

# Organizational learning in the development of comparative HIV/AIDS policies: Cases from Mexico

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## 1 Introduction

The HIV epidemic has confronted many of the world's countries with a challenge of social relations and natural scientific information. Over the course of the epidemic, the biomedical information about the disease has often been incomplete, difficult to understand, and constantly updating. As HIV has become, in some places at least, a manageable chronic disease, the focus has shifted from the strictly biomedical to socio-economic interventions to control the spread of the virus. The path toward results has often been murky.

In all of this, official decisionmakers have encountered several information problems affecting their decisions: low overall information on available courses of action and associated costs and benefits, rapid changes in basic scientific knowledge about the epidemic, and separation of different types of expertise with relevance for addressing the problem. The question come down to: how do individuals and organizations gather information and derive conclusions in such an environment? In the fight against HIV/AIDS, actors have had to update their knowledge quickly and constantly and draw implications for public health policy and politics.

As a disease *per se*, HIV has presented unique difficulties for most countries. It requires discussion and persuasion on delicate or controversial socio-political issues and structures: e.g., sex practices, the roles of men and women, and the structure of the family. As regards treatment, HIV drugs have not been particularly cheap, even with specially negotiated pricing for less rich countries. Even were universal ART access achievable or available, the drugs certainly cannot cure AIDS—only stave off its advance. Although societies have historically regarded many diseases as punishments for moral or ethical failures, HIV/AIDS has carried a particularly heavy stigma. Because HIV is costly to address, information about what does or does not work may be the most valuable resource available, even if it is of variable quality. Those concerned are looking to get the greatest efficiency. The lessons of experience, which can reduce information costs, can provide a significant guide for states that are assessing policy choices.

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In this paper, I consider the relationship of organizational learning and information; how learning plays an important role in the articulation, development, and testing of policy regimes; and the various institutional and political forms that learning takes to encode lessons learned. First, I describe a theory of the *process* of organizational learning. One important aspect of my theory is that it *does not necessitate policy change* to demonstrate that an organization has learned from information and experience. Second, I consider several cases from the history of Mexico's response to the HIV epidemic, to show how organizational learning can shape the means and forms of policy response.

## 2 Theory

Social scientists have used organizational learning approaches extensively to explain policy preference and change, in a wide range of policy areas.<sup>1</sup> Some (potential) policy changes are larger, more difficult, or more costly than others, and learning approaches have provided students of the state with leverage to determine which of competing explanations for state action best fit a particular situation or class of situations (Hall 1993).

Organizational learning theories are about the movement and management of information. Although there is disagreement on the nature of the process of learning, whether it is indicated by change in policy action, or the behavioral implications of an organizational learning process, most analysts do agree that instances of organizational learning start when the actors in question acquire new information about some phenomenon that has occurred and apply that information to a matter at hand.

There is much disagreement about the final implications of organizational learning as a causal force in international and comparative politics. Some political scientists treat learning as a behavioral outcome, where "learning" causes a direct change in the behavior of the individual, organization, or entity observed. (Levy 1994, p. 282), for example, notes this and several other problems in the use of learning models in theories of foreign policy (such critiques can apply to more subjects than foreign policy alone).

- Researchers employing learning approaches have failed to distinguish learning, as a source of policy change, from other possible causes of policy change.
- Restrictions of learning to "desireable" or "correct" lessons.
- Failing to distinguish analytically between individual and collective learning.
- Not differentiating between "genuine" learning and "the rhetorical or strategic use of historical lessons to advance current purposes."

Learning theory offers a framework for understanding state responses to infectious disease epidemics because organizational learning theory focuses on the information analytics of pol-

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1. Representative theoretical contributions include: (Hall 1993); (Hecl 1974); (Huber 1991); (Johnston 1996); (Knopf 2003); (Levitt and March 1988); (Levy 1994); (Reiter 1994).

icy response. The policy response entails managing what is known about both the biological and the social processes associated with a disease.

## 2.1 Process Steps

My theory of organizational learning starts with an idea laid down by (Huber 1991). Most theories of organizational learning argue that behavioral change is the directly observed manifestation of a learning process. That is, the outcome of a learning process is altered actor behavior. My argument is that an organizational actor learns when it understands that its overall options have expanded or increased over some previous set of policy options.

My theory assumes, like most organizational theories, that organizations are made of individuals, and that organizational processes are manifestations of individual processes. These individual learning processes may aggregate “upward” or they may take on their own ontological reality, apart from the existence of the individuals within the organization. Most analysts of organizational learning agree that we can speak of an organization or social group having a process akin or analogous to individual learning but which can be separated from the constituting individuals. Organizations encode information for later use, through standard operating procedures, reports, and their particular configuration of elements (sub-organizational organizations) as portrayed in “org charts.”

There are five steps in the organizational learning process I propose. The learning that a social actor like an organization or government agency undertakes is being *process-based* rather than the result of a series of information outputs and consequent behavioral outcomes.

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1. *Problem identification*: Organizational actors or the individuals within them must first agree that there is a situation or problem that differs from the past sufficiently to merit (re-)examination. In some cases, the identification of a problem need not come from the actor itself — as (Hall 1993) shows, organizations like think tanks and academics can bring new situations to light for organizational or political actors.
2. *Acquire information*: Actors then engage in a process of gathering information for use in examining the problem.
  - (a) The information acquired will almost certainly be some subset of that which is relevant and available to the problem situation at hand. An organizational actor will rarely hold, have access to, or have capacity to analyze all the information that might possibly bear on the problem at hand (a la bounded rationality). Actors will not value or collect information indiscriminately.
  - (b) Beliefs about the way the world hangs together influence the process of acquiring (not to mention analyzing) information. Actors will not value all information with equal weight. Social actors have beliefs about the types of information they consider relevant, and these will influence the search process. Actors engaged in organizational learning—because the process relies upon comparing new to old

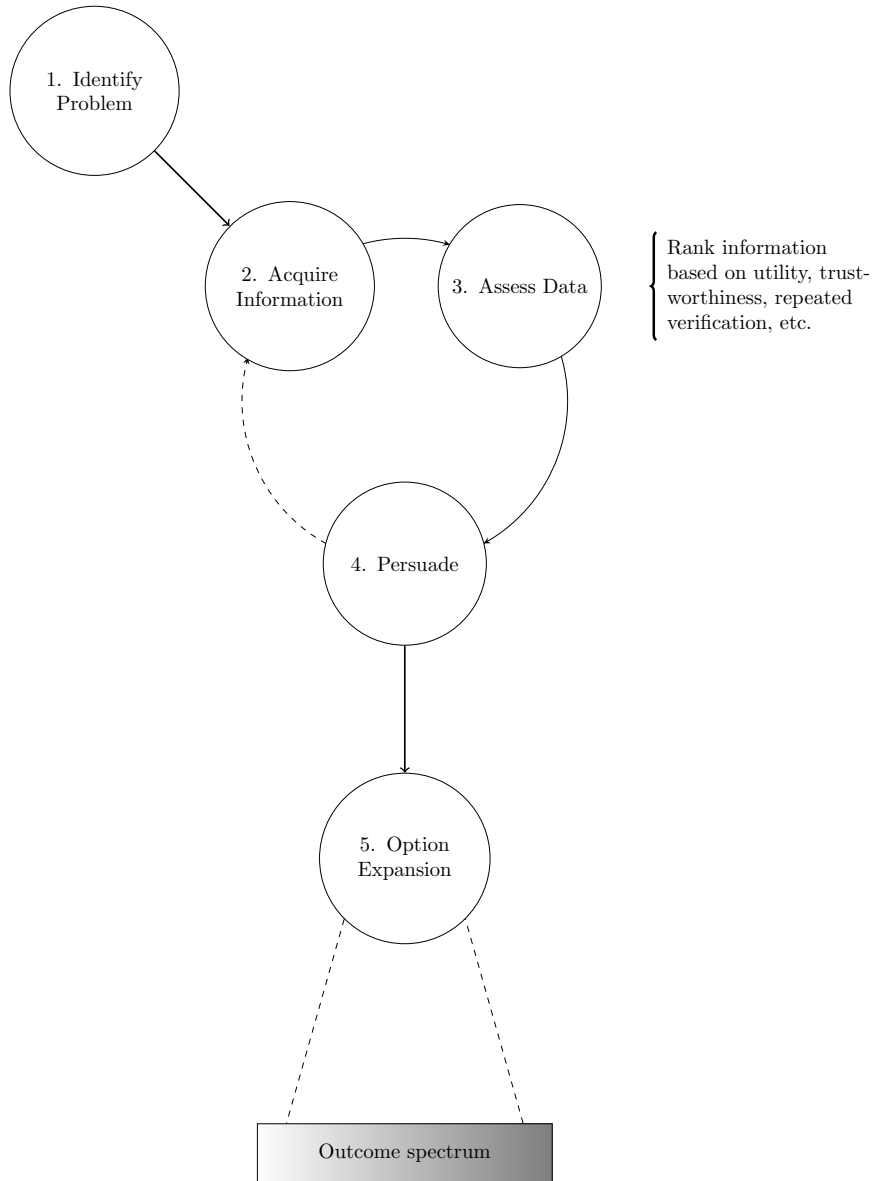


Figure 1:

information—may well prioritize the same classes or types of new information as they had previously collected.

