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Political science(s) and HIV: a critical analysis

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The academic discipline of political science has substantially addressed the politics and policy of the HIV/AIDS epidemic over the last two decades, but the epidemic has not become a full-fledged research agenda of its own. The author analyses and groups the extant research into four research programmes. He suggests some future directions that political science may take, so as to further the investigation of the empirical problem of HIV/AIDS, as well as to meet the disciplinary imperative to advance more general theories and explanations of political phenomena.

Keywords: HIV/AIDS; political science; global health; international development; governance; security studies

Introduction

In the 30 years that we have recognised HIV's existence among us, we have encountered a disease requiring and entailing an engagement like no other of academic scientists with policy-makers, activists, and politicians. This epidemic, perhaps more than any other recent communicable disease or naturally derived phenomenon, has required the collaboration of social and natural sciences to find viable solutions to the problem of its spread.

The political aspects of the epidemic cannot be ignored, nor can they be left to natural scientists or politicians. The world has need for the expertise of politics scholars in the same way it needs that of economists. At their best, these scholars can stand apart from short-term or partisan views, to point out alternatives, analogues, and paths not taken in this issue area or in parallel ones. Political sciences have the potential to make a unique contribution to the study of and response to the epidemic, oriented as they are to the explanation of decision-making actors, institutions, ideas, and processes. Political science has produced a large amount of research into the epidemic, but it has occurred across a wide variety of research programmes and traditions. This article discusses the several ways that the political sciences have addressed the worldwide epidemic, with an eye towards taking a categorical and critical view of the supply of academic political research. I discuss four research programmes into which political scientists have ensconced research on HIV, noting strengths and weaknesses and assessing the extent of coverage and elisions.

I attempt to take a fairly catholic view of what constitutes 'political science' in this analysis. A full discussion is beyond the scope or focus of this article, but in broad terms the major divide as to what constitutes a political science falls along the lines of disciplinarity and geography. North Americans tend to see themselves as members of a coherent discipline of 'political

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science' with its own departments, associations, values, criteria for research acceptability, and differentiation from other academic fields. In the rest of the world, social scientists who study politics work more interdisciplinarily and accept a greater range of epistemology and methodologies as legitimate fur use in research.

Scholars using HIV as a substantive focus have contributed to a broad range of theoretical research programmes, across the range of the discipline. That said, there has been and remains the impression that political science is uninterested in the epidemic.

The number of works that address the politics of the epidemic in a social scientific fashion and in a form recognisable to academic practitioners as constituting 'political science' is substantial. In larger terms, however, it does not constitute a coherent research programme of its own, and it has constituted a substantial portion of only one or two research programmes.

Political science has considered four major aspects of the HIV epidemic, integrating those into its concerns with the political world.

(1) the growth and extension of global and comparative health policy;
(2) how the spread of the epidemic has affected the progress of international development;
(3) effects on state security environments, internally and externally;
(4) how HIV's politics have affected and been affected by trends in governance, on all political levels.

Once separated into these substantive research agendas, we see many of the same approaches and types of questions recurring across agendas. Institutional analysis, administrative quality and changes, and the emergence and environment of civil society recur often. The research question generally involves delineating the relations among affected actors, as well as examining the use of power and politics in those relations. Some research begins from relatively theoretical questions, and investigation leads to better understanding of the results of public policy decisions and regimes. Other research starts from public policy concerns, and it ties into theoretical and scientific agendas.

Global and comparative health

Over the last 15 years, political researchers have turned their attention to the socio-political problems of health and disease that inhere in a globalised society. The system of identifying and managing disease outbreaks has necessarily exceeded the grasp of any one country, no matter how powerful it is in conventional terms.

Human health is a good that relies upon the coordination and cooperation of a variety of global, national, and international actors in a variety of frameworks, institutions, and organisations. Political researchers have examined the formation and functioning of global institutions to manage the spread of HIV; the provision of resources for treatment and prevention; and the establishment of scientific, governmental, and activist bodies and networks of cooperation. Some global health politics research also examines the institutional relations and inter-/intra-organisational politics of these actors, while other research has sought to understand what policies have come from the health regime's actors. Social movements research has attempted to understand how activists use the instruments at their disposal to expand health regimes and policies.

