the “special” status of HIV, imported from the West, with its associations with “perverted sexuality” and mandatory emphasis on confidentiality has not coalesced with indigenous ideas to magnify the negative aura surrounding the disease” (Heald, 2006)

In South Africa, racial and cultural identity have been at the heart of the public discourse on AIDS (Gauri and Lieberman, 2006; Youde, 2005; Robins, 2004). Policy implementation stalled as a result of the government’s controversial interpretation and use of research and evidence. In the late 1990s, President Thabo Mbeki rejected the widely accepted scientific view that HIV was causally linked to AIDS and supported the position of a minority of dissident scientists. This enabled him to support indigenous science against a Western orthodoxy based largely, but not exclusively, on research from outside Africa. His ideas and beliefs were designed to resonate with the black African population, including the notion of poverty as a cause of the disease and the useful role played by traditional medicines and “witch doctors” in combating AIDS. President Mbeki used ideas such as drug toxicity, drug resistance, pharma profiteering and (un)affordability to support his stance against widespread provision of ARVs. His openness to Virodene – a possible treatment against AIDS - was seen as championing the idea of African-initiated science, in the wider context of his agenda to revive Africa’s place in the world through an African Renaissance (Schneider, 2002).

Ideas of *who* is at risk of contracting HIV are important for policy-making. Since the mid 1990s, major global efforts have been made to foster the social construction of a “generalised” epidemic so as to facilitate a more robust political response – even where the threat of a general epidemic was patently remote (Pisani, 2008). The papers we reviewed did not address this dynamic at national level, but do reveal that the construction of risk plays an important role in the nature of HIV responses. In Brazil, for example, high levels of social interaction across racial lines meant that the virus was interpreted as affecting the whole population and there has been little opportunity to portray interactions between vulnerability to infection, ethnicity, class and gender. In South Africa, by contrast, the idea of concentration of HIV within particular racially defined groups has been clearly reflected in the arrested development of policy. For example, whites often believed AIDS was a black or gay disease whilst many blacks believed it was a white disease or a plot to control the black population (Robins, 2004). Scientists with the know-how in comprehensive care were largely white, male, urban-based (Rampole quoted in Gauri and Lieberman, 2006) and many were working in health sector institutions widely viewed as havens for apartheid-era officials (Butler, 2005). Mistrust of the previous racist system that denied

scientific literacy to the majority of South Africans constrained evidence-informed policy making (Gauri and Lieberman, 2006).

The ideas, values and morals of implementers are invoked in determining the nature of policy at service delivery level. A study of nurses' motivations in implementing the government's ARV policy in South Africa's Free State province illustrates how frontline workers appropriate ideas and narratives for their own purposes. In this case, nurses were found to use religious metaphors alongside medical ideas of effective treatment to help themselves and their patients involved in ARV programmes. These linked discourses of religion, biomedicine, human rights and social responsibility helped to explain how nurses created and sustained hope for themselves and their patients to manage the many uncertainties of the programme, including who will receive treatment, whether drugs will be available, and whether adherence will be possible (Stein et al., 2007). Another study highlights how and why the implementation of international guidelines on HIV-related breast feeding advice is hindered by health care workers' ideas, values and morals. In this case, nurses and midwives trained to support breastfeeding felt undermined and marginalised by HIV agendas and resisted the need to revise their breastfeeding advice and practice, or challenge WHO/UNICEF orthodoxy on breastfeeding (Seidel et al., 2000).

Epidemiological evidence and the value that leaders attach to the importance of scientific and medical knowledge can provoke certain types of responses. In Uganda, President Museveni held expert advice in high esteem and used medical research to demonstrate the extent of the epidemic to the population. Medical evidence shaped the ideas and messages he delivered through the call for all-out action e.g. compelling the population to reject witchcraft which may influence behaviour change and urging them to seek professional medical advice. Subsequently, Uganda's success in lowering HIV prevalence was called into question by Parkhurst (2002). He argues that selective information was used to compile official figures in order to provide the international community with the African success story it badly wanted and needed to mobilise support and funds for the global response. Similarly, low morale among health workers could be boosted by a success story.