- (c) Actors are not restricted to acquiring information at only one linear stage of the overall organizational learning process. Information is the key input of organizational learning, and it can enter the process at several places.<sup>2</sup> What’s important is that it *must* enter here. If an organization defines or recognizes some problem, and it subsequently obtains no information, it cannot be said to have learned. This is common to all theories of organizational learning, whether in the way I outline here, or in any other variant I am aware of.

3. *Assess/analyze data*: Organizational actors make meaning of the information they have collected. Facts must be fit into frameworks, and order must be made from messy data. Assessment occurs with respect to extant organizational policy and environment. Organizations try to categorize the new within what is known. Policy and procedure are the organizational encoding of part lessons and inferences, and so they provide a starting point for assessing new data. The learning organization evaluates new information against current policy. Organizations take three types of action in assessing information.

- (a) *Contextualize*: Does a datum relate to a particular policy, procedure, regulation, etc, and how closely do the datum and the policy touch on one another?
- (b) *Compare*: How well does the information converge or diverge from the expected results of a current policy regime? As divergence increases, the organization must decide whether either to discount or disregard that information as anomalous, or consider the information as evidence to discount the current policy.
- (c) *Decision toward resolution*: Divergence between expectations and outcomes reaches a point where resolution is necessary. That is, evidence becomes sufficiently “large” that real and ideal worlds do not match “enough.” There is no “objective” point at which we can expect revisionary decision from the organization, as different organizations and the people within them will have different tolerances for different levels of divergence. From foresight or experience, an organization may have pre-set a level of difference that triggers policy, procedural, or regulatory regime re-evaluation. Alternatively, social, political, and economic feedback will also build pressure for re-evaluation and change.

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2. There are at least four paths for information entry. 1. Prospecting/investigation: Gathering information to test alternative theories of policy outcome, for choosing the “best” model overall. 2. Monitoring/verification: Obtaining information to check that what is happening in the world matches the causal model the actor holds about why the problem exists and how it can be addressed. (Analogous to Hall’s “third-order” learning, where the “settings” of particular policy are adjusted. 3. Receiving: Outside actors provide the organization with information on the existence or scope of a policy problem or the results of their own investigation. 4. Persuading: organizational actors gather information relevant to persuading policy partners or policy masters to undertake the action the organization wants to put in place.

This is the stage when the social actor—be it person, group, sub-organization, organization, or government—becomes convinced that policy does not work in line with its intended goals or that the procedurally encoded lessons of the past do not apply in the same way under the current circumstances.<sup>3</sup>

4. *Persuasion*: Once an actor decides that a policy or procedural regime needs changing, it must persuade others to the same point of view. Under normal circumstances, I envision the persuasion step moving from the individual or small group level on up the organizational chain.

Organizations have many moving parts, and it is rare that any one part can unilaterally implement change in procedures. Even in a very hierarchical organization like the modern business corporation, the different components of the entity will exhibit varying levels of buy-in to the new goals encompassed in a policy change. As one example, the bureaucratic politics model, which tends to assume a high degree of hierarchy in the organizational structure, is an acknowledgement that where command and control are high, subordinate components have power to subvert the will of their masters when they believe some change to violate organizational identity or purposes.

The most basic info to be presented will be that which pertains to the digression between current regimes and stated or understood goals. That is, the change advocates must articulate the existence of a problem and its magnitude. Then, the changers will have to lay out information demonstrating that a proposed option (or set of options) decreases the difference between expectations and observations for the policies and procedures under examination.<sup>4</sup>

Those advocating for procedural or policy change will have to provide subordinate, parallel, and superior groups within their organization with the information the change advocates believe can balance out two tensions in the amount of information needed to persuade. First, they must figure out what is the minimal amount of information likely to persuade other organizational units to open up new policy regime options. Second, change advocates try to figure out the maximum quantity of information that a person or organization can absorb before it reaches its computational limits.

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3. In the latter case — where assessment indicates that the lessons of the past do not apply — there may occur another iteration of the acquire and assess steps of the learning process. The goal here would be to figure out what aspects of the past and present differ and by how much.

4. This could occur in a variety of ways. Proposed solutions to the divergence could, for example:

- (a) Modify the regime's mechanics so as to make the observed outcomes more closely match the goals.
- (b) Alter the goals to be more inline with what actually seems to occur. So, if the goals for a policy are quite ambitious and the outcomes seem to be more modest, the goals can be altered, tempered even, to acknowledge the presence of confound factors of whatever sort that decrease the magnitude of outcomes. The reverse, where outcomes exceed expectations, might also be true, and the process of modifying in line with divergence observed is the same functionally.
- (c) Focus on an alternative causal pathway/mechanism

To persuade people and groups that some other potential paths are viable, the information-receiving actor needs enough of the “right” type of information to overcome potential objections to change. However, the full information set would likely be too much for the actor to process, especially as the set of information grows and the problem and solution wend their way up the organizational ladder. Of course, to persuade different audiences will also require different types of information; economists and epidemiologists judge actions and policies by different criteria.

Persuasion will almost certainly require re-iterating through the acquisition and analysis steps of the organizational learning process. The greater the scope, needs, or authority embodied in the “new” policy option, the more the process will have to repeat, to reach an appropriate level of organizational actor who can expand (and attempt to approve and implement) policy options. Individuals and groups at different levels and locations in an organization integrate the information from various analysts and pass those judgments through the organizational structure. When these judgments are applied to current state policy, they permit policy analysts to decide to what extent the degree or direction of previous policy choices needs to be changed.

*Credentialing* can serve as a shortcut in persuasion. Credentials are an assurance of particular expertise, and they allow the holder to speak and act, in the area of the credential at least, in an “unbiased” (or perceived to be) fashion. Beyond singular credentials, like advanced degrees or famous prizes, people who combine multiple sorts of expertise or renown, demonstrating success in both academia and politics for example, may be able to operate with greater speed and reach than those who have excelled in only one realm.

In the arena of global health, we often observe that the leaders of government agencies, advocacy groups, non-governmental or international organizations are biomedical clinicians or researchers. We have no reason to presume that physicians or virologists necessarily have better organizational management or political skills than other professional categories. What these people do is translate the language of the natural sciences into a language that decision-makers can understand, so as to inform the decisions about what to do. If those scientist-managers also turn out to have some political skills (as some do), then they can be even more effective, leveraging the expertise (especially if that as perceived as having little to no bias) into persuasion for a preferred policy position.

Strategic deployment of information, credentialing, knowing one’s audience — all are tactics in a greater strategy of iteratively persuading widening circles that a policy, as currently implemented, stands in need of re-examination and possible revision.

5. *Expanded Option Adoption*: Persuasion may only force or encourage re-examining a particular policy. It will not necessarily lead actors to cast about for alternative action. We cannot argue for entities to have “learned” some “lesson” (the conclusions about changes to be made in response to a divergence between expectations and outcomes) if

they do not identify an alternative pathway. This is the critical point of the organizational learning process. Without the articulation of alternatives to the present course, an entity has only engaged “critical reflection”, as it were.