State performance

One of the most significant questions that politics scholars have engaged with respect to global and comparative health has been in understanding how differences in societies affect the scope and intensity of anti-HIV response.

Cultural explanatory models have proved popular and persuasive. The different policy regimes that various African states undertook, based on political culture – 'the dynamic and heterogeneous ground of collective identities, ideologies, and historical pathways of different political forces' – explain a large part of the differing paths Cameroon, Côte d'Ivoire, Senegal, South Africa, and Uganda took (Eboko 2005, p. 38). Patriarchy underlies many of the features of African governance (Siplon 2005). With women excluded from many of the highest levels of power, there are fewer advocates for strong national HIV responses, along with a number of policy choke-points that can render even the best intentioned and resourced programmes ineffectual. Altman (2006) focuses upon sexual culture and mores; these taboos surrounding uncomfortable topics go a long way towards explaining why governments fail to implement policies and programmes, even when the outcomes are clear and beneficial.

Another strand of policy output research contends that the main causal factors explaining differential state action are organisational or institutional in nature. Comparing Uganda and South Africa in the 1990s, Parkhurst and Lush (2004) focused on four aspects of political institutions: political leadership; extant bureaucracies and configuration; health systems and infrastructure; and what governments allow or assign non-governmental organisations (NGOs) and civil society organisations (CSOs) to do. As they point out, government organisation and bureaucratic performance appear to have a strong effect upon a country's policy output performance. Allen and Heald (2004), comparing Botswana and Uganda, argued that leaders' engagement helped ameliorate the problems occurring with 'one-size-fits-all' prevention strategies. A country's degree of press freedom, income equality, and overall HIV prevalence can explain much of political leaders' commitment (Bor 2007). Culture and institutions can mutually reinforce each other. Lieberman investigates the independent variable of 'boundary institutions': the 'sets of rules that regulate racial and ethnic group categories and intergroup behaviour' (Gauri and Lieberman 2006, p. 46). Although 'boundary institutions' are not identical to sub-national or ethnic identities, boundary institutions depend upon cultural identity constructs. Removing the institutions may therefore not change policy output, due to the underlying cultural constraints. Boundary institutions that reinforce cultural identities can impede the design, implementation, and output of anti-HIV policies, due to different degrees of risk perception for in- and out-group members (Lieberman 2009).

Some studies investigate a 'tough case' version of the question above ('why are some countries better performers than others?'). Elbe (2002) explained how a poor country with recent civil strife and little democracy (Uganda) was able to get in front of the epidemic. As President Museveni became aware of the extent of HIV infection in the military, he worked to curtail the disease, because the military was his power base and provided general social stability. Youde (2005) traced South Africa's failure to implement a treatment programme to a 'fundamental disjuncture' between South African politicians and the international HIV epistemic community, giving rise to a counter-community in South Africa.

States in partnership for health

States have not managed to build policy solutions that work without coordinated action among various types of actors, either under their own auspices or by delegation to other entities. For researchers interested in how states interact with actors like NGOs and multi-national corporations (MNCs), study of the global and comparative health regimes has provided a number of examples.

The requisite role of states or other actor types is yet indeterminate. While states rely upon and partner with non-state actors under the best of circumstances, in a number of countries, NGOs and corporations have addressed the pandemic when the state government has failed to

do much. NGOs are seen at the 'forefront' of the response, with influence over government and international organisation (IO) activity (Clarke 2002), and the state and its structures sometimes do not figure very much in fighting the pandemic (Barnes 2008). Others point out that cooperative efforts between state and civil society, or the development of 'policy networks', are crucial for policy agenda-setting, development, and implementation (Tantivess and Walt 2008). In other research, central or national governments are necessary; research on Uganda and Senegal indicates that an effective and sufficient response requires central government involvement (Putzel 2006). Sometimes the interaction between states and their non-governmental partners is formalised in a 'public–private partnership' (PPP) (Ramiah and Reich 2006). The organisational aspect of these partnerships – particularly institutional memory and stability – cannot be neglected, given the potentially high rates of attrition for local staff who are HIV-positive or care for someone who is (James and Mullins 2004).