"Statements of success have often been based on misinterpretation of epidemiological data, and can sometimes not be supported when all the Ugandan evidence is assessed. Unfounded claims of Uganda's success have persisted in international policy discourse." Parkhurst (2002)

In contrast, South Africa's government challenged the findings of the Medical Research Council's report in 2001 estimating that AIDS accounted for 25% of all deaths in 2000, and delayed its release. It has been argued that political interference arose because the findings were thought to imply that the government was not managing the pandemic effectively (Robins, 2004).

Interests

While it is generally accepted that interests and political incentives facing stakeholders play an influential role in understanding how and why HIV policies and strategies emerge and are sustained, we found that analysis of interests is lacking in the set of papers we reviewed. Literature that discusses this concept usually identifies a range of actors involved in HIV policy issues but reveals less about the underlying interests pursued and how their actions, to further or protect these interests, affect policy outcomes. The obvious interests relate to political leaders' concern for the impact of positions on their popularity and authority (not just with voters but with the business and global communities). Those living with HIV or AIDS as well as their families, friends and employers have an interest in treatment and care as well as prevention of mother-to-child transmission. The demands for the protection of their human rights – including from discrimination – are also evident and pursued with vigour. It is also evident that health care workers such as nurses, in some contexts, are motivated to implement ARV policies in part due to their own perceived vulnerability to HIV. There is some discussion of how private interests conflict with wider public interests in preventing the further spread of the virus using proven public health tools (including routine testing, treatment and partner notification). The demand for treatment was shared with the trade unions, particularly in South Africa, but unions also pursued better workplace policies – including around issues such as pre-employment screening for HIV. Pharmaceutical companies revealed their support for ARV roll-outs as demonstrated in Botswana's Public Private Partnership, but also their interest in maintaining strong patent protections as the court case in South Africa attests. Apparently, large corporations in South Africa opposed public ARV programmes and encouraged the government to provide resources for their employees instead (Butler, 2005).

The literature generally fails to identify the incentives facing politicians, but where they are discussed, political incentives appear to be critical in explaining the sources of political leadership and why support for HIV policy is generated and sustained (see Tables 1-3 for more detail). Concepts of political commitment, political will and leadership are used interchangeably in much of the literature but are not particularly helpful unless framed within a broader analysis of a country's political and economic context. The literature suggests that political commitment is necessary but not sufficient to guarantee an aggressive HIV policy response. For example, high level support for condom use in Botswana in the late 1980s was largely unsuccessful because of the lack of social mobilisation around HIV. Social silence on AIDS persists despite the support and leadership of President Mogae on universal access to ARVs, with the result that significant reductions in prevalence have yet to materialise (Bor, 2005; Heald, 2006).

“Any complex policy environment cannot be just the creation of leaders, but must be understood in the context of the institutions and intellectual discourses that allow its political and administrative viability” (Butler, 2005)

The case studies of Botswana, South Africa and Uganda (see Tables 1-3), reveal that it is possible to identify specific institutions, interests and ideas that have been associated with HIV policy change. They also demonstrate that institutional features, interest groups and ideas interact in complicated ways. Consequently, reductionism in policy analysis is prone to limitations. These and other cases also reveal a range of strategies and tactics used by state and non-state actors to pursue interests in relation to HIV (Box 2 & 3).

Box 2: Successful state-led strategies: examples from Senegal and Uganda

- **Invest in evidence to generate a convincing policy story:** At early stages of the epidemic, sentinel surveillance sites were established in Uganda in 1986 and in Senegal in 1989. These sites measured HIV prevalence and provided valuable evidence for the HIV response. Leaders based their decisions regarding HIV policy on available scientific evidence.
- **Use of an international event to focus attention** (the World Health Assembly 1986) by Uganda to openly announce the AIDS epidemic. This facilitated a WHO team to assist government in developing a five year action plan and laid the basis for a donor conference in May 1987 and subsequent support.
- **State engagement with:** (i) international development partners to raise financial support for the response; and (ii) national and international technical and scientific alliances.
- **State engagement with and involvement of respected religious leaders** and organisations to ensure their support to respond to the epidemic in appropriate ways. President Museveni urged his officials to avoid antagonising the religious community and negotiated a position with them on the use of condoms. The Senegalese government engaged with Muslim leaders through Jamra, an NGO, which conducted a survey on HIV knowledge and then worked with the highest Islamic leaders on how Islamic teaching could prevent the spread of HIV. Messages were negotiated with religious communities and complemented secular public health messages and information.
- **State engaged with and created space for non-state actors to mobilise** around AIDS. In both cases, it was the state that called associations together, urged them to develop activities, and encouraged the formation of new organisations. International NGOs and donors contributed to establishing and building the capacity of local NGOs and the formation of networks.
- **Strategy of incorporating local and traditional leaders in systems of hierarchical authority to disseminate key HIV prevention messages.** The centralist characteristics of the Senegalese socialist party and Uganda National Resistance Movement allowed both authorities to reach down through their associations and military organisation (in the case of Uganda) to every corner of the country, which enabled rapid and far reaching dissemination of HIV messages.
- **State liberalisation of media in Uganda** in 1994 enabled a plurality of messages to reach the population and pushed public debate.

