Political Science(s) and the HIV Pandemic: A Critical Analysis

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Abstract

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, instead fitting HIV into. I analyze and group the extant research into four research programs. I suggest some future directions that political science may take, so as to further 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 thirty years that we have recognized HIV’s existence among us, we have encountered a disease requiring and entailing an engagement — like no other — of academic scientists with policymakers, political 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, analogs, and paths not taken in this issue area or in parallel ones. “…[A] failure to appreciate the political dimensions of HIV can frustrate efforts to promote and implement evidence informed policy” (Buse et al. 2008, 573).

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 study and 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 programs and traditions. This article discusses the several ways that the political sciences have addressed the worldwide epidemic, with an eye toward taking a categorical and critical view of the supply of academic political research. I discuss four research programs into which political scientists have ensconced their research on HIV and AIDS, noting strengths and weaknesses thus far as well as 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 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 for use in research.

Given that my training and professional milieu are within the US context, the analysis will tend toward the North American view. In preparing this article, however, I have taken steps to consider non-North American views, and I have attempted to include analyses from sociology, anthropology, history, and other disciplines, so long as they seemed to be about “politics” broadly understood.

Scholars using HIV as a substantive focus have contributed to a broad range of theoretical research programs, across the range of the discipline. That said, there has been and remains the impression that political science is uninterested in the epidemic. I argue that the situation is different than that proffered in one literature review — “ . . . [M]ore than any other social science, political science has been largely silent on the issue of HIV outside of the developed world. Our review of this field revealed very few empirical studies, and fewer programmatic statements than in other areas” (Nguyen and Stovel 2004, 39–40).

Some political scientists have called for the discipline to address the complexities and puzzles that the epidemic raises.

- “Political science has been slow to address the political and policy issues of AIDS. . . [It] has not only acquiesced in trivializing this deadly disease and in marginalizing groups initially identified with it, but it has also squandered an important opportunity for itself. To what degree might the study of AIDS test the breadth of current explanatory theory? What testable hypotheses might be generated from studies of AIDS policies? What does AIDS tell us about processes of political mobilization, policy making, the creation of political networks or alternative power maps? ” (Sherrill et al. 1992, 688, 692).

- Siplon (1999) discussed difficulties conducting research in this issue area, when the disciplinary pressures often are to be either a “researcher” (who is dispassionate and objective) or an “activist” (who is prejudiced but doing something).

- “Political science as a discipline, including the branch of international relations, has been slow to grapple with the AIDS crisis. It seems that the HIV-AIDS issue has been conceived of as too private, too biological, too micro-level and sociological, too behavioral and too cultural . . . . . . When it comes to the more political, institutional, and macro causes and effects of HIV-AIDS, the literature is very sparse indeed” (Boone and Batsell 2001).

- ”Here is a major global issue with potential ramifications as great as any war, yet hardly any political scientist shows scientific interest in it!” (Lanegran and Hyden 1993).

- Finally, in an HIV thematic issue of Perspectives on Politics, Densham (2006) noted that there had been little activity in the subject area since Siplon’s articles in a non-peer-reviewed, professional journal seven years earlier.
Some scholars — not all political scientists in a formal, disciplinary sense and mostly outside of the US — of varying disciplinary backgrounds and nationalities have devoted substantial portions of their careers and output to the problems of HIV and AIDS. Examples include: Dennis Altman (politics/sociology, Australia), Tony Barnett (interdisciplinary social scientist, Britain), Alex de Waal (anthropologist, Britain and U.S.), Nana Poku (international political economy and development studies, S. Africa and the U.K.), and Alan Whiteside (economist, S. Africa).

As we will see, the number of works that address the politics of the epidemic in a social scientific fashion and in a form recognizable to academic practitioners as constituting “political science” is substantial. Political science on HIV/AIDS exists, and it has grown over time. In larger terms, however, it does not constitute a coherent research program of its own, and it has constituted a substantial portion of only one or two research programs.

Political science has considered four major aspects of the HIV/AIDS 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 HIV epidemic has affected the progress of international development efforts;
3. Effects on state security environments, internally and in relations with other political actors;
4. How HIV’s politics have affected and been affected by trends in governance, on the national and global levels.