Why does collaboration between state and non-state actors either fail to coalesce or break down? Such collaboration apparently depends upon the civil society environment generally. In Ghana, a unique case of a state that transitioned to democracy and where HIV seemed to be at a critical point between control and crisis, a broad response to HIV has not developed, due at least in part to a relatively weak civil society (Haven and Patterson 2007). South Africa's difficulties in the period when both HIV and AIDS were on the rise (particularly the 1990s) were legion, involving the 'difficulties of implementing a comprehensive response to AIDS in a country undergoing restructuring at every level' (Schneider and Stein 2001, p. 723).

Corporations face consequences from the pandemic, and relations with the state can hinder or help companies' actions against HIV. South African corporations were slow to address HIV, given the potential economic losses from employee morbidity and mortality (Dickinson 2004). Corporations face complex socio-economic cleavages or race, class, gender, and their confluences, and the companies lack the power to resolve them. In the southern African mining sector, companies in reality have little financial incentive to prevent employee infection, miners' unions lack institutional power, and government ministries are subject to capture and lack bureaucratic capacity (Stuckler *et al.* 2010, pp. 5–7). The regional nature of mining makes it hard for any one state to address.

International and global governmental organisations have also played important roles in the political management of HIV. HIV responses demonstrate both the workings of international institutions and the changing basis of relations between citizens and the state, at least *vis-à-vis* supranational institutions. One of the most important shifts has been in the role that IOs, NGOs, and CSOs have played in the formation and work of organisations like WHO's Global Programme on AIDS; its successor, UNAIDS; the Global Fund; and so forth (Gómez 2009). NGOs have also played a role in the formation and implementation of policies and norms, with the support of and independent of national government support (Swidler 2006).

The HIV pandemic has provided some researchers with an excellent opportunity to examine what happens when global institutions and local programmes partner directly. There can be a disjuncture between the international institutions of global response that set the priorities for policy, expenditure, and prioritisation and the localised realities that shape people's experience and understanding of the disease; global actors often do not see how their efforts play out both in limited space and medium-term time (Seckinelgin 2008). Local actors in Kenya, Malawi, and Zambia sensed a lack of coordination among different global donor programmes. Consultative mechanisms that bring local concerns and ideas to global implements and funders have, for example, improved treatment and care of people living with HIV and AIDS (PLWHA), as well as improve acceptance and adherence to care programmes (Edström and MacGregor 2010, Mallouris *et al.* 2010).

Social movements and activism

Social movements, identity politics, and activism enjoy an active and well-consolidated research agenda in political science. From the beginning, identity politics has played one of the most important roles in the formation of the movements around HIV. In part, this is because HIV first manifested in the developed/northern countries in gay men; it drew upon, merged with, and provided fuel for the lesbian and gay rights movements that had begun one to two decades previous. Scholarship on gay and lesbian activism in the last 30 years has thus had to grapple with the place of the HIV pandemic in the movement. Gay men (and to lesser degrees, lesbians, haemophiliacs, and those who worked with injecting drug users and immigrants) pressured governments, rich community members, medical professionals, and others to step up research and care, speed drug approval, provide legal protections against discrimination, cooperate in medical decision-making, and include PLWHA in decision-making (Smith and Siplon 2006).

Outside of the USA, gay liberation and HIV activism co-occurred regularly. In Mexico and Brazil, the emergence of HIV among men who have sex with men provided a spur to sexual minorities to organise around their political and civil rights (de la Dehesa 2010). Sex workers in Southeast Asia and Latin America have often used their marginal social status and 'otherness' to create, refine, or re-invigorate strong collective identity and to make demands for protections and changes. In Singapore and Malaysia, the HIV movement 'allowed them to play critical roles in spurring and supporting queer – especially GLBT [gay, lesbian, bisexual, transgender] – mobilisation, including fostering a sense of a "gay community", despite legal proscriptions on homosexual behaviour and associations' (Weiss 2006, p. 674).

In sub-Saharan Africa, identity politics has relied upon a person's HIV status itself to be the marker of identity. Some studies point to the difficulty of organising around identity, as HIV-positive status alone may not be sufficient to create an activist movement. In Tanzania, HIV activism has not (yet) had very much of a political impact, in part for this reason of identity basis (Beckmann and Bujra 2010). In Ghana, newly consolidated democracy, weak civil society, and a very small or marginal identity politics lobby has resulted in little political attention or action on HIV (Patterson 2006).