Sources: Putzel 2004, 2006

Box 3: The Power of Change: Strategies employed by South Africa's Treatment Action Campaign to bring about HIV policy change

The Treatment Action Campaign (TAC) was launched in 1998 and has campaigned successfully for equitable access to affordable treatment for all people with HIV and AIDS. Its actions have brought about changes in national HIV policy – specifically the production of generic ARVs in South Africa, following a successful court case with the government against global pharmaceutical companies, and the nationwide provision of Nevirapine for all HIV positive women and new born babies. This policy u-turn was the result of TAC's successful court case against the national Department of Health and nine provincial health departments, which compelled them to provide Nevirapine in provincial hospitals and to plan a comprehensive national prevention of mother to child transmission (PMTCT) programme. Strategies and tactics included:

- **Building powerful alliances among different constituencies.** For example, TAC forged links with the media, which seized the opportunity to hold the government to account. Activists collaborated with progressive elements in the legal system to undertake litigation (for example over failure to provide PMTCT). The Campaign interacted with international “credentialed” NGOs (e.g. Médecins sans Frontières) which also provided access to resources, and to South Africa's Confederation of Trade Unions which linked activism with the political domain. This represented a globally connected community that contested the dissident line and applied pressure on the government to change its policies and stance on AIDS.
- **Adopting pro-knowledge stances.** TAC was able to successfully obtain and communicate knowledge about scientific developments to large numbers of people – important in mobilising support for TAC.
- **Learning techniques of activism from the North (ACT-UP) but framing the AIDS struggle within broader political and economic struggles of South Africa.** The focus on ARVs for poor and working classes mobilised black township residents. Class based politics resonated widely and was seen as a departure from the cultural and identity politics of President Mbeki.
- **Appropriating political symbols, songs and styles** of the anti-apartheid struggle and alliance with trade unions helped it avoid being perceived as a “white conservative camp”. Widely publicised acts of civil disobedience provided visibility with a globally connected post-apartheid public sphere.
- **Making use of “focussing events”** such as the 2000 International AIDS Conference in Durban and the 2001 access to drugs court case to increase visibility and galvanise support to change government HIV policy.
- **Threatening to roll out alternative ARV programme** – thereby undermining legitimacy of government position.

Sources: Schneider (2001), Robins (2004).