Once separated into these substantive research agendas, we see many of the same approaches and types of questions recurring across agendas. Institutional analysis, governance quality and changes, and changes in or the emergence of civil society recur often in the research agendas analyzed below. Many political scientists would argue that the underlying structural causes of political phenomena can be characterized as “interests, institutions, and ideas.” 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 globalized society. Just as a butterfly can flap its wings in one place, creating a cascade that leads to a storm on the other side of the globe, a cough at the antipodes of the globe can mean an outbreak in one’s own home. 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 organizations. 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 political research also examines the institutional relations and inter-/intra-organizational politics of these actors, and 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.

Some of this research adopts a cultural explanatory model. 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, 38). Patriarchy underlies many of the features of African governance, argues Siplon (2005). With women excluded from many of the highest levels of power, there are fewer advocates for strong national HIV and AIDS responses, along with a number of policy choke-points that can render even the best intentioned and resourced programs ineffectual. Altman (2006) focuses upon sexual culture and mores; these taboos surrounding uncomfortable topics go a long way toward explaining why governments fail to implement policies and programs, even when the outcomes are clear and beneficial.

Another strand of policy output research contends that the main causal factors explaining differential state action come from organizational or institutional factors in government or governance institutions. Comparing Uganda and South Africa in the ’90s, 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 NGOs and CSOs to do. As they point out, government organization 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). The Indian government’s (as of 2004) failure to address HIV stemmed from two sources: bureaucratic inflexibility and inefficiency (especially within the mixed public-private health sector), and official policies (on national and local levels) that criminalize or penalize sex workers, transgender people, and AIDS outreach workers (Vicziany 2007).

Culture and institutions can mutually reinforce each other. Lieberman focuses on the independent variable of “boundary institutions,” defined as “those sets of rules that regulate racial and ethnic group categories and intergroup behavior” (Gauri and Lieberman 2006, 46). Although “boundary institutions” are not identical to sub-national or ethnic identities, such 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 2007, 2009).

Some studies present more limited versions of the question above (“why are some countries better performers than others?”), examining a “tough case” and showing the independent variable provides the best explanation. Elbe (2002) explained how a poor country with recent civil strife and little democracy like 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 (2005a) traced South Africa’s failure to implement a treatment program to a “fundamental disjuncture” between South African politicians and the international AIDS epistemic community, giving rise to a counter-community in South Africa.

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2These include “the census and other protocols for gathering and disseminating information in terms of group identities; policies granting access to jobs, political offices, schools, and certain rights of citizenship on the basis of group membership; and group-differentiated personal law” (49).
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 constitutively different actors, like NGOs and MNCs, the global and comparative health regimes that have evolved provide a number of examples.

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 (MacDonald 1996; Wilson 2007). NGOs are seen at the “forefront” of the response, with influence over government and IO activity (Clarke 2002). The state and its structures do not figure very much in some analyses (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). Central or national governments are necessary; research on Uganda and Senegal indicates that central government involvement is crucial to an effective and sufficient response (Putzel 2006). Sometimes the interaction between states and their non-governmental partners is formalized in a “public-private partnership” (PPP). (See, for example, the case of ACHAP in Botswana (Ramiah and Reich 2005; 2006).) The organizational 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? Several studies indicate that such collaboration depends upon the civil society environment generally. In Ghana, a unique case of a state that transitioned to a democratic polity 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 AIDS was on the rise (particularly the ’90s) were legion, involving the “difficulties of implementing a comprehensive response to AIDS in a country undergoing restructuring at every level” (Schneider and Stein 2001, 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, mining 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 esp. 5–7). The regional nature of mining makes it hard for any one state to address.

International and global governmental organizations 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 organizations like WHO’s Global Program on AIDS; its successor, UNAIDS; the Global Fund; and so forth (Altman 1999a,b; Gómez 2009; 2010). 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 2004; 2006).

The HIV pandemic has provided some researchers with an excellent opportunity to examine what happens when global institutions and local programs partner directly. There can be a disjuncture between the international institutions of global response that set the priorities for policy, expenditure, and prioritization and the localized 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 and harmonization among different global donor programs.Consultative mechanisms that bring local concerns and ideas to global implementers and funders have, for example, improved treatment and care of PLWHA, as well as improve acceptance and adherence to care programs (Edström and MacGregor 2010; Mallouris et al. 2010).