South Africa has demonstrated a particularly robust activist movement. In particular, the success of the treatment action campaign (TAC) has provoked analysis on alternatives to identity politics. TAC – along with its partner, MSF (Medecins Sans Frontieres) – avoided conflict over the origins of HIV. Instead it devoted itself to 'class-based politics that concentrated on access to anti-retroviral drugs' (Robins 2004). Heywood (2009), on the other hand, contends that the TAC focused on human rights discourse over other sources of political coherence and power.

Identity can also have pernicious effects, especially when different identities cut against one another. Youde (2005, 2007) found that South African political elites' self-identity of independence and anti-colonialism, combined with the legacies of apartheid, formed an 'epistemic community' that culminated in Mbeki's denialism. For African-Americans, where identity politics cut against acknowledging and addressing HIV, PLWHA experienced 'secondary marginalisation' (Cohen 1999).

International development

HIV has not been spread equally around the world. Countries in lower and middle income tiers have borne the greatest burden of this disease, with sub-Saharan Africa particularly hard-hit. These are also countries that have been engaged in continuing programmes of socio-economic development. Two questions about the relationship of HIV to development have tended to dominate. The first has been to examine how the pandemic has affected development gains made in

the last 50–75 years. The other dominant question asks how the international community has changed its ideas about development assistance in light of the widespread, slow-moving epidemic disaster that HIV has proved to be. Unlike many other communicable epidemic diseases, HIV appears slowly, proves biologically challenging to fight, and appears to spread best under political conditions of discrimination, stigmatisation, and human rights violations. These conditions add to the complexities of a challenging endeavour.

It is largely uncontroversial that HIV threatens development in the countries of sub-Saharan Africa. The changes that donor and partner governments and organisations have asked of African countries and peoples – such as rapid changes in gender roles, Western understandings of sexuality and sexual behaviour, the denial of denial, and so forth – may be necessary from a biomedical or epidemiological perspective, but they also engender many African countries' perceptions of re-colonisation (Fredland 1998). The tragedy of South African policy under Thabo Mbeki has at least part of its basis in this cause (Schneider 2002, Butler 2005).

In the late 1990s and early 2000s, a near-universal condition for debt reduction and write-down was 'structural readjustment'. Although structural readjustment may have freed monies to do such things as fight HIV, the reduction of the state's role in the economy and society mean that it may not have the reach to tackle HIV comprehensively or effectively (Poku 2002, Whiteside 2002).

Indeed, the policies required for structural adjustment programmes created conditions that spread HIV more effectively (Poku and Sandkjaer 2007, pp. 134–136). Whiteside warned, in this context, that researchers and policymakers have ignored HIV too much in development policies, forgetting that HIV is a long-wave, inter-generational event, where the effects will play out for decades, even if the disease itself were to stop tomorrow (Whiteside 2006).

Politics has proved a vital ingredient in the success the HIV response has enjoyed in developing countries. Political activity, issue framing, and strategic communication may be equally or more central to raising and furthering particular global health issues like HIV than demonstrating the burden of a particular disease or the cost-effectiveness of treatment. The policy community around HIV has better advanced its ideas regarding problems and solutions, and they have better institutionalised these ideas, which in turn increases the attention the policy community can gain from policymakers (Shiffman 2009).

Much of the rich world's response to HIV in the developing world has relied in great measure upon the work of various types of NGOs: medical, political, advocacy, humanitarian, and religious. The proliferation of these organisations makes them virtually indispensable to the fight against HIV (Clarke 2002, White and Morton 2005). International donors and funders often seem to prefer NGOs to government involvement, both because NGOs are perceived to be more free-form or 'local' (and thus potentially more flexible and responsive) and because there can be concerns about the ability or corruption of governments. It often seems the developed world considers Africans too poor, too unsophisticated, too corrupt, or too sexual to adequately handle treatment programmes (Jones 2004).