Case studies: Botswana, South Africa and Uganda

Table 1: Botswana

AIDS Policies	Institutions	Ideas	Interests
<p>1987 onwards: surveillance and mass education/ behaviour change campaign</p> <p>2001 onwards: free ARV policy</p> <p>2003 onwards: break with 'exceptionalist' position and introduction of routine testing</p> <p>(Sources: Heald, 2006; Heald and Allen, 2004; Ramiah and Reich 2006)</p>	<p>Highly centralised government influenced policy development and implementation by:</p> <p>(i) consulting with international agencies for advice and developing AIDS plans based on international best practice but;</p> <p>(ii) excluded key interest groups in policy development such as traditional doctors, clergy and communities;</p> <p>(iii) by-passed village hierarchical structures which reduced community mobilisation and support for the policy and hindered local action.</p> <p>Despite solid health care system and significant financial resources behind the policy, ARV implementation was stymied by lack of testing facilities and human resource constraints.</p> <p>Recently, implementation of ARV policy hampered by institutional aspects of response:</p> <p>(i) proliferation of poorly coordinated donor ARV programmes;</p> <p>(ii) complex aid architecture creating turf issues between agencies; and</p> <p>(iii) high transaction costs and competition for personnel.</p>	<p>Adopted western inspired model of prevention with condom use as central plank and health promotion messages in English. Condom promotion proved to be culturally inappropriate, leading to policy failure.</p> <p>Local scepticism and opposition on moral grounds fuelled development of parallel discourses: official "top down" western model; and non-official discourse borne out of Tswana beliefs system. Resulted in rejection of condom messages, stigma and silence.</p> <p>Free ARV was seen as a humanitarian intervention by the Government but the Government also framed ARV provision as breaking the cycle of denial, infection and death by knowing ones status.</p> <p>Public Private Partnership (PPP) touted on the basis that private sector style management could make a novel contribution to fighting AIDS.</p> <p>Key focussing event on testing policy held in 2003 served as forum for UNAIDS representative to denounce AIDS exceptionalism paradigm on public health grounds.</p> <p>Domestic and international human rights organisations reframed routine testing as "forced testing" in violation of human rights. Resulted in elaborate guidelines perceived by some as slowing down ARV programme implementation.</p>	<p>Population disbelief in impact of AIDS as little evidence of mortality until mid-late 1990s. Consequently, little incentive to change sexual behaviour.</p> <p>Lack of vigour in policy implementation explained partly by predicted impact on adult mortality among miners and the economy. A small number of workers were required for mines (main source of govt revenue) and these interests were protected through private health schemes, therefore the epidemic would not spell economic collapse.</p> <p>Fears of litigation dissuade local chiefs from intervening in local youth behaviour which they viewed as promiscuous, illustrating power of two discourses of HIV and human rights felt even in rural areas.</p> <p>Mid-term transfer of power to President Mogae in 1997 instrumental in re-launching AIDS campaign and PPP was developed. Botswana considered a good bet for making a free ARV programme work plus strong pharma interests in ensuring an African success story and pioneering a model for Southern Africa.</p> <p>In 2003, President Mogae puts weight behind routine testing after he falls ill, is concerned about his status and is tested for HIV.</p>

Table 2: South Africa

AIDS Policies	Institutions	Ideas	Interests
<p>1992: National AIDS Committee of South Africa develops AIDS policy and plan based on extensive consultation</p> <p>1994: New ANC government starts to implement plan</p> <p>1997: Policy review leads to reinvigorated government plan to scale up STI management</p> <p>2000: Presidential Advisory Panel established which questions scientific orthodoxy</p> <p>2003: Government commits to drastically scaling up ARV</p> <p>Sources: Butler, 2005; Gauri and Lieberman, 2006; Lush and Parkhurst, 2004, Robins, 2006; Schneider & Stein, 2001; Schneider,</p>	<p>A number of government features influenced implementation of AIDS plan by new government:</p> <p>(i) expensive and inefficient administration inherited from Apartheid;</p> <p>(ii) AIDS placed under leadership of relatively weak MOH;</p> <p>(iii) quasi federal system resulted in diminished authority of MOH and confusion over roles and responsibilities between centre and provinces;</p> <p>(iv) established and technically functioning health system inherited from Apartheid set stage for HIV prevention policy - a policy which lent itself to national government-led approaches based on standardised international protocols but not to wider community - based prevention and treatment programmes. Non state providers remained outside of this system and antagonistic to this approach.</p> <p>Structure of political executive and gradual concentration of power over the decade following 1994 makes Presidency less open to outside sources of advice and limits relations and communications with society. Leadership increasingly isolated from public health communities and AIDS activists which contributes to politics of acrimony.</p> <p>Provincial autonomy allows for</p>	<p>Strong societal perceptions that HIV is concentrated within certain race groups. Political actors, such as government, church leaders and citizens have portrayed HIV as a problem for “them” not “us”. Consistent political discourse concerning who is afflicted and that AIDS is some other group’s problem has undermined efforts, leaving little collective demand for action against HIV.</p> <p>Racist representations of African sexualities as diseased, promiscuous and uncontrollable, trigger defensive reactions from President Mbeki that draw on dissident AIDS science and conspiracy theories. Denialist stance causes confusion and dismay with ordinary South Africans and undermines behaviour change and drug adherence strategies, and perpetuates intolerance.</p> <p>Long history of colonial and apartheid scientific racism meant that AIDS statistics were not interpreted by nationals as products of scientific enquiry but were the results of historically constructed processes serving racial ends. This helps explain the contestation over “scientific” vs “local knowledge” and why Mbeki mounted a critique of scientific certainty.</p> <p>From late 1990s to 2000 two paradigms compete for support:</p> <p>(i) Mbeki adopts a pro-African and developmental stance to AIDS which rejects western biomedical discourse of scientific and activist groups in favour of socio-economic discourse looking at sources of</p>	<p>With demise of the cold war, Africa had largely disappeared from foreign policy agendas. President Mbeki harboured an interest in creating a new African identity to enhance his own legitimacy and bring Africa back to the international table. This interest was articulated through the establishment of a new African Renaissance-inspired identity.</p> <p>Scientific evidence in Medical Research Council report in 2001 of extent of AIDS was suppressed by government possibly due to:</p> <p>(i) perceptions that the situation was out of control and would negatively impact on much needed international investment;</p> <p>(ii) implications that government was not managing the policy response effectively;</p> <p>(iii) racial and geographical profiling of AIDS would reinforce media and popular prejudices that this was a black disease.</p> <p>History of competing interests and ensuing conflicts between the provinces, government, scientific and non-state actors, post 1994. For example, activist networks of people living with HIV have a critical interest in receiving treatment for life and fight for constitutional right to health by using courts to sue government.</p>

