WHO GOVERNS PUBLIC HEALTH?

THE SPHERES OF INFLUENCE IN SOUTHERN AFRICAN HIV/AIDS POLICY-MAKING

BY

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Thesis Presented for the Degree of

DOCTOR OF PHILOSOPHY

In the Department of Political Studies

UNIVERSITY OF CAPE TOWN

October 2013

DEDICATION

To my family

"So much of what is best in us is bound up in our love of family. It remains the measure of our stability because it measures our sense of loyalty"

– Howett Haniel Long

PREFACE

I'll never forget the room full of faces of the commercial sex workers staring up at me as I entered the room. In Kawempe, a small slum on the outskirts of Kampala, Uganda, there are few opportunities for these women. However, on this day, they sat quietly at their sewing machines, absorbing vocational training in tailoring, aimed at providing them with economic options and an alternative to sex work. More than half of these young women were HIV positive. This experience, occurring within my first three days in Africa, created a pretty strong emotional foundation for my work over the next four months - writing funding proposals for a the African Medical and Research Foundation, Uganda. As I set to work crafting 200-page grant applications for agencies like the United States Agency for International Development (USAID) and the Centre for Disease Control (CDC), I began to come up against political stumbling blocks. The request for proposal would stipulate that our project must fall in line with the policy objectives of the donor agency in the US, but also complement and work alongside the local National AIDS Control Programme of Uganda. How, now, do I reconcile pleasing the donors in the US, who mandate condom distribution in all their programs, with Uganda's policy emphasis on abstinence? Billboards were everywhere across the country; your choices were to abstain, or be faithful to your partner. When I confronted a colleague with my dilemma she rolled her eyes and sighed, indicating to me that I was not the first person to uncover this disconnect.

This was my first experience with external policy pressures coming from above that did not match local strategies and grassroots attitudes, but it would not be the last. A little while later into my time working in Uganda, I attended a documentary film premier entitled *Miss HIV*. Comparing and contrasting the HIV/AIDS policies and programs of Uganda and Botswana, the documentary made a case for local policy making initiatives, rather than donor-driven Western ideological transplants such as The President's Emergency Plan for AIDS Relief (PEPFAR). While the ideas in this movie ignited a passion within me, they also raised handfuls of questions. If the HIV policies of Uganda and Botswana are such polar opposites, where did these strategies come, how did they evolve and which one is more effective? This issue formed the research question for my Master's thesis, which made a post-colonial argument for the role of political histories in contemporary policy making. In a similar vein to *Miss HIV*, my project disrupted the mainstream trend of global policy making in the public health arena, calling for a return to 'the local' as the HIV policy focal point. This investigation of contemporary HIV policy making through the post-colonial imaginary led me to arrive at an entirely new set of questions. While I had touched on global policy making, I had not fully engaged with the ways in which global development partners and program funder exert control over domestic HIV/AIDS policy.

After a year and a half, I returned to Kampala, only to find all the abstinence and faithfulness billboards replaced by messages on sexual networks and circumcision. The policy shift was swift and noticeable. I had to know more about how and why these policies were changing so quickly, and what the potential impacts on health outcomes would likely be for people at the community level, like the women in Kawempe.

ACKNOWLEDGEMENTS

I would first and foremost like to thank my family, to whom this dissertation is dedicated, for all their emotional and financial support over the past three years. I am so lucky to be surrounded by a family that values the pursuit of knowledge and education so highly. Many of my best ideas for this project came from brainstorming argument summaries over wine on the porch and debating the logic of findings over dinner conversations. I hope that I, too, was able to help stoke ideas for my sister, who is completing her Masters in Psychology at New York University, and my mother who has gone back to school to do her Doctorate in Business Administration at Henley/Rotman Business Schools.

Secondly, I would like to thank my supervisor, Professor Robert Mattes, for teaching me about quantitative methods in political science and stretching my ability to visually represent data in effective and interesting ways. These were not skills I had before coming to the University of Cape Town, and the results of my project are all the more rich as a result.