Worries exist, however, that NGOs reproduce or create new forms of colonialism. Locals, 'at least initially, inevitably regard an international organisation as a potential source of money, goods or contacts that are otherwise unavailable' (Swidler 2006, p. 277). As time passes, there is often a mismatch, culturally and politically, between the NGOs' ways of doing and those of the encompassing society.

HIV assistance policies meant to be sustainable serve to highlight extant power inequalities while creating new ones. In Malawi, HIV assistance has exacerbated the problems of a class of 'interstitial elites'. These elites – who mediate between national and foreign NGO staff in the national capital and local village chiefs or heads – are relatively capable and educated but expected to volunteer their efforts. These interstitial elites exist in fiscal, social and professional

insecurity and they are more and more dependent upon irregular payments (Swidler and Watkins 2009).

HIV has also provided developing countries with the means by which they can and have resisted the preferences of developed countries and pursue their own preferences, through institutions above and alongside developing countries.

States and IOs are hardly powerless in the face of MNCs. Research into drug manufacturers' decision to begin producing generic anti-retroviral therapies (ARVs) in 2001 shows that governments created markets for generics by altering regulatory environments and 'buying drugs for people living with HIV in developing countries' (Roemer-Mahle 2010, p. 9), and countries have been able to leverage international intellectual property (IP) law regimes against drug manufacturers and their home countries (Cleary and Ross 2002, Cullet 2003). IP rights regimes create a scarcity in knowledge, increasing their economic value but which also increases dependence on the state. Rights-holders, like pharma companies, cannot let the costs of their goods become too high, lest the state cease rights enforcement (May 2007).

The most well known of these IP law resistance actions took place with respect to the TRIPs (trade-related aspects of IP rights) agreement and the Doha round of the World Trade Organization talks. The TRIPs agreement, although often interpreted as being to the benefit of developed countries and 'big pharma', contains provisions that were leveraged against the same. Developing countries have used the tools of 'national emergency', and 'compulsory licenses' to local manufacturers to extract more favourable terms, under threat of depriving the pharmaceutical producers of further revenues (Sell 2007). Furthermore, developing countries re-framed the access problem, such that appeals to norms, ethics, and legitimacy became the terms of the debate over generic ARVs. Powerful actors were internationally shamed, and the eventual result was the 2001 Doha Declaration on the TRIPs Agreement and Public Health. This opens new possibilities of action in international politics, especially for South-South cooperation. These cooperative engagements can allow for creative and perfectly legal ways around TRIPs and Doha (Aginam 2010).

Country-specific analyses have helped to illuminate how developing nations have sometimes defied of current trends or the wishes of the powerful in international development. Brazil has proved particularly interesting for analysis because it sits at the intersection of 'local, foreign, and transnational actors. ... The full mobilisation of Brazil's government, both in its relations with the USA and in international forums, as well as the support this government received from transnational advocacy networks were critical in enabling it to resist ... pressures' from developed country governments and major pharmaceutical companies (de Mello e Souza 2007, pp. 37–38).

Security

One of the primary foci of international relations is the concern with how a polity protects itself internally and with respect to other polities. The traditional focus of such inquiry has been upon interstate war, but with the end of the Cold War, studies of civil and ethnic warfare became more prominent. Expansion of what 'security' encompassed also arose, as 'human security' – which looks to the factors that make human beings, not just states, safer – took greater prominence. Significant analysis has focused on how HIV may pose either a traditional or human security threat.

Elbe (2006) cautions against tying HIV too tightly into the security paradigm, for 'securitisation' of the disease has implications beyond simply raising its priority on a country's preference agenda. Securitisation could allow for more space to move a country's response from civilian control to military control, thereby affecting civil liberties and the balance of power

between military and civilian leaders. Militarising or securitising HIV also creates a greater possibility that care for elites and military heads will be formally prioritised, and it mitigates against continued efforts at normalisation of the disease.

Several questions have emerged linking HIV and security. There is the question of whether HIV constitutes a threat in traditional or in human security terms. There are also studies that examine how HIV might affect the (generally traditional) security position and posture of states. Finally, there are studies that investigate how war and conflict affect or exacerbate the problem of HIV in developing societies.