<p>2002; Willen, 2004.</p>	<p>independent action to defy national policy on ARV and facilitates a policy u-turn on provision of PMTCT.</p> <p>International forces such as the launch of WHO's 3 x 5 plan in 2003 make it increasingly difficult for the government to continue questioning the efficacy and affordability of ARVs and forces it to encourage parallel importation and the manufacture of cheaper generic drugs.</p> <p>Informal institutional norms (about gender roles, sexuality, initiation rights etc) limited condom use and are difficult to influence over the short term.</p>	<p>vulnerability, and promotes home grown solutions (e.g. Virodene – to regain legitimacy; and; (ii) the medical establishment and campaign groups promote a biomedical perspective (which was considered by the President too narrow and did not provide a compelling social-epidemiological narrative. Advocacy of ARV was seen by the liberation movement as ahistorical and pro-profit and pitched the President against medical/scientific and campaigning groups. E.g. Mbeki dismantles the Medicines Control Council in move widely seen as retribution for its doubt over Virodene and in 2000 launches National AIDS Council but excludes activists and scientists.</p> <p>Mbeki camp frames ARV in discourse of toxicity, profiteering and unaffordability which serve to stall policy development and implementation.</p> <p>TAC (Treatment Action Campaign) frames the AIDS controversy as a class-based struggle, appealing to working class, black township residents. TAC used rights-based provisions in the constitution to secure access for the poor to treatment. Legal challenges created the space for a radical democratic discourse on health citizenship. Represented a departure from the cultural/identity politics of Mbeki.</p>	<p>Trade unions, many of whose members are HIV positive, share the same interests and form strategic alliances.</p> <p>The political will of the executive on the ARV issue was undermined by its interest to avoid the risks associated with the policy. One risk arose from the logistical and infrastructural requirements of ARV programmes. Another risk arose from the opportunity costs to other programmes and the need to deal with the social and political fall out.</p> <p>Political calculus determines which policy course chosen by ANC on ARVs. At the elections in 1999, the marginal overall impact of treatment on mortality was low. By 2002, public opinion placed AIDS further up the agenda suggesting that the electoral costs of delay might be greater than the costs of action - hence increased government support for ARVs.</p> <p>U-turn on ARV policy partly attributed to threat of losing ANC voters to opposition parties as reality of AIDS deaths affecting townships and government denialist policy providing opportunities for opposition parties to gather disgruntled voters. Many supporters of the TAC come from townships and also from ANC's historical support base. ANC could no longer neglect or anger its historical support base through dragging its feet on ARV policy.</p> <p>International pharmaceutical companies pursue patent protection interests through national courts.</p>
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Table 3: Uganda