Learning requires the drawing of actionable conclusions. Analysis is a *necessity* in a learning process — but it is not a *sufficiency* for the purpose of saying that an entity has learned. Expanded or alternative options arise in the analysis step

In some ways, option expansion may seem an adjunct of the persuasion step, because it occurs when the actor in question becomes convinced that an action is possible. When an action is possible, I take that to mean that the actor possesses the *ability* to put the action in place, freed from resource, political, legal, or other constraints that limit *opportunity*. That is, option expansion is achieved when, *ceteris paribus*, an organizational actor at some level possesses the present power to take some action. Option expansion becomes analytically distinct from persuasion (ideally) when being persuaded unites with power possessed.<sup>5</sup>

6. *Action/Inaction*: Policy options are pursued in this step. We *may or may not see changed behavior* that the organization demonstrates, depending on whether other actors in the policy environment support or oppose the policy option proposed and choose to further or block its adoption. *Per se*, this step is not strictly part of the learning *process*, but for those who focus on inputs and outcomes rather than processes, this step has been the focus and observational locus for observing a learning process.

For some analysts, behavioral action has been the critical step, at least for empirical analysis, in organizational learning process theories. There are at least two mistakes with such a view. First, looking for a change in final outcomes misunderstands the phenomenon under examination, as an *output* rather than as *process*. Second, a focus on changed behavior biases the selection of cases for examination to observed change in policy, leaving out some cases where learning has occurred (in the sense of having expanded options) but has not resulted in changed behavior. Focus only upon behavioral changes leaves one unable to identify (a) those cases where learning occurred but the lessons were somehow prevented from implementation, (b) cases where learning did not occur at all.

With a focus on behavior change outcomes, it would be sensible to think that change is the key in organizational learning. At such a stage, we can see the residue (policy/procedure) of one type “successfully” completed process. If we focus on learning as a process of information analysis and persuasion, we would, in theory, be able to see the residues of analysis and persuasion — encoded in items like policy memos, the recollections of key participants, advocacy or recommendations provided to legislative or executive bodies — even if final policy did not change.

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5. The world never turns out to be ideal. In a plural or polyarchic system, few actors possess the sort of unilateral ability to act or behave independent of other actors’ checks on action.



If we confine learning to observations made at the end of the process, we can only observe two states: behavioral change or status quo. There are, however, three outcomes: learned conclusion and resulting policy change, learned conclusion and policy stasis (due to blockage, etc.), and no learned conclusion.

## 2.2 Orders of learning

Peter Hall, in one of the seminal works on organizational learning (Hall 1993, 278–279) (which he calls “social learning” but which cites and dovetails with what I call “organizational learning”), argues that there are three “distinct kinds of changes in policy” that social learning processes operate upon: policy goals, policy instruments, and policy instrument settings. Within a “framework of ideas and standards”, the “paradigm”<sup>6</sup> defines the scope and space of the policy subject area (i.e., what “counts” as belonging to a particular policy realm), how to examine and evaluate the policy regime, the hierarchy of goals permissible or possible to pursue, and what particular tools or “instruments” should be used.

Hall points out that most organizational learning, and indeed most policy change, occurs at the level of “settings”; “first-order” change is marked by satisficing and by policy formulation, evaluation, and justification with reference to the immediate past. This sort of change is often what analysts think of, when they think of organizational learning, because it is relatively isolated from the pressures of politics, particularly in pluralist or polyarchic systems.

Second- and third-order change (changes to policy instruments, or to a system of policy goals) can also exhibit features of organizational learning. For second-order, instrument-based change, the feature marks changes as driven by organizational learning are that the impetus for the change be driven by “dissatisfaction with past policy rather than in response to new events alone” as well as that officials (civil servants) played the central role in the process instead of politicians (283). Third-order change as a result of learning appears to have two aspects that we can look for, even if eventual policy change does not come about. First, the most important actors are politicians, media groups, and (perhaps) civil society actors, especially when engaged in political rather than technocratic advocacy. Second, “the process of policy change did not take place primarily within the confines of the state itself” (287). The dispute over and the eventual paths by which the goals of policy shifted were a “societywide affair, mediated by the press, deeply imbricated with electoral competition, and fought in the public arena” (287).

I describe this aspect of Hall’s treatment—differentiating among orders of change—because I want to argue that the learning model I am offering is commensurate with these degrees of policy changes. My model accords easily with Hall’s “first-order” version of learning. Second- and third-order change are harder to grasp, especially since Hall’s learning is stipulated post behavioral change. This is not to say that Hall’s understanding of organizational learning is incompatible with mine, but rather that he sought to explain the causes of observed change, and how ideas (as opposed to or different from institutions and interests) underlay transformations in policy both small and large.

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6. Hall is quite explicit in acknowledging his analogical debt to (Kuhn 1970).

Just as Hall describes orders of change, I would assert that there are orders of learning. Organizational actors can learn and develop expanded policy options for settings, instruments, and goals of policy, even if those options do not result in linked change. The greater the order of learning, the more that the process described above will have to re-iterate through its steps, in particular the acquire, analyze, and persuade steps. Greater orders of learning will require greater swaths of organizational buy-in to the prospect of increased policy options, and that will require more cycling through the steps of the process.

### 3 Mexican HIV epidemic overview

I examine my theory of learning by considering the situation of Mexico and its HIV policy regimes, from the rise of its epidemic in the early to mid-1980s to the first decade of the 21st century. I focus my analysis primarily upon the actions of governmental or bureaucratic actors, tracing causes and consequences of policy decisions, with particular emphasis on critical or significant events and decisions. Although NGOs/CSOs<sup>7</sup> played important roles in the furtherance of AIDS policy programs, especially with regard to the (post-1996, triple-cocktail) treatment regimes, I only address them as they interact with the government's HIV apparatus. As regards IOs<sup>8</sup> or state-to-state topical intercourse, on the other hand, I pay somewhat more attention to these, both because they are subjects of explanation in my theory, as well as phenomena of interest in International Relations more generally.

There are several good reasons for the seemingly counter-intuitive cases of health policy learning found in Mexico. First, it is outside the region of sub-Saharan Africa. HIV is so often thought to be equivalent to "Africa" (never mind that such a term that covers 40-odd countries with vastly different resources bases, economic and political systems, and ecological geographies) that we forget that one-third of the world's HIV/AIDS cases are found outside sub-Saharan Africa. The HIV epidemic in sub-Saharan Africa may be sufficiently different from those that are found in other parts of the world (Pisani 2008, Ch. 3) that an analysis restricted to sub-Saharan Africa may have lesser explanatory power and portability than one that also examines other parts of the world.

Second, as well as being the second largest country in the region, Mexico has the second-highest burden of HIV-positive persons in the region. Brazil, the Latin American country with the highest burden, has received much attention and analysis of its HIV epidemic and the resulting state, civil society, and international response. As of 2013, according to UNAIDS statistics, Mexico had about one-quarter of the number of HIV-positive people that Brazil has, with about 55 percent of Brazil's population; Brazil's overall prevalence is 0.5 to 0.6 percent, and Mexico's is 0.2 to 0.3. Mexico's epidemic resembles that of Brazil (and the United States) in that the primary populations infected are men who have sex with men and their partners, as well as male and female commercial sex workers.

In this article, the "shadow" comparison for Mexico will be the United States. Although this may seem counterintuitive, it makes sense for several reasons. By all rights, the U.S.

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7. Non-Governmental Organizations, Civil Society Organizations

8. International Organizations

should better manage its response to HIV/AIDS as compared to Mexico. The U.S. is richer, has a greater scientific and technological apparatus, is more democratic, has more extensive modes of communication, and generally outperforms Mexico on those factors thought in the international HIV/AIDS “industry” to make the greatest difference in anti-HIV performance and outcomes. This is not what occurs. Depending upon the area of evaluation, Mexico and the United States either perform about equally well in their domestic responses to the epidemic or Mexico outperforms the United States. This is unexpected and thus bears explaining.

Even the demographic shapes of the epidemic itself in the two countries are more similar to each other than to other countries or regions in the Western Hemisphere. Generally half or more of all HIV+ people in each country fall into the MSM<sup>9</sup> category, with the high-risk heterosexual epidemics as the second highest component of the overall total in each.