The causal pathway linking HIV to security is a difficult one to trace (Barnett 2006). HIV sunders fundamental social units, like the linkage of grandparent to parent to child, as it kills off parents and leaves the elderly to raise the young. Although analysts can explain that such change in fundamental institutions will 'hollow out civil society', the exact repercussions are unclear and HIV is a (large) part of a complex of factors and causes breaking down trust between government and citizens (Price-Smith 2002). Traditional security studies scholars have hewed close to examining HIV as the cause or consequence of war and peace, violent conflict, and state survival (for an overview of a recent comprehensive research programme, see de Waal 2010b). Some connections between HIV and state security are sensible and substantiated. States with a norm of international cooperation are more likely to identify HIV as a security threat, and states seeking foreign investment are more likely to de-emphasise the HIV-security linkage (Girshick 2004). HIV does not seem to pose a threat to the security postures of the rich, developed countries like the USA; in poorer countries, it has a high degree of association with human rights abuses and civil conflict (Peterson 2003).

In other cases, the connections are harder to piece together. Examining the Security Council's claims in 2000 that HIV posed risks to state stability, national security, peacekeeping operations, and that violence exacerbates the virus's spread, McInnes (2006) noted that the evidence since 2000 showed the linkages to be less clear, more complex, and more case-dependent. HIV is a long-term event – the dying-off of the infected is only the first effect the disease will have on populations (Barnett 2006). There is perhaps 20 years of evidence available, providing only the most basic understanding of what will happen to these complex systems, and so short-term actions may be as damaging as helpful to the long-term situation.

The relationship of HIV and the conduct of war is complex and indeterminate in both causal directions. On a micro-level, Elbe (2002) noted that HIV has become one of the weapons that armed groups deploy; rape of civilian populations becomes more terrifying a tactic when rolled up with the peril of infection. Experience and anecdotes from IO, NGO, and other observers solidified a consensus around how war and sexual violence spread HIV. However, controversial work (Spiegel 2004, Spiegel *et al.* 2007) examined the epidemiology of HIV prevalence in the presence of conflict; no consistent relationship could be found. To the contrary, Iqbal and Zorn (2010) find a 'clear, positive relationship' between war and increased prevalence of HIV, indicating that wars do affect the progress of the epidemic. Some work considers the effect that HIV may have on military structure and organisations. Rosen (1987), for example, provided early theorising that HIV could damage military efficacy. Since prevalence is often higher in the military than in the general population, we should expect to see a greater proportion of the military's personnel contracting HIV; this decreases the activity of those individuals (with their skills and experience) from the organisation. This can eventually lead to decreased organisational effectiveness and increased instability.

Most empirical confirmation of such arguments have taken place in the sub-Saharan African context. Ostergard (2002) discusses the effects of HIV upon the military in a number of countries, with attention to Nigeria, DR Congo, and Uganda. Elbe (2002) notes that African militaries have experienced loss of organisational capacity and lowered effectiveness, using

descriptive statistics from several countries. Within sub-Saharan Africa, because many militaries engage in extended peacekeeping missions, higher levels of HIV in the ranks will affect peacekeeping abilities and operations in the region (Patel and Tripodi 2007).

High prevalence of HIV in the military has increased the incidence of illness and death. While militaries are designed to address the problem of large-scale personnel loss, challenges remain. HIV pushes militaries functionally and organisational as they grow beyond conventional competencies: dealing with post-conflict situations, getting civilians and military leaders to learn from one another in their HIV control strategies, and increasing the HIV readiness and response of paramilitary organisations (de Waal 2010a). Soldiers cannot carry out their duties at an increasing rate, and this affects staffing decisions, as well as recruitment and conscription needs.

Governance

The governance of a society – the interrelation of government, economy, civil society, citizens, and private enterprise to *one another* and how those joint interactions shape and constrain 'public affairs' – is a major concern for political scientists. Those who study governance 'explore abstract analyses of the construction of social orders, social coordination, or social practices irrespective of their specific content' (Bevir 2007, p. 365). A particular concern of this research agenda has been in examining how various public sector reforms to lessen the hierarchy and centralisation of social functions in government. HIV experienced a coincident rise with such trends in public sector management, and many attempts to address the pandemic have relied upon a variety of non-state actors, including NGOs, private enterprises, PPPs, and special-purpose global organisations, among others.