AIDS Policies	Institutions	Ideas	Interests
<p>1987 First five year AIDS action developed</p> <p>1988 All out HIV/AIDS campaign launched</p> <p>Mid 90s promotion of syndromic management</p> <p>1998 feasibility trial to test roll out of ARVs</p> <p>2004 Policy of free ARVs</p> <p>Sources: Putzel, 2004; Putzel, 2006; Lush and Parkhurst, 2004; Parkhurst, 2002; Parkhurst 2001</p>	<p>Unity behind initial HIV/AIDS campaign was achieved in part due to several factors:</p> <p>(i) National Resistance Movement (NRM) came to power uncontested resulting in little dissent to policy;</p> <p>(ii) NRM enlisted local and traditional authorities to support policy. They were given considerable latitude in implementing policy and played a significant role in regulating local behaviour change;</p> <p>(iii) Centralist authority of NRM and its military basis made quick dissemination of the message about HIV to every village possible;</p> <p>(iv) Presidential authority convinced a diversity of social groups to organise around HIV;</p> <p>(v) Central state created favourable environment for non-state participation while engagement with international donors ensured financial support for NGOs and medical research;</p> <p>(vi) The impact of President's commitment and his all out educational campaign had the effect of putting the epidemic beyond partisan politics – making it illegitimate for political authorities to oppose the drive against AIDS.</p> <p>NRM inherited a collapsed health system and encouraged non-state providers to expand services whilst state rebuilt health system. AIDS provided an</p>	<p>In 1986 new Minister of Health uses state media to report the extent of the HIV problem. Promotes idea that there is no pride in hiding the HIV prevalence and that denial of the problem destroys national standing and pride.</p> <p>Ideas that informed President Museveni's leadership on AIDS included:</p> <p>(i) shunning mythologies associated with HIV/AIDS and listening and valuing scientific and medical knowledge and communicating these ideas to the public, explaining that medical research had proved HIV had reached epidemic proportions in some parts of the country, and advised public against linking AIDS with witchcraft, which might deter them from listening to and acting on behaviour change messages;</p> <p>(ii) favoured public delivery of health care and the regulation of private providers including traditional healers;</p> <p>(iii) advocated protection of the rights of women and children, and promoted a socially conservative agenda, calling for the revival of traditional values. Resistance Committees were encouraged to restore traditional codes of morality through old corporal punishments to deter adulterous behaviour and criminal charges for anyone knowingly spreading AIDS;</p> <p>(iv) The President's call for all out campaign was carried out by all civil servants, not just those working on health, and all government officials would discuss AIDS at all meetings without exception;</p> <p>(v) President Museveni's conservative stance and opposition to condom promotion resonated with Christian leaders who joined the campaign to fight</p>	<p>Early evidence that HIV/AIDS was pervasive in the armed forces provided incentive for President Museveni to act resolutely and quickly.</p> <p>Uganda's economy was devastated by years of misrule and warfare and Museveni had more to gain from attracting international assistance to tackle HIV/AIDS than he had to lose in tourism revenue and investment.</p> <p>The promise of substantial international financial aid to address AIDS provided an incentive for action.</p> <p>Local communities with few income generating opportunities engaged in the response to AIDS as a means of gaining funds and employment.</p> <p>Religious leaders had an interest to join the AIDS response coalition because their clergy and parishioners were affected by the epidemic.</p> <p>Uganda's success story in reducing HIV prevalence comes under fire in 2001 with suggestions that epidemiological data has been misused in order to maintain commitment to AIDS from interest groups, primarily international donors (strong interest in ensuring an African success story).</p>

	<p>opportunity to centralise surveillance whilst a variety of community- based approaches flourished.</p> <p>NRM liberalised media in 1994 and radio programmes on health and HIV/AIDS proliferated, ensuring that information about behaviour change reached large numbers.</p>	<p>AIDS and with their parishioners who believed in the authority of their religious leaders. NRM believed strongly in the importance of non-state organisations to the reconstruction efforts and encouraged their expansion.</p> <p>Philosophy of National Resistance Movement influenced and reinforced policy response through its ideas of:</p> <ul style="list-style-type: none"> (i) avoidance of political isolation of interest groups; and (ii) consolidation of national unity (through consensus not conflict with interest groups). <p>No one policy line was promoted by government too strongly. The policy “love carefully” could be interpreted in different ways and thus avoided political isolation of interest groups. More recently, President Museveni and the First Lady have argued that abstinence has triumphed over AIDS in Uganda. Museveni speaks out against use of condoms in 2004 arguing strongly that they encourage promiscuity.</p>	
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5. What are the lessons for those wishing to influence policy?