If you believe the official figure—and many experts don’t—only 0.3% of the adults in Mexico are infected with HIV. That’s half the U.S. prevalence. “It’s very difficult to say what’s happening in Mexico,” says [Luis] Soto-Ramírez, who runs an HIV/AIDS lab and clinic at the National Institute of Nutrition [and Medical Sciences] in Mexico City. “The numbers say very different things from what I think.” From his vantage point, the prevalence must be higher — and increasing. “I’m seeing many more women and many more rural cases,” he says (Cohen 2006a, 478).

Even if the official statistics deserve some skepticism, Mexico remains quite comparable to the U.S. in the contours of its epidemic. Most of the criticisms that can be leveled at Mexico’s assessment of population and sub-population statistics may be similarly applied to the United States. The methods and models are largely the same. This is not to say that each country undercounts its HIV+ population by the same factor, only that there are similar problems present in each disease control and statistical system. Figures for the recent state of the Mexican epidemic may be found in Table [2008 Descriptive Statistics on HIV/AIDS in Mexico].

[2008 Descriptive Statistics on HIV/AIDS in Mexico]]

Indicator	2008	2012	2013
HIV Prevalence, percent	0.3	0.24	0.24
Registered new HIV diagnoses	2,415	5,712	5,804
Total registered HIV diagnoses	26,200	44,501	48,216
Estimated total people living with HIV	198,000	179,478	174,303
New registered cases of AIDS	3,574	5,191	5,548
Total reported cases of AIDS, since 1983	124,505	161,742	167,933
AIDS deaths	5,093	4,737	4,974
Source: CENSIDA			

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9. Men who have Sex with Men, Males who have Sex with Males

### 3.1 Sources

I collected data from a variety of sources. I conducted in-person and telephone interviews with approximately 15 senior members (past and present) of the Mexican Health Secretariat, NGO and CSO representatives, and health policy researchers and analysts, in Mexico City during August 2008, as well as some followup discussion in late 2009. I gathered primary documents, official government publications, publicity and educational materials, and academic articles relating to the progress of Mexican AIDS policy over the past 25 years. Furthermore, I drew on published materials describing and quoting interview research on the development of HIV policy, as a supplement to my own interviews. Most of these materials are in Spanish and have not been translated or previously available in English, and they have been largely unused in American research (in social or natural sciences) on HIV/AIDS and policy, with respect to Mexico or otherwise.

## 4 Forms of response in the Mexican epidemic(s)

Mexico's experience with the HIV/AIDS epidemic began in 1983. In that year, just two years after the first cases of what the world would soon come to call "AIDS" were detected in 5 men in Los Angeles (Centers for Disease Control (CDC) 1981), Mexican health authorities detected their first cases of the disease. In 1983, the underlying cause of AIDS was still unknown, public health authorities around the world were searching for a viral cause. In the absence of a direct or indirect test for the causal agent, physicians diagnosed the disease by the complex of opportunistic diseases that presented in a patient, most prominently including *Pneumocystis* pneumonia, Kaposi's sarcoma (a rare viral skin cancer), and cytomegalovirus. By 1985, the number of cases of AIDS had grown sufficiently large that Mexican health authorities began to track the epidemic on a national level (Magis Rodríguez and Parrini Roses 2003).

In this section of the paper, I consider several ways in which a learning process occurred and (eventually) manifested. In particular, I examine how learning can occur and make itself evident through organizational structures, with respect to both structural innovation and evolution; how particular personnel can be key to the furtherance of a learning process; and some dynamics of the key resource of learning, information.

### 4.1 Ad hoc responses

As in the rest of the world, the first official responses to the growing disease were relatively *ad hoc* and catch-as-catch-can. For the first four years of which we were aware of HIV, the number of infections increased more quickly than information on how the disease spread, which groups of people were most affected, and the social and medical etiology of the disease.

In many parts of the world, the first and initially most affected group were MSMs. In Mexico, the disease took hold among upper and middle class MSMs, transmitted by men who had studied or worked in the United States or Europe in the mid to late 1970s, participated in gay life there, and acquired the virus through sexual contact.

At first, then, the focus of monitoring and (slight) outreach was on the homosexual/gay/MSM population. In 1985, when national tracking started, the number of diagnosed AIDS cases was still low enough (367 diagnosed cases) (CENSIDA 2000–2008) that any official efforts were basic. Mostly, public or private doctors treated AIDS cases in their practices, epidemiologists tracked the expansion of the disease, and — in the very underground gay world of mid-'80s Mexico — both sets of medical professionals provided basic information about increasing the safety of sexual activities. In its early stages, the Mexican epidemic virtually mirrored that of the U.S. The official response was also quite similar, focusing primarily upon public health and epidemiological research. (The US government and academic institutions also conducted much basic scientific research, owing to the US's extensive and singular capacity in this category.)

## 4.2 Organizational innovation

In 1985 and 1986, the Mexican HIV epidemic took a turn not seen in the U.S.: a contaminated blood supply that infected *both donors and recipients*. Although the AIDS epidemic in the US did infect people via contaminated blood products received, this subset was never a very substantial proportion of the total. Blood donors in the U.S. never received HIV as a result of donation alone. Mexico, however, underwent a major series of scandals and difficulties regarding its blood supply, and the focus of public attention and official efforts on AIDS quickly shifted to cleaning up the blood supply, most critically through the prohibition of commercialized blood products (Magis Rodríguez and Parrini Roses 2003). In 1985, the first year that a test for HIV was available,<sup>10</sup> the first clusters of cases that could not be traced back to MSMs began to appear. At this time, significant numbers of women and, to a somewhat lesser extent, children (who had been infected *in vitro*) tested positive for HIV (interview with senior researcher on HIV, August 2008) .

“With the exception of patients with hemophilia, transfusion-transmitted HIV in developing countries primarily affects women—specifically women who receive blood for obstetric reasons” (Rio and Sepúlveda 2002). Once these women have received infected blood, they can then pass the virus onto their children *in vitro* or via breast milk. Thus, approximately 70 percent of the women who were infected in Mexico between approximately 1981 and 1987 came from blood transfusion infections (interview with senior researcher on HIV, August 2008). (The balance of HIV+ women were commercial sex workers and people involved in high-risk heterosexual relationships.)

At this point in time the Mexican government began to step up its response to the outbreak of AIDS, moving from ad hoc responses to more coordinated official policies. In part, the sheer magnitude of the blood epidemic drove the official response: “In only 4 years (1984–1988) blood and blood products transfusion associated AIDS in Mexico went from being unheard of to comprising over 10 percent of all cases” (1446, emphasis added).

More than the dramatic increase in cases, the *means* of infection drove official reaction:

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10. The tests available in 1985 allowed for the testing of antibodies to HIV, allowing diagnosis of infection even before the signs of AIDS had manifested.

people who *gave* blood were getting HIV. The essential problem of this blood-products epidemic lay in the means by which the Mexican blood industry<sup>11</sup> went about its business. In the 1980s, Mexico had no centrally coordinated system of blood “procurement” (neither did the U.S.). In each case, this facilitated the spread of the virus. Although some regulatory structures did exist, there were multiple blood and plasma collection and distribution enterprises. Many operated on a for-profit basis, and this could and did lead to conflicts between the safety of the blood supply and profit maximization. By 1986, epidemiological study indicated that not only blood product recipients were in danger (as in the U.S. and other countries) but blood donors were also at risk. Subsequent research indicated that blood and plasma centers re-used their collection equipment (like plasmapheresis supplies, needles and syringes, which allowed the injection of small amounts of infected plasma or blood) and spread HIV “to previously healthy donors” (1446–1447); (Sepúlveda-Amor et al. 1995, see also)].<sup>12</sup>

It was at this time and for this reason that the Mexican government established its first national-level coordinated response to the epidemic.

Compared to the speed of responses in other parts of the Americas, the Mexican response was neither particularly rapid nor slow. In late 1987, Mexico’s highest health official, Health Secretary Guillermo Soberón, had characterized AIDS as a “problem of the highest national priority” (Soberón 1988, 505). In the United States, officials of the Health and Human Services Department had also addressed the epidemic publicly and early. HHS Secretary Margaret Heckler (1983–85) said she wanted to “create the priority of AIDS as the number one issue at the Department of Health and Human Services”, but the Reagan White House was most interested in “fiscal restraint.” Ultimately, she never had a discussion with Reagan himself about AIDS and its spread, and Reagan wouldn’t give a speech on the topic until May 1987 (Heckler 2006).