To some degree, the governance research agenda overlaps with elements of the preceding research programmes. It differs in that rather than focus on the particular *issues* of content, governance studies examine the question of *how or how should* a society self-manage, the *justifications*, and the *ends* of such management. Here HIV is interesting not only for its own political implications, nor as a sub-topic of a larger class of political phenomena, but because of what it tells us of the interior and exterior understanding of the society.

Several pertinent questions arise:

- What effects does the disease have on the state and society? How does HIV change the social and political institutions of the state?
- Why do some states fail so utterly in responding and even well-managed states 'miss' the problem of HIV? How does the epidemic bring the state's pathologies into focus?
- How do countries' HIV responses demonstrate the well-functioning of the state and its components?

The first question ponders how the effects upon aggregated individuals bring demographic, political, economic, and other social impacts into being.

> ... [T]he pandemic threatens structural transformations in African economies, institutions and governance. Decreased adult life expectancy has important adverse impacts upon savings, capital accumulation, skills acquisition, and institutional functioning. ... [T]he impacts of the pandemic can be envisaged as running processes of demographic transition, economic development and the growth of a bureaucratic state, in reverse. (de Waal 2003, p. 12)

HIV affects social function and stability in sub-Saharan Africa because it can radically deplete human capital. It strains medical facilities already under pressure, increases the risk of infection due to the disruptions caused by refugee flows, pushes HIV into rural areas via urbanisation or civil conflict, and 'inverts priorities' (Elbe 2002) for all sorts of people, as day-to-day survival becomes more pressing than infection avoidance. de Waal (2010a) notes

that militaries have often been faster and more effective than other parts of their governments to deal with the human capital costs of HIV. Some institutions and organisations, however, will suffer an inversion of priorities, as workers take time off or quit outright to care for themselves or family members; and as human, economic, and political capital must be expended upon HIV prevention, control, and treatment rather than other facets of social development.

HIV response management signals the politico-technical capacity of a government and society to national and international publics; it is a sign of governmental competence and legitimacy (Compton 2007). Especially when setting up programmes, there is often a failure to appreciate that HIV is a problem of governance: many actors seek remedy in 'an organisational fix' rather than facing the 'political challenge of prioritising HIV/AIDS in government and non-government sectors' (Putzel 2004a, p. 1137).However, at least with respect to the Global Fund, adaptation over time has led to more efficient use of resources as countries have better fit required national-level structures into local context (Dickinson and Druce 2010).

On a philosophical level, the nexus of international institution, national government, and NGO bears a particularly North Atlantic mark of 'governmentality': '... the conventional focus on organisational form and getting management technologies right in order to be able to participate in the international policy environment neutralises our understanding of what these NGOs can actually do' (Seckinelgin 2008, p. 69). That is, by co-opting local organisations and institutions, whatever form they originally take, global actors diminish local capacities to have an effect in their environments.

The (mis)management of HIV responses, which is the heart of the second question above, provides opportunity to examine how organisational or leadership pathologies can lead to an active avoidance of the problem, even as evidence mounts that the government's active denial or neglect of that problem contributes to the problem. Well-run countries, whether developed or developing, have demonstrated similar inabilities to recognise the severity of the epidemic. To be effective, HIV management has to rank high on a society's priorities. Where it is not, even capacious, well-run countries can be caught off guard and encounter difficulty catching up to the disease. For example, in the early 1980s, France could have responded forcefully and effectively, but because of emphasis on fiscal austerity, public service privatisation, and the association of the disease with American gays, the French government did not implement prevalence minimisation programmes (Bosia 2006).

Governance in a democracy may not provide the 'right' incentives for leaders to address the pandemic because HIV requires a more sustained, long-term point of view. Strand (2010) points out a contradiction at the heart of what he calls 'democratic AIDS governance': if political leaders show leadership on HIV, especially in East and Southern African contexts, they encounter opposing populist politics that scapegoat PLWHA and add to discrimination and denial. Democracies may also be short-sighted, with leaders focused only on the next election, but the evidence here is mixed. Dionne (2011) finds that lengthened time horizons are associated with greater funding for HIV, but that shorter time horizons for leaders leads to 'more comprehensive AIDS policy'. One reason HIV has not become an issue in Ghana (which is democratic and well-governed) has been because there has been little to no constituency calling upon political leaders to act (Haven and Patterson 2007).