- **Know your context:** a country's unique history and culture influence the development of ideas, the country's institutions, who has power and which interests prevail. These factors appear to be more influential in shaping a country's policy response to AIDS than the nature of the epidemic itself. What is therefore required is the identification of those political dimensions (Buse et al., 2008) and working with the grain of politics to facilitate evidence-informed policy development within the constraints imposed (Buse, 2008).
- **Discourse is the name of the game:** for more effective HIV policies, greater consideration needs to be paid to understanding how and why discourses around HIV emerge, how they affect perceptions of social problems, how they frame (and support or undermine) evidence-informed policy, and how they can be reframed to tell convincing stories to address the real drivers of the epidemic (Fischer, 2006). For example, when AIDS was framed as a "gay cancer" in the United States, the national response was distinctly different to when AIDS was framed as an infectious disease that could strike anyone (Youde, 2005).
- **Ditch the cookie cutter approach:** HIV policies and models cannot be transferred from one country to another and be expected to work in the same way without greater appreciation and adaptation based on a sound analysis of the institutions, interests and ideas shaping a country's policy environment.
- **Consult:** policies that are developed in a "top down" manner, without adequate involvement of health care providers and/or those affected by the epidemic, often result in poor implementation. Policy development needs to include front line policy implementers and beneficiaries to ensure that their concerns and interests are addressed. NGOs and organisations of HIV positive persons made important contributions to the development of Thailand's policy to scale up ARVs through their close involvement in policy networks (advisory panels) set up by government. Advice from the panels led to substantial changes in treatment delivery, revisions of ARV regimens and decisions to involve NGOs and people living with HIV in training and care delivery. The contribution of non-state actors was important not only in setting the agenda, but also in the development and implementation of the policy (Tantivess and Walt, 2008). UNAIDS' policy brief on greater involvement of HIV positive persons makes recommendations to policy actors on how to engage people living with HIV and AIDS in policy processes, and gives country examples of where this has happened.²
- **Coalesce:** coalitions among different stakeholders that span local, national and global spaces, as well as state and non-state actors, represent important vehicles for challenging vested interests in national HIV policy processes (Buse et al., 2006). Such coalitions have, for example, proven invaluable in policy conflicts over HIV pharmaceutical access in countries as diverse as Brazil, South Africa and Thailand.
- **Collaborate:** collaboration among researchers, AIDS constituencies and policy-makers on the barriers to evidence-based policy can generate better quality, more relevant and widely owned analysis and, consequently, more effective evidence-informed policies in the future.
- **Invest more in understanding the politics of policy change;** particularly the role of interests and power in AIDS policy processes.

² http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf

6. Conclusions: future research

While our review is not comprehensive, the search reveals that the political analyses of HIV policy are limited in the peer reviewed literature. Existing literature leads us to conclude that analysis of the political dimensions of policy can direct attention to the drivers and constraints to change and that such analysis ought to constitute a standard component of each and every national response. Our approach suggests that country case studies that examine the interactions between institutions, interests and ideas in specific policy areas can challenge established mantras in the AIDS field, and can inform and guide future responses. Future research should include:

- A comprehensive literature review examining the role of institutions, ideas and interests in national HIV policies. The expanded review would build on this pilot review and would include a wider literature of book chapters, peer-reviewed articles and grey literature.
- Analysis that aims to understand the determinants and possibilities for sustaining political commitment for AIDS given the need to refocus many national responses on highly stigmatised groups and persons with risky behaviours – such as men who have sex with men and injecting drug users.
- Analysis of the politics of “normalising” AIDS responses. This includes assessing the response of institutions and interests of stakeholders at country and global level to the growing debate that questions the AIDS exceptionalism paradigm.
- Analysis of the political bottlenecks impeding progress on universal access targets should be undertaken on a country by country basis. Similar analysis of political bottlenecks impeding progress could be undertaken for specific policy areas such as PMTCT and the integration of sexual and reproductive health and HIV services.
- The “architecture” for managing aid and other resources at national level, taking into account institutions, ideas and interests which sustain Country Coordinating Mechanisms and National AIDS Commissions in, for example, forthcoming Global Fund national strategy application processes.