From 1929 until 2000, Mexico was a one-party state under the PRI,<sup>13</sup> and the messages of state ministers were strictly controlled by the party and government. Soberón thus could not have made such a statement without the support of the president and administration. This support, in particular, was attributed by many involved in the policy process in those years to the fact that Soberón was both a political decision-maker and a scientific researcher, and he could thus translate his clinical, scientific knowledge into the type of arguments that would

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11. Until HIV/AIDS hit in most countries of the world, the donation, transport, and transfusion system for blood and blood products was a largely commercial affair. Although supervised by governments, it existed in large part as a for-profit enterprise. As we shall see, this brought it into direct conflict with the need to provide safe and “clean” products. “In many countries, infection of the blood supply is chiefly an economic phenomenon. For example, prior to 1987, selling one’s blood or plasma was such an attractive source of income. . . that commercial blood and and plasma donors. . . formed a significant percentage of total blood supplies” (Rio and Sepúlveda 2002, 1446).

12. About 70 percent of the women infected in those years came from blood transfusion infections. Resultantly, there was a law passed in 1986, prohibiting the sale of blood (this was before the US took similar measures) and requiring an HIV antibody test on blood. By 1992, blood transfusion cases dropped off rapidly (given HIV’s 7 to 9 year incubation period before manifesting as AIDS, this is ). In those years years, the F:M ratio was 25:1 (thus, MSM transmission became more prominent\citealt{hernandez-tepichin2008a}).

13. Partido Revolucionario Institucional (Institutional Revolutionary Party)

persuade fellow politicians (Magis Rodríguez 2000). More specifically, in the mid-'80s, there is a process of organizational learning at work to change the policy of the state. In interview and historical research, (Magis Rodríguez 2000) documented the pathway by which policy change was effected. As one informant explained, the director-general of epidemiology, Jaime Sepúlveda, first became convinced of the import and immediacy of the epidemic, owing to his epidemiological training and his witness to the initial rise of the epidemic. Sepúlveda worked to convince the Health Minister, Soberón. Another interview informant indicated that this process was furthered by Soberón's own research background, as this allowed him to understand the technical aspects of the scientific arguments that Sepúlveda made. Lacking such a background, the health minister would have been just another politician with whom the heads of the various departments of the Health Ministry would have had to lobby (and probably unsuccessfully, according to Magis-Rodríguez's informant).

"I believe that if Soberón would not have gone to that meeting (referring to [a] meeting of [various national] health ministers on AIDS in London, 1986) or would have been [just] a politician that had been put there [—] nothing in the Ministry of Health[,] no mat- ter how much the director general of Epidemiology or of IMSS [the state medical system for salaried workers] or of Nutrition [one of the primary biomedical research institute] was saying, hey, some- thing has to be done, these people would not have had sufficient support to achieve a change" (interview quotation from (n.p.). To attach responsibility for policy change to one person, however, would be a partial understanding of the dynamics of the policy environment and information movement and use.

Within Mexico, information existed and entered the policy system from a variety of conduits in the health system. The monitoring activities of several components of the health policy structure—the state insurance scheme, the epidemiological monitoring and investigation service, and the nutrition department (which fulfills a variety of medical and clinical research functions, not exclusively confined to a narrow definition of nutrition)—all provided information about the increase of AIDS in Mexico.

In 1986, Mexican officials established the National Committee for the Prevention and Control of HIV/AIDS. The National Committee existed at first for the exchange of information among experts from the Department of Epidemiology and from medical doctors and researchers with experience in AIDS: it had "the objective of evaluating the national situation concerning AIDS and HIV infection, as well as establishing criteria for the diagnosis, treatment, prevention, and control of the epidemic, and also to coordinate the implementation and evaluation of norms, rules, and appropriate control activities" (Magis Rodríguez 2000). The National Committee was originally designed to serve as the hub of a network of entities engaged in the fight against HIV/AIDS—it did not generally implement programs but rather provided a coordination mechanism for other entities and their programs.

International institutional mechanisms also contributed to the total reservoir of information, by both contextualizing the Mexican epidemic alongside others and sharing strategies for addressing it. The collective lessons and knowledge promulgated across countries in the

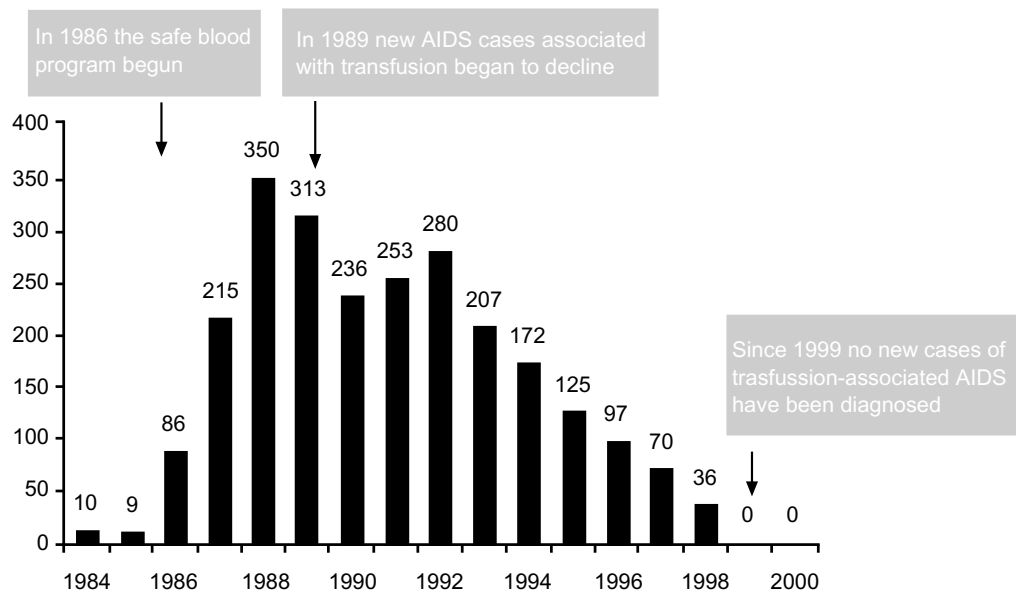
London ministers' meeting, for example, heightened and highlighted both the scale of the challenge but also the sense that something could be done with respect to the problem of AIDS. As fortune would have it, a key gatekeeping decision-maker (Soberón) integrated the roles of both researcher and politician, allowing persuasion from below on scientific and technical grounds, while permitting him to persuade above with politically relevant presentation. Nothing was foreordained about the outcome. Once Soberón came to the conclusion that the blood supply had a problem beyond that faced in other countries or situations, i.e., that blood donations posed a risk, engagement with the policy process and other political actors still lay ahead.

One of the first policy decisions to come out of the National Committee arrangement, in May 1986, was a requirement that all blood and plasma centers must test donor blood for HIV. This policy change came about in the attempt to gain some state of information on the extent of the epidemic. Until this point, based upon what health officials knew about the profile of the typical paid donor (an un(der)employed young man from a rural area who had migrated to the shanty towns of the major urbanizations and had no previous risk factors for HIV), they suspected that compensated donation posed a special risk. The previous year (1985), a voluntary testing policy—in essence, a recommendation with no enforcement provision—had been put in place, with little practical effect. Once the new mandatory testing policy started, the specific danger of paid donors came into clear focus: prevalence among those in the paid group was more than ten times as high as among unpaid donors.