As a global health issue, HIV has also drawn attention to the process of politico-economic globalization. Most tellingly, with first recognition of the disease in the rich, industrialized countries and because of its association with particular constructions of identity (especially sexual ones), the epidemic has spread ideas about sex, identity, gender, sexual experience and practice, and the cultural memory of these. Brazilian and Mexican gay activists look to the New York City Stonewall riots in 1969 as the beginning of “their” gay movements (de la Dehesa 2010). One finds the reification of a fairly fixed sexual orientation as identity marker all over the world, even in those places where sex has not generally been regulated morally or vigilantly in the manner of the North Atlantic cultures.

AIDS in the era of globalization has proved a disease of contradictions and juxtapositions. “Ironically the new behavioral surveillance required by AIDS comes while there is a retreat from state responsibility in other areas” (Altman 2001, 84). HIV and AIDS point out the contradictions inherent in the current global political economy, in that the “first” and “third” world are only feet apart, HIV is present in each of them, but the experience and treatment can vary radically over a few meters: “…the Bronx is close to Manhattan;…St. John’s Wood is not far from Tower Hamlets;…the 16th arrondissement — the richest in Paris — is next door to Seine Saint Denis…” (Barnett and Whiteside 2002, 7). Rich and poor are situationally very remote from one another, even as they geographically occupy the same spaces: “the mechanisms for intervention are often so far from the lives of those, particularly the very poor, who are acutely affected” (382).

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 and forwarding of the movements around AIDS. In part, this is because HIV first manifested in the developed/Northern countries in gay men, and it drew upon, merged with, and provided fuel for the lesbian and gay rights movements that had begun one to two decades previous to the advent of AIDS. 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. Initially, of course, activism centered on and overlapped the gay liberation movement. Gay men (and to lesser degrees, lesbians, hemophiliacs, and those who worked with IDUs and immigrants) pressured governments, rich members of their communities, medical professionals, and others to step up research, speed drug approval processes, provide legal protections against discrimination, increase research and care funding, cooperate in medical decision-making, and include PLWHA in all levels of decision-making (Smith and Siplon 2006).

Outside of the US, gay liberation and HIV activism co-occurred regularly. In Mexico and Brazil, the emergence of HIV among MSM provided a spur to sexual minorities to organize around their political and civil rights (de la Dehesa 2010). Sex workers in Southeast Asia (Hunter 2005; Pisani 2008) and Latin America (Frasca 2005) have often used their marginal social status and “otherness” to create, refine, or re-invigorate strong collective identity and to make demands upon the state and society for protections and changes. In Singapore and Malaysia, the HIV movement “allowed them to play critical roles in spurring and supporting queer — especially GLBT — mobilization, including fostering a sense of a “gay community,” despite legal proscriptions on homosexual behavior and associations” (Weiss 2006, 674).

Later including bisexual, transgender, intersex, “queer” and other sexual minorities.
In Sub-Saharan Africa, identity politics has relied upon a person’s HIV status itself to be the marker of identity, rather than on another socio-personal identity which has a high degree of co-incidence. Some studies point to the difficulty of organizing around identity, as HIV-positive identification alone may not be sufficient to create an activist movement. In Tanzania, AIDS 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 and Haven 2005; 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 the alternatives to identity politics. Robins (2004) finds that TAC — along with its partner, MSF — avoided conflict over the origins of HIV, and instead it devoted itself to “class-based politics that concentrated on access to anti-retroviral drugs.” 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 (2005a, 2007) found that the South African political elites’ self-identity of independence and anti-colonialism, combined with the legacies of apartheid, lay underneath the formation of an “epistemic community” that found its culmination in Mbeki’s AIDS denialism. For African-Americans, where identity politics cut against acknowledging and addressing HIV, PLWHA within this group experienced “secondary marginalization” (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 having been particularly hard-hit. These are also countries that have been engaged in continuing programs of socio-economic development. Two questions have tended to dominate. The first has been to examine the pandemic’s effects on development gains made over the last 50–75 years. HIV has rolled back average life expectancy, hollowed out adult working-age generations, led to productivity loss from sickness and death, and created great numbers of orphaned and vulnerable children (OVC) with few or no resources of recourse. The other dominant question asks how the international community has changed its ideas about development assistance (in a variety of forms) 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, stigmatization, and human rights. These conditions add to the complexities of a challenging endeavor.