References

- Allen T, Heald S (2004) HIV/AIDS Policy in Africa: What has worked in Uganda and what has failed in Botswana. *Journal of International Development*. 16:1141-1154.
- Berkman A et al. (2005) A critical analysis of the Brazilian response to HIV/AIDS: Lessons learned for controlling and mitigating the epidemic in developing countries. *American Journal of Public Health*. 95(7):1162-1172.
- Bor J (2007) The political economy of AIDS leadership in developing countries: An exploratory analysis. *Social Science and Medicine*. 64 (8):1585-99.
- Buse K et al. (2006) Management of the politics of evidence-based sexual and reproductive health policy. *The Lancet*. 368(9552):2101-2103.
- Buse K (2008) Addressing the theoretical, ethical and practical challenges inherent in prospective health policy analysis. *Health Policy and Planning*. 23(5):351-360.
- Buse K, Jones N, Hawkes SJ (2008) *How to Analyse Policy to Effect Change: Practical guidelines*. ODI.
- Butler A (2005) South Africa's HIV/AIDS policy 1994-2004: How can it be explained? *African Affairs* 104(417): 591-614.
- Fischer F (2003) *Reframing Public Policy: Discursive politics and deliberative practices*. Oxford University Press.
- Gauri V, Lieberman ES (2006) Boundary institutions and HIV policy in Brazil and South Africa *Studies in Comparative International Development*. 41 (3): 47-73.
- Gilson L, Raphaely N (2008) The Terrain of Health Policy Analysis in low and middle income countries: a review of published literature 1994-2007. *Health Policy and Planning*. 23 (5):294-307
- Heald S (2006) Abstain or Die: The development of HIV/AIDS policy in Botswana. *Journal of Biosocial Science*. 38:29-41.
- HLSP (2007) *A synthesis of institutional arrangements of National AIDS Commissions in ten African countries*. London: HLSP.
- John P (1998) *Analysing Public Policy*. London: Cassell.
- Lush L, Parkhurst J (2004) The political environment of HIV: lessons from a comparison of Uganda and South Africa. *Social Science and Medicine*. 59:1913-1924.
- Parkhurst J (2002) The Ugandan success story? Evidence and claims of HIV-1 prevention. *The Lancet*. (360)9326: 78-80
- Parkhurst J (2001) The crisis of AIDS and the politics of response: the case of Uganda. *International Relations*. 15:69-87
- Piot P et al. (2008) Coming to terms with complexity: a call to action for HIV Prevention. *The Lancet*. 372(9641):845-859.
- Pisani E (2008) *The wisdom of whores: bureaucrats, brothels, and the business of AIDS*. London: Granta.
- Putzel J (2006) A history of state action: the politics of AIDS in Uganda and Senegal. In Denis P and Becker C (eds.) *The HIV/AIDS epidemic in sub-Saharan Africa in a historical perspective*. Senegalese Network "Law, Ethics, Health". Accessed on 081008 at <http://www.refer.sn/rds/IMG/pdf/01TITRE.pdf>
- Putzel J (2004) The politics of action on AIDS: A case study of Uganda. *Public Administration and Development* .24:19-30.

Putzel J (2004) The global fight against AIDS: How adequate are the National AIDS Commissions? *Journal of International Development* 16: 1129-1140

Ramiah I, Reich MR (2006) Building effective public-private partnerships: experiences and lessons from the African Comprehensive HIV/AIDS Partnerships (ACHAP). *Social Science and Medicine*. 63 (2): 397-403.

Robins S (2004) Long live Zachie, long live: AIDS activism, science and citizenship after Apartheid. *Journal of South African Studies*. 30(3):651-672.

Schneider H, Stein J (2001) Implementing AIDS policy in post-apartheid South Africa. *Social Science and Medicine*. 52:723-731.

Schneider H (2002) On the fault line: the politics of AIDS policy in contemporary South Africa. *African Studies*. 61(1):145-167.

Seidel G, Sewpaul V, Dano B (2000) Experiences of breastfeeding and vulnerability among a group of HIV positive women in Durban, South Africa. *Health Policy and Planning*. 15: 24-33

Stein J, Lewin S, Fairall L (2007) Hope is the pillar of the universe: health care providers' experiences of delivering anti-retroviral therapy in primary health clinics in the Free State province of South Africa. *Social Science and Medicine* .64:954-964.

Tantivess S and Walt G (2008) The role of state and non state actors in the policy process: the contribution of policy networks to the scale up of antiretroviral therapy in Thailand. *Health Policy and Planning*. 23 (5):328-338.

Willen S (2004) Briefing: Recent changes in the South African Government's HIV/AIDS policy and its implementation. *African Affairs*. 103: 109-117

Youde J (2005) The development of a counter-epistemic community: AIDS, South Africa, and international regimes. *International Relations* 19(4):421-439.

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