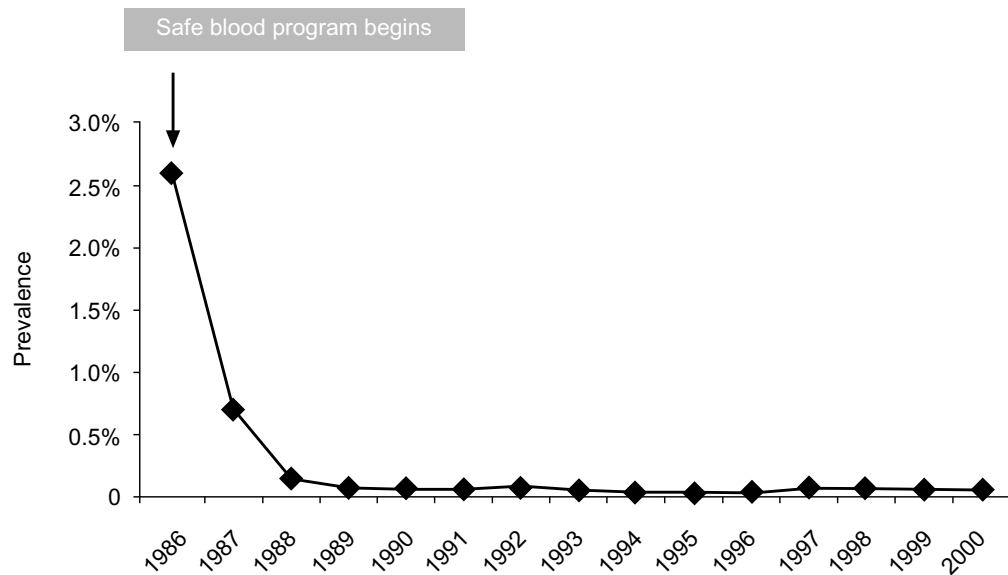
In 1987, because of the research and policy persuasion work done in the National Committee, a second mandatory blood policy was instituted: the commercial blood industry was shut down entirely, and Mexico moved to an entirely voluntary blood donation system, with blood screened by a national, state-approved network of laboratories (Rio and Sepúlveda 2002). By the most important rubric of all—new HIV infections from blood donations and transfusions—this policy brought the problem under control.

We can see the effect brought about by the change in policy in Figure 11 (which reproduces evidence from (Rio and Sepúlveda 2002)). In 1986, the ratio of male-to-female HIV+ people was 26:1, which is expected in and largely indicative of an epidemic primarily affecting MSM. By 1992, that ratio was down to 5:1, remained stable until 1999, and then began to climb once again (1446). Such change signifies a transition to an epidemic dominated by non-MSM transmission (either blood-borne transmission or heterosexual sexual contact) and then back to a primarily male-dominated epidemic.





**Fig. 2.** AIDS cases associated with blood transfusion in Mexico (through July 2000, by date of diagnosis).



**Fig. 3.** HIV prevalence among blood donors, Mexico 1986–2000. From the National HIV Laboratory Network.

“The effect of blood policy interventions. From del Rio and Sepúlveda (2002).”

### 4.3 Organizational evolution, great and small

For Mexican policy-makers, the commercial blood donor epidemic served as the catalyst for coordinated and planned public policy and action with respect to the growing HIV/AIDS epidemic. Once it became clearer that the problems of the blood donor population were on

their way toward being under control, attention turned toward taking steps to better manage the various streams of knowledge and connect the dissimilar constituencies.

Even with the successful intervention on blood policy, it had become apparent that a simple working group of biomedical experts was insufficient for the future management of the disease's spread and developing appropriate responses to the epidemic. (Engel 2006) points out that by 1988, public health authorities the world over had concluded that the organizational and bureaucratic measures that had worked in the past would not work or apply in the case of this epidemic. Mexico's realization was occurring in tandem with similar ones in many other countries. Talking fora for interdisciplinary collaboration did not provide the sort of repeated interactions that this disease seemed to demand if it were to be defeated.

In 1988, the Mexican Ministry of Health transformed the National Committee through formal institutionalization, creating the National Council for the Prevention and Control of AIDS (Consejo Nacional para la Prevencion y Control de SIDA)—CONASIDA.<sup>14</sup> According to (Magis Rodríguez and Parrini Roses 2003, 16), CONASIDA was founded “as an entity decentralized from the Secretariat of Health and with the fundamental objective of ‘promoting, supporting, and coordinating the actions of the public, social, and private sectors to combat the AIDS epidemic, as well as promoting measures to further that purpose.’” The most significant difference between what I have called the “National Committee” and CONASIDA was that changing the committee to a council “gav[e] it a multisectoral composition that went beyond the scope of individual health sector response” (Rio and Sepúlveda 2002, 1445).

In CONASIDA, a variety of “technical” and “academic” (research) committees<sup>15</sup> were put in place, to provide more appropriate fora for discussion and policy recommendation development than had been possible under a single committee like the first CONASIDA. “Particularly novel” for the Mexican health system, these committees operated in a fairly decentralized fashion, which one analyst characterized as rather successful for pushing forward the work that they had to do (Magis Rodríguez 2000).

At the same time, Mexico also received international financial support to allow for the exchange and analysis of information from a variety of sources and disciplinary perspectives, primarily under the auspices of the Centro Regional de Intercambio, Documentación e Información sobre SIDA (CRIDIS),\* which was funded by the Pan-American Health Organization (Magis Rodríguez and Parrini Roses 2003, 16).

By 1988, although HIV/AIDS was primarily still seen as a public health matter (as it was in the USA and most if not all of the rest of the affected world), Mexican HIV policy had developed across conventional boundaries within the field of public health. AIDS required attention to medical product sanitation (ensuring “clean” blood), outreach to marginalized and criminalized groups (MSMs and sex workers), advanced medical care for the sick and dying (and although this was almost always palliative care for opportunistic infections, be-

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14. Confusingly, the Spanish acronyms for both the Committee and the Council are the same (CONASIDA). I have chosen to refer to the committee/working group as the “National Committee” and to reserve the “CONASIDA” designation for the formally organized bureaucratic entity/council.

15. The former group consisted of committees on Health Education, Epidemiological Research and Monitoring, Blood Banks, Clinical-Therapeutic matters, and Legal Aspects; the latter category of committees included Pathology, Perinatology, Social Aspects, Epidemiological Models, and Psychological Aspects.

cause many infections were so weird as to require special resources or knowledge), and special medical and media work with cross-border migrants, who were at particularly greater risk.

As the 1980s wore on, another unusual group (at least as compared to the “usual” risk groups) began to emerge as at particular risk for HIV infection. Cases in Mexico’s rural areas began to rise exponentially, although it was initially difficult to understand the source of the infections (Magis Rodríguez et al. 1995). It soon became apparent, however, that the rise in rural AIDS cases, especially among women, was a consequence of cross-border migration back and forth between Mexico and the United States. Men would travel (temporarily) to the United States for work and engage in practices they would not have done much or at all had they been at home (unprotected sex, hiring commercial sex workers, and MSM activity). These practices put them at higher risk for HIV infection, and some acquired the disease. On returning home to Mexico, they transmitted the disease to their wives, fiancées, and girlfriends. Because HIV had, until this time, primarily affected people in urban centers, most rural residents had not been exposed to information as to how the virus infected people and how to prevent infection.

Although the linkage between HIV’s spread and migration patterns has since been observed in a variety of settings and seen as commonplace (Specter 2001) (Waldman 2005), Mexico was one of the first countries to identify the connection. The research indicating that there was a new risk group to which to pay attention came from of CONASIDA.

The problem of migrants as potential HIV risk group was common to both the United States and Mexico, as the vast majority of Mexico’s cross-border human traffic takes place along the nearly 2,000 miles of its border with the U.S.<sup>16</sup> U.S. authorities were not the ones to notice first the connection of economic migration and the spread of HIV: the prominence of MSM in the U.S. epidemic and the significant flows of illegal immigrants from Mexico who remained out of sight to public health officers both lessened the noticeability in the U.S. of migrant-based HIV transmission.