Questioning the alignment of power and wealth has been a focus of of the examination of HIV and development. Bancroft (2001) argues that the impact of AIDS has largely been distributed along extant lines of power and inequality. The epidemics disproportionate effect on African and other developing countries has been heavily dependent upon their relative disadvantages in global society, politics, and economics. Altman (1998) argued that globalization creates an environment wherein ideas and values — such as the need or right to access drugs — are changeable, or at least more easily changeable than the underlying structures of rich and poor and the gaps thereof. For Altman, the preponderance of power lies in science and medicine and in those who allocate resources. “In global terms both sorts of decisions involve considerable negotiation across national boundaries; AIDS programmes

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4In later work, Altman (2006) does indicate that these values are still quite hard to change. He notes that AIDS is quite a preventable disease, insofar as people and cultures are willing to address sexual practices and customs. Such acknowledgment, discussion, and some degree of acceptance of these taboo behaviors has been difficult to elicit, he shows.
and biomedical knowledge tend to replicate the flows of capital and influence within the global economy” (Altman 1998: 235).

It is largely uncontroversial that AIDS itself threatens development in the countries of sub-Saharan Africa. The changes that donor and partner governments and organizations have asked of African countries and peoples — such as rapid changes in gender roles, Western understandings of sexuality and sexual behavior, 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-colonization (Fredland 1998). The tragedy of South African policy under Thabo Mbeki has at least part of its basis in this cause (Butler 2005; Schneider 2002).

In the late ’90s and early 2000s, a near-universal condition for debt reduction and write-down was “structural readjustment.” This generally requires the reduction of government expenditures, through program reductions, service privatization, and other aspects of the neo-liberal “Washington consensus” (Cheru 2002). Although structural readjustment may have freed monies to do such things as fight AIDS, the reduction of the state’s role in the economy and society mean that it may not have the reach to tackle the AIDS problem comprehensively or effectively (Poku 2001; 2002; Whiteside 2002).

The policies required for structural adjustment programs created conditions that spread HIV more effectively (Poku and Sandkjaer 2007: 134–36), obviating a country’s development progress. 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 success the HIV response has enjoyed in the 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 AIDS has better advanced its ideas regarding problems and solutions, and they have better institutionalized these ideas, which in turn increases the attention the policy community can gain from policymakers (Shiffman 2009). Lack of their own policy communities may help explain why attention to HIV as a health matter did not create concomitant spillover in attention for other health issues. Non-communicable diseases control funding for development remained constant between 1998–2007, and funding for health system strengthening appears to have decreased dramatically in the same period (Shiffman et al. 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. Indeed, the proliferation of these organizations makes them virtually indispensable to the contemporary fight against HIV (Jönsson and Söderholm 1995; Clarke 2002; Batsell 2005; Swidler 2004; White and Morton 2005). International donors and funders often seem to prefer NGOs to government involvement, both because NGOs are perceived to be more freeform or “local” (and thus potentially more flexible and responsive to conditions on the ground) and because there are (legitimate, in some cases) concerns about the ability or corruption of governments. The developed world considers Africans too poor, too unsophisticated, too corrupt, or too sexual to adequately handle treatment programs (Jones 2004).