Democracy may require trade-offs that run counter to maximising anti-HIV policy. One reason for Uganda's relative success under Museveni may have been the regime's lack of democracy. 'The centralist character of the Museveni regime was crucial not only to mobilising state organisations and foreign aid resources, but also to ensuring significant involvement from non-state associations and religious authorities' (Putzel 2004b). Disease emergencies require centralised coordination and distributed instruments for efficient information movement, and these are in tension with one another. Putzel concludes democracy would not have helped

Uganda's response, because the centralist state 'was crucial not only to mobilising state organisations and foreign aid resources, but also to ensuring significant involvement from non-state actors' (p. 29).

The same factors that impede effective state response may also be those that in a different context facilitate action and demonstrate a state's capacity for functioning well. Democracies, for example, may also contain unique institutional advantages that may assist the fight against HIV. The TAC has used constitutional guarantees of human rights, due process of law, and peaceful protest and political pressure to either ally with or defy South Africa's government (Friedman and Mottiar 2004). The tension between hierarchy and distribution exists not only in the state's character but also in its bureaucracy. State organisational configuration matters. Paxton (2010), in qualitative analysis of Mexico and Botswana, finds that when state organs have a networked organisational configuration, they have higher policy responses than those organised as hierarchies or market-anarchies.

Many have attempted to understand the Mbeki regime's vehement biomedical, social, and demographic denialism. Mbeki, however, was only the most extreme example of the trend; a more general denial also occurred in the apartheid, de Klerk, and Mandela administrations. Pursuit of a 'national agenda' of apartheid, nation-building and reconciliation, economic development, or an 'African Renaissance' justified the subversion of all other concerns. HIV served as a political tool for governments to use or ignore, depending on how it integrated with the administration agenda (Fourie and Meyer 2010). South African governments, although inclusive in policy formation post-apartheid, have proved exclusive in (HIV) policy implementation and management. 'Time and again, the South African government acts on a proclivity to want to monopolise such implementation, and when this fails, it reverts to blaming extra-governmental forces. Instead of allowing the explicit bottom-up implementation of these appropriate policy documents, the government has insisted on a top-down approach' (Fourie 2006, p. 179). The effects have been substantial: South Africa has suffered economically, demographically, politically, and as a regional security hegemon. 'The long- and short-term political and economic stability of the entire southern African region will be jeopardised as South Africa becomes less capable of coping with the fallout of the epidemic' (Price-Smith *et al*. 2007, p. 242).

Conclusion

Little more than a decade ago, in a survey of what political science could contribute to addressing the greatest disease epidemic of our time, one article noted, 'Nearly two decades into a pandemic that poses one of the gravest threats to public health and development that sub-Saharan Africa has ever faced, political science can no longer afford to ignore the political implications of AIDS in Africa. A rich array of research agendas linking AIDS and politics is worthy of systematic attention . . .' (Boone and Batsell 2001, p. 26).

This is not the case on the eve of the first International AIDS Conference to be held in the USA in over 20 years. Political sciences have contributed a grand array and scope of studies, expanding our knowledge and understanding of the socio-political aspects and consequences of this latter-day scourge. The large majority of the research surveyed here has taken place since 2001. This research may not always have fit into a coherent policy agenda, nor has it necessarily moved in directions that policy professionals might prefer. But we know exponentially more now than we did 10 years ago. Plenty of potential research remains, and the possibilities touch on all corners of the systematic study of politics, whether one is interested in responses to HIV *per se* or as an example of some other political phenomenon.

There is much that we still do not know about the interrelationship of this disease with the politics of developed and developing countries. The political sciences, however, are uniquely

equipped among disciplines of knowledge to examine how ideas, interests, and institutions relate to power, decisions, and the disease. That, indeed, is the comparative advantage of political science *vis-à-vis* the other social sciences. Political science researchers may not ask or answer exactly the questions that policymakers have. But while in pursuit of advancing the frontiers of knowledge, political researchers can provide foundations for the betterment of the human world.

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