Epidemiologist Carlos Magis-Rodríguez, CENSIDA’s research director, has found a surprising degree of heterosexual spread in rural Mexican communities and disturbing new evidence that migration is a major factor. "We find a lot of at-risk behavior in these little towns," says Magis-Rodríguez. . . . Preliminary data suggest that the migrants have more sexual partners, use drugs and alcohol more frequently, and hire sex workers more often. Cohen (2006a, 478)

As migrants travel to the US for economic opportunities, they are often relatively alone and isolated from people who know them. Thus, a major brake on their behavior is removed, owing to lack of persons who know their past and social network and who can provide report of their behavior to people they know back at home. They engage in more risky behavior, because while in the US they have more opportunity and more resources to, e.g., hire prostitutes or to use drugs. One dominant pattern for migrants to the US is to move seasonally

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16. Mexico’s southern border also has immigrant traffic, of poor people from Belize and Guatemala entering Mexico along the way to the U.S. or for Mexico’s own opportunities. There is some increase in HIV infection from this southern border traffic, but that attributable to the northern border dwarfs it in magnitude. See (Magis Rodríguez et al. 1995).

or annually back and forth between the sites of work in the US and home communities in Mexico. When they return to Mexico, they reunite with wives and girlfriends,<sup>17</sup> and if the migrants have acquired the virus, they can transmit it to their sexual partners. Even if they have no wives or girlfriends, the migrant workers can spread the virus to their village when they come home because the money they have acquired in the US allows them to continue to engage in drug use and hire commercial sex workers, just as they did in the US. "... today IDUs are a major driver along the Mexico-U.S. border..." Cohen (2006b, 469) -

One of CONASIDA's first new initiatives was to work with migration authorities and the Los Angeles Consul General; they founded an office in that city that met with approximately 450 people per year from 1990–1993. Starting in 1989, CONASIDA also began working with other units of the national government (like the Education Secretariat), the military, and provincial governments on media campaigns directed at various groups believed to be at greater risk, such as MSMs, IDUs, homeless children, adolescents, and women (Magis Rodríguez and Parrini Roses 2003, 17).

Throughout the 1990s, CONASIDA engaged in a variety of programs, initiatives, and research projects, collecting and disseminating information throughout Mexico, as well as collaborating with other government and civil society partners. A key highlight of the period was a mass media campaign to educate the public in general, as well as particularly focusing on high risk groups (17); for MSM in particular, the principal strategy was the distribution of condoms, leaflets, and posters (*ibid.*, 18).

By the end of the decade, the responsibilities and role of CONASIDA had increased significantly. "In 2001, stock was taken of what CONASIDA had been able to accomplish, and it was deemed necessary to strengthen it as a collective body, both in its power and its integration" (20). CONASIDA was elevated to the status of a national center, CENSIDA (the Centro Nacional para la Prevención y Control de SIDA). This gave CENSIDA further independent status vis-à-vis the Ministry of Health, so that although it remained bureaucratically organized under Health, it conducted its operations with minimal oversight or interference. This autonomy allowed CENSIDA to augment its learning quickly, as well as to put the policy implications about which it drew lessons into action.

#### 4.4 Static organizations, dynamic personnel

An organization's learning process does not always occur or manifest through the organizational structure alone. As seen before, sometimes lessons learned come about via the particular constellation of actors involved in an issue area, even including the participation or entry of particular individuals into the process. Bennett and Howlett (1992) refers to this form of learning as "lesson-drawing" (289). In such a case, the actors and learning process are embedded in a policy network, where particular individuals can serve as powerful, central, or bridging nodes in that network.

In the following section, I examine how a policy network, along with a particular individual

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17. Men constitute the majority of migrants who cross back and forth across the US border. Women and children are more likely to stay put once they have crossed to the US.

who bridged the advocacy, medical, and policy worlds, effected a substantial and surprising change in Mexican social policy, for the purpose of making a dent in HIV prevention efforts.

#### 4.4.1 MSM epidemic

As in the United States, AIDS first arrived in Mexico in homosexual men, appearing most often among those from medium to high socio-economic backgrounds who had worked or studied in the U.S. in the years previous to 1983. Having some level of interaction with the U.S. gay community, these Mexican men had become aware of the growth of the mysterious disease that appeared to stalk gay men, and they were greatly alarmed at what was befalling American friends and lovers, suggested one interviewee. So when the first cases of AIDS showed up in Mexico in 1983, not only public health officials knew what was going on.

Mexican elites tend to pay attention to what occurs in the US, whether in politics, science, or society. Mexican doctors and epidemiologists were well aware of the growing crisis in America and Europe over the new disease with an unknown etiology. Similar to what was happening in the U.S., since the disease was mainly confined to gay men, gay men also paid great attention to developments in the science of the new disease.

Gay life in Mexico in the 1980s remained largely underground, primarily restricted to the large urban areas of Mexico City, Guadalajara, Cuernavaca, Monterrey, and Tijuana (this remains at least somewhat true even today). Mexican gays had experienced no comparable movement or demands for civil rights such as that sparked by the Stonewall Riots in New York, after the 1969 death of Judy Garland (for a good overview, see Shilts (1982)). But as AIDS began to strike Mexican MSM, it proved a rallying point for what gay community did then exist. Numerous of my interview subjects, as well as the work of Dehesa (2010) indicated that demands for treatment access, human rights protections, and greater medical assistance originated in the gay NGOs, and that even today, these are still probably the most powerful and influential voices among those affected HIV/AIDS.

Throughout the 1980s and early '90s, Mexican AIDS efforts, after addressing the blood donor and recipient crises, focused primarily upon MSMs and, to a lesser extent, commercial sex workers (the latter group is discussed extensively in Rio and Sepúlveda (2002)). But, as in countries around the world, targeted prevention efforts and palliative care for the illnesses associated with advancing HIV were virtually all that was possible in terms of treatment until 1996, when results for trials of HAART<sup>18</sup> were announced at the World AIDS Conference in Vancouver, revolutionizing HIV care and treatment.

AIDS and homosexuality remained difficult to discuss in Mexico, and this has affected the shape of official responses to the epidemic in the country. Mexico has certainly made great strides in recent years: “Although machismo leads many Latin American countries to play ostrich about homosexuality, Mexico and Peru each openly report that their epidemics are driven mainly by men who have sex with men (MSM)—including many who also have sex with women” (Cohen 2006b, 468). That said, openness in gay life has come only recently; for example, Mexico City’s “gayborhood”, the Zona Rosa, appears fairly open and rather like

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18. Highly Active Anti-Retroviral Therapy. Often also called “triple cocktail” or “combination” therapy.

urban gay enclaves in the US or Europe, but at least two of my informants indicated that this state of affairs had only occurred in the last five or seven years.<sup>19</sup>

Since the mid-1990s, the epidemic among MSM has emerged as the most significant and constant component of the HIV epidemic in Mexico: new infections emerge at a fairly constant and consistent rate from year to year. Seeing this, researchers and policymakers in CONASIDA/CENSIDA resolved to address this population more directly.

One of the more significant results of this determination has been the launch of an anti-homophobia campaign as one of the critical legs of HIV prevention strategies among MSM. As in other Latin American countries, in Mexico a fairly large number of MSM do not identify as “gay” and also have sex with the women who are their girlfriends, partners, or wives. After the measures taken to stop the blood epidemic, therefore, most Mexican women who became infected HIV received it from their partners who had or were having sex with men.

The problem is similar to that faced in the U.S. African American community. As Cohen (1999) and Denizet-Lewis (2003) (among others) have documented, in communities where quite traditional norms of masculinity prevail, same-sex sexual activity does not fail to exist, but it is driven deeply into secret activity. This creates a problem in terms of HIV: deeply hidden MSM will not receive prevention information as often as more “out” men about the various methods by which they can reduce their risk for HIV. (Health authorities target most such information within the spaces and programs associated with the out gay community. Those who do not interact with that community, whatever the reason, have less opportunity and exposure to prevention efforts.) Because they are having sex with other men, their risk is much higher than that for the general population, and if they are also having sex with women, they can accordingly put these women at much higher risk for contracting HIV. These men “on the down-low” (as it is known in U.S. African-American MSM circles) are overall less likely to receive preventive education, to be tested for HIV and know their sero-status, and to seek and access treatment. Just as with the blood donation-driven epidemic of the late '80s, this situation creates a perfect situation for the virus to spread widely and relatively unimpeded.<sup>20</sup> As a (partial) result of the foregoing social circumstances, MSM are Mexico’s single largest group by category of transmission, constituting somewhere between 35 and 45 percent of all AIDS cases (Cáceres 2002, S25).

The anti-homophobia campaign primarily consisted of a variety of public awareness campaigns to normalize and destigmatize homosexuality.