Worries exist, however, that NGOs — especially those that are not completely local — reproduce or create a new form of colonialism. Locals, “at least initially, inevitably regard an international organization as a potential source of money, goods or contacts that are otherwise unavailable” (Swidler 2006: 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. They only receive remuneration in the form of workshop *per diem* or stipends, which hardly provides a sufficient income, nor does it represent the scope of their talents and contributions. 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 and AIDS have not served only to direct more resources toward development or to recapitulate the colonization process in a more indirect way. The pandemic 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 international organizations are hardly powerless in the face of multi-national corporations. Examining drug manufacturers’ decision to begin producing generic ARVs in 2001, governments were able to create the market for generics by altering regulatory environments and “buying drugs for people living with HIV in developing countries” (Roemer-Mahle 2010 9). Countries have been able to leverage international intellectual property law regimes against drug manufacturers and their home countries (Cleary and Ross 2002; Cullet 2003; Kobori 2002; Mameli 2000; Mann 1995; Palmer and Dor 1995; Siegel 1996). Intellectual property 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 5 agreement and the Doha round of the WTO talks. The TRIPS agreement, although often interpreted as being to the benefit of developed countries and “big pharma” companies, contains provisions relating to health matters and drugs. In the case of “national emergency,” governments may override patent protections and issue “compulsory licenses” to local manufacturers. The circumstances under which such action may take place were initially under-defined. Developing countries have used these tools to extract more favorable terms, under threat of depriving the pharmaceutical producers of further revenues (Sell and Prakash 2004; Sell 2007).

Developing countries re-framed the problem, such that appeals to norms, ethics, and legitimacy became the terms of the debate over access to generic ARVs. Powerful actors were internationally shamed, and the eventual result was the 2001 Doha Declaration on the TRIPs Agreement and Public Health. Regimes like TRIPs open 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).

In-depth analyses of specific countries have helped to illuminate the ways in which developing nations have exercised defiance of current trends in international development. de Mello e Souza (2007) considers Brazil’s example of “successful” policy regime, and Brazil has proved particularly interesting for analysis because it sits at the intersection of “local, foreign, and transnational actors” (37). “The full mobilization of Brazil’s government, both in its relations with the United States 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 (38).

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5Trade-Related aspects of Intellectual Property
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 starting in the 1990s 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. HIV may pose either a traditional or human security threat, depending upon the actors considered and the sector of society under consideration.

Perhaps one of the more fruitful areas of investigation in political science — or at least in international relations and comparative politics — for the study of HIV or AIDS lies in the relationship between the disease and war, conflict, and security.

Two groups of security analyses predominate. There are the more traditional scholars of security studies, who restrict themselves to the study of inter- and intra-state warfare and civil conflict. In recent years and in contrast with this group the concept and study of “human security” has arisen (Barnett 2006; Barnett and Prins 2006; Buzan 1991), as both challenge to and augmentation of the traditional guns-and-bombs view of security.

Elbe (2006) cautions against tying HIV and AIDS too tightly into the security paradigm, for “securitization” of the disease has implications beyond simply raising its priority on a country’s preference agenda. Securitization 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. Militarizing or securitizing HIV also creates a greater possibility that care for elites and military heads will be formally prioritized, and it mitigates against continued efforts at normalization of the disease.

Several questions have emerged in the linkage of HIV and security. There is the question of whether HIV and AIDS constitute a threat in traditional or in human security terms. There are also studies that examine how HIV and AIDS 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 and AIDS in developing societies.

The causal pathway linking HIV to security is a difficult one to trace (Barnett 2006). AIDS sundered 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 AIDS is a (large) part of a complex of factors and causes breaking down trust between government and citizens (Price-Smith 2002). Youde (2005b) argues that human security scholars and analysts would encounter more scholarly and advocacy success by integrating their ideas into extant schools of thought in International Relations rather than advocating the creation of a new paradigm.

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 study program, see de Waal (2010b)). Some connections between HIV and state security are sensible and substantiated. Feldbaum et al. (2006) notes that AIDS and security seem to have some obvious linkages with militaries and state stability, but that more evidence is needed to confirm the linkages. States with a norm of international cooperation are more likely to identify AIDS as a security threat, and states seeking foreign investment are more likely to de-emphasize the AIDS-security linkage (Girshick 2004). HIV does not seem to pose a threat to the security postures of the rich, developed countries like the United Nations Development Program 1994; Ostergard (2007b); Paris (2001). For two, of many, interesting operationalizations of the concept, see Bajpai (2000); King and Murray (2001–02).
States (Peterson 2002/2003); it also has a high degree of association with human rights abuses and civil conflict (Peterson and Shellman 2006).