On the national front, Saavedra has spearheaded an anti-homophobia campaign

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19. Other potential enclaves exist. In my field work, I noted US and European émigrés and highly educated Mexican citizens tend toward a general acceptance of homosexuality, or at least of its existence. Mexicans with idiosyncratic connections to world events also evince a form of toleration: when I visited a church associated with the Anglican Communion, which has been riven by divisions over human sexuality in recent years, discussion with parishioners there indicated that they were somewhat aware of the associated issues and at least not outspokenly hostile.

20. Within the U.S. African American community, the culture of the “D.L.” has been held at least partially responsible for HIV rates driven to levels that WHO would classify as a generalized epidemic, were it a country.

of radio and TV ads—so provocative that two Mexican states refused to run them—and posters, including one that shows a man and a woman both leaning their heads against the archetypical macho Mexican man dressed in revolutionary garb. “The anti-homophobia campaign really has opened a lot of discussion on this issue,” Saavedra says (Cohen 2006a, 479).

Based simply upon a combination of past actions and the arrangement of political players in the Mexican system, a campaign like the one against homophobia is extraordinary. First, with the exception of Brazil,<sup>21</sup> there is no other country in Latin America doing anything like this — most Latin American countries are very reticent to discuss issues around sexuality and sexual practice. In part, this occurred because under the administration of President Vicente Fox (2000–2006), he delegated substantial authority for policy to his ministers, as a way of demonstrating his party’s (PAN<sup>22</sup>) break with the heavy centralization of the PRI presidential regimes (Díez 2010, 42).

Fox’s decentralizing, democratizing ethos extended to cabinet ministers, including Julio Frenk, the Health Minister. As Díez (2010) notes, Frenk and Saavedra had known each other and collaborated with one another on HIV issues since the early 1990s, when Saavedra was Frenk’s student at the Harvard School of Public Health (42–43).

Second, the particular constellation of players in the Mexican system during this period would not be expected to provide support or allow such a campaign. Although the Roman Catholic church is powerful and by far the dominant religious voice in Mexican society, there is a norm of very strict separation of church and state (in part, an outcome of the early 20th century *cristero* movement, where the socialist government sought to stamp out religious authority and expression).

The Church’s power is exercised primarily via the bully pulpit, and Mexican authorities appear willing to resist the direction of the bishops when good policy or science dictate. In large part, this is possible because the Mexican Constitution strictly prohibits religious institutions from “lobbying” the government, and the informal constitution of “lobbying” is fairly strict.

Díez analyzes the anti-homophobia campaign on the basis of policy entrepreneurs and competing policy frames, a la Kingdon (2003), arguing that once Saavedra and confederates had put in place the media campaign and anti-discrimination policy, they deployed a legal and scientific framework to counter the conservative opposition, including the Roman Catholic hierarchy. In my interviews, interlocutors pointed out to me that the separation of church and state is taken so seriously that the Mexican president is expected to attend religious services in public rarely, if at all. To be seen in church would be seen as “taking directions” from the religious hierarchy. Church action beyond public pronouncement seems as “lobbying,” and the church’s letters to the President, Ministry of Health, and the Ministry of the Interior crossed a line in many minds.

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21. Brazil is almost always the exceptional case in Latin America and in the world generally. As a country, it has historically moved quickly on issues around HIV/AIDS, putting in place prevention and treatment programs considered significant and revolutionary.

22. Partido Acción Nacional (National Action party)

Finally, the dominant national political party for more than a decade after the democratic consolidation (from 2000–2012), the PAN, is a socially conservative party. On the other hand, it wishes to distance itself from the PRI's reputation for ignoring experts and for not governing in the interests of the Mexican people (as opposed to party cronies). Thus, the PAN became willing to support the program to demonstrate its commitment to science, openness, and democratic values. In their work to keep President Fox persuaded of the wisdom of the anti-homophobia and anti-discrimination policies, they pointed time and again to the scientific consensus regarding the relationship of discrimination and increased risk for HIV infection (Díez (2010) as well as my interviews).

## 5 Conclusion

Mexico saw the linkage between researchers and policy-makers strengthened during the AIDS epidemic. Two reasons seem to be most significant. First, the entire novelty of AIDS as an infectious disease and as a problem for public health policy led decision-makers to act with “humility” (Trostle, Bronfman, and Langer 1999, 110) and seek out all the information that they could find — information that lay primarily in the hands of scientific researchers. Even as much of the research on the etiology and epidemiology of AIDS was conducted in the United States and Western Europe, Mexican scientists had to translate (often literally, since much of the scientific literature was in English or French) scientific language into terms upon which policymakers could understand what was happening to individuals and populations. Mexican AIDS scientists also provided information specific to the progress of the disease in their own country. Second, besides the fact that the disease was new and unknown, “policymakers needed support and justification for decisions” (Magis Rodríguez 2000). In Mexico, as in the U.S. and Europe, AIDS found and finds its greatest prevalence in groups that are mostly marginal and socially unacceptable, such as IDUs, MSMs, sex workers, and lower socio-economic classes like immigrants. Although perhaps convinced of the need to recognize and assist such populations, decision-makers also recognized the unpopularity of acknowledging and helping such people; researcher evidence and results provided cover.

We also see that in the Mexican response to HIV/AIDS, linkages to international organizations, especially those of or affiliated with the UN system, proved important. Not only did organizations like the WHO, UNAIDS (and its predecessor within the WHO), PAHO, and the U.S. CDC provide funding to Mexican initiatives against HIV (the initial establishment of CONASIDA, for example, received support from the UN), but they also brought in information and perspectives that were otherwise not seen in Mexico. By providing information on groups at-risk and the methods of transmission for the virus, international organizations opened up the space of discussion in Mexican politics and bureaucracy. Uncomfortable topics like homosexual activity, drug use, prostitution, and even how the continued commercialization of the blood business could be more easily discussed when the weight of influential and respected international organizations was behind addressing such matters. As one interview subject in (Magis Rodríguez 2000) indicated, the WHO's forceful work on AIDS — via its declarations, publications, and convocations of health ministers — “definitely for us were an



invaluable support.” And as a result, such support also provided political cover for those making decisions, since the impetus of initiatives addressing undesirable populations came from outside the Mexican political system and from people who could be portrayed as health technocrats with no real stake in Mexican politics.

One of the principal architects and analysts of Mexico’s HIV/AIDS policies has argued that the Mexican policy response has very much relied upon a learning-model process to make adjustments, corrections, and revisions to the policy-of-the-moment.

The strategies for confronting the HIV/AIDS epidemic have been changing over time. We have had the opportunity to learn from our own experience and from that of other countries as we go about adapting our response to this disease on the basis of existing knowledge and on our capacity to access medical advances and new technologies to combat HIV/AIDS. One example of this is the diverse changes of structure that have the main responsibility for monitoring and preventing the dissemination of the HIV/AIDS epidemic, just like the state health care centers that are in direct contact with the affected populations throughout whole country.

Another example of the changes [in response to things learned] are the prevention campaigns in the mass media, which were directed at different populations and used different approaches, according to the information and the available resources, the recommendations and the lessons learned throughout the country and the world. Initially, the greater part of the preventative strategies were directed at trying to change people’s behavior; later it was seen that it is fundamental to design strategies in order to try to change the contexts of risk or vulnerability that hinder prevention—that is to say, to promote changes of social and legal standards, improve access to health services, or to decrease the violence and human rights violations associated with HIV/AIDS infection (Magis Rodríguez and Parrini Roses 2003, 24).

One might argue that this is what governments do with respect to policy regimes, but the purported obviousness of such an explanation belies the fact that organizational learning is hardly overdetermined when compared to alternative explanations, such as interest group politics, as narratives of HIV politics since (Shilts 1987) have argued. In HIV/AIDS policy regimes, both within countries and at the international level, the conventional wisdom is that policy outcomes are driven by the desires of the most powerful actors or interest groups, with little or no regard to dispassionate analysis and re-analysis. The case of Mexico indicates, however, that policymakers can strive (and succeed) to develop and enact evidence-based policies, based upon consistent and new flows of information that are used for the evaluation and revision of measures to fight against the HIV epidemic.

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