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/AIDS is a long-term event — the dying-off of the actually infected is only the first effect the disease will have on populations (Barnett and Prins 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. 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. 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. Data problems potentially plague each of these preceding studies: Spiegel’s studies take no account of quantitative datasets commonly used in political science to measure war. Iqbal and Zorn use older, less accurate data about HIV prevalence.

Some work considers the effect that HIV has had or could have on military structure and organizations. Rosen (1987), for example, provided early theorizing that HIV could damage the 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 organization. This can eventually lead to decreased military effectiveness and organizational instability.

Most empirical studies of such arguments have taken place in the sub-Saharan African context. Ostergard (2002, 2004) 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 organizational 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 organizational 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 organizations (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” — has been a major concern for political scientists. Those who

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*It is important to note that no author in the Spiegel studies appears to have formal training in or affiliation with the study of politics or political science.*
study governance “explore abstract analyses of the construction of social orders, social coordination, or social practices irrespective of their specific content” (Bevir 2007, 365). A particular concern of this research agenda has been in examining how various public sector reforms to lessen the hierarchical and centralization of social functions in government, such as with privatization restructuring since the 1980s. 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, public-private partnerships, and special-purpose global organizations, among others.

To some degree, the governance research agenda overlaps with elements of the preceding. 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 policy and political implications, nor as a sub-topic of manifestation of a larger class of political phenomena, but because of what it tells of the interior and exterior understanding of the society in question. De Waal (2003b) contends the pandemic’s impact “can be envisaged as running processes of demographic transformation, economic development, and the growth of the bureaucratic state, in reverse.”

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? How does the epidemic bring the state’s pathologies into focus? Why do even well-managed states “miss” the problem of HIV?
- 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 2003a, 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 urbanization 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 than other parts of their governments to deal with the human capital costs of HIV. Other institutions and organizations, 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 programs, there is often a failure to appreciate that HIV is a problem of governance: many actors seek remedy in “an organizational fix” rather than facing the “political challenge of prioritising HIV/AIDS in government and non-government sectors” (Putzel 2004a, 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 did not originate with the HIV response, and it 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, 69). That is, by co-opting local organizations 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 organizational 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. Excellent analysis in this regard is being conducted by long-form journalists, such as The New Yorker’s Michael Specter (Specter 2004, 2007) and Science’s Jon Cohen (Cohen 2006, 2008, 2010).

Well-run countries, whether developed or developing, have demonstrated similar inabilities to recognize the severity of the epidemic. To be effective, HIV management has to make its way up 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. In the early 1980s, France had the right conditions to respond forcefully and effectively, but because of emphasis on fiscal austerity, public service privatization, and the association of the disease with American (and American-associating French) gays, the French government did not implement programs to minimize prevalence (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 political leadership on HIV, especially in East and Southern African contexts, they engage populist politics that scapegoat PLWHA and add to discrimination and denial. Democracies may also be short-sighted, with leaders focused only on the time horizon of 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 (Patterson and Haven 2005; Haven and Patterson 2007).

Democracy may require trade-offs that run counter to maximizing 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 centralized 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” (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 Treatment Action Campaign (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, depending upon TAC’s particular policy goals (Friedman and Mottiar 2004). The tension between hierarchy and distribution exists not only in the polity’s form but also in the bureaucracy. The state’s organizational configuration matters. Paxton (2010), in qualitative analysis of Mexico and Botswana, finds that when state organs have a networked organizational configuration, they have higher policy responses than those organized as hierarchies or market-anarchies.
South Africa has provided particular focus in an attempt to understand the Mbeki regime’s vehement biomedical, social, and demographic denialism. Mbeki, however, was only the most extreme example; 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 the implementation and management of HIV policy. “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, 179). The effects have been wholesale: 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 jeopardized as South Africa becomes less capable of coping with the fallout of the epidemic” (Price-Smith et al. 2007, 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, 26).

This is not the case on the eve of the first International AIDS Conference to be held in the US in over 25 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 — more than 80 percent — 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. There is still plenty of research to undertake, 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 don’t 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.

References


See also Schneider and Stein (2001); Butler (2005) for related analysis of the effects of South Africa’s top-down, hierarchical government implementation.


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