I also received some extremely helpful preliminary advice from Dr. Per Strand, who helped me conceptualize the project in its proposal phase. I would like to thank him for helping me use more straightforward language and clearer methodological design.

My inclination to come to South Africa to further study HIV/AIDS policy was significantly cultivated during my time working with Professor Richard Saunders at York University. I owe the choice of coming to Cape Town to him, after his many fond stories about its beautiful landscape and exceptional opportunity in the field of health research. We remain close friends and I would like to thank him for the project brainstorming sessions we shared over runs along the Sea Point Promenade or by the fire at his partner Penny's house in Observatory.

I also received some invaluable intellectual support from my peers in South Africa, including Dr. Rebecca Hodes, Post-Doctoral Research Fellow at the University of Cape Town, and fellow PhD Candidate (ABD) Mark Daku from McGill University in Canada. I would like to thank them both for helping me with conceptual issues throughout the project phases. Thanks to Mark in particular for proof reading sections of the project and offering thoughts and suggestions over cocktails by the pool.

The chapter featuring my interview case studies would not have been possible without opportunities afforded to me as a Research Fellow at AIDS Accountability International (AAI). I would like to thank Phillipa Tucker for seeing the potential in me to manage large projects, conducting field research all across Southern Africa.

Lastly, I would like to thank the Post-Graduate Funding Office at the University of Cape Town for providing me with an International Scholarship in 2012. The funding provided went towards publishing this dissertation in the academic peer-reviewed Journal, *Sociology Study*.

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LIST OF ACRONYMS

ABC	Abstain, Be faithful, Condomize
AIDS	Acquired Immunodeficiency Syndrome
ANC	Anti-Natal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BCG	Bacillus Calmette-Guérin
BONEPWA+	Botswana Network of People Living with HIV & AIDS
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CCT	Confidential Counseling and Testing
CDC	Centers for Disease Control
CHAI	Clinton Health Access Initiative
CHAZ	Churches Health Association of Zambia
COHRED	Council on Health Research for Development
CSW	Commercial Sex Worker
DFID	UK aid from the Department for International Development
DIB	Department of Information and Broadcasting
DNA	Deoxyribonucleic Acid
DRC	Democratic Republic of Congo
EU	European Union
KFF	Kaiser Family Foundation
FBO	Faith-Based Organizations
FPM	Fund Portfolio Manager
FY	Fiscal Year
GARPR	Global AIDS Response Progress Reporting
GFATM	The Global Fund to Fight AIDS Tuberculosis and Malaria
GNI	Gross National Income
HAART	Highly Active Antiretroviral Therapy
HEDEC	Health Environment & Development Consulting
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
IDU	Injecting Drug User
LEGABIBO	Lesbians, Gays and Bisexuals of Botswana
LGBT	Lesbian, Gay, Bisexual and Transgender
M&E	Monitoring and Evaluation
MARPS	Most-At-Risk Populations
MAP	Multi-country HIV/AIDS Program for Africa
MICH	Maternal, Infant and Child Health
MOESC	Ministry of Education, Sport and Culture

MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MTCT	Mother-To-Child Transmission
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Commission
NACA	National AIDS Coordinating Agency
NACOSA	Network AIDS Community of South Africa
NAEC	National AIDS Executive Committee
NAFTA	North American Free Trade Agreement
NANASO	Namibia Network of AIDS Service Organizations
NIP	Namibia Institute of Pathology
NGO	Non-Governmental Organization
NSF	National Strategic Framework
NSP	National Strategic Plan
ODA	Official Development Assistance
OIG	Office of the Inspector General
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
PR	Principal Recipient
RMC	Resource Mobilization Committee
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV & AIDS Information Dissemination
SANAC	South African National AIDS Commission
SOGI	Sexual Orientation and Gender Identities
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TAP	Treatment Acceleration Project
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session in HIV/AIDS
UNHCR	United Nations Refugee Agency
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization
WTO	World Trade Organization
ZNASP	Zimbabwe National AIDS Strategic Plan

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ABSTRACT

Background: For the last decade, discussions about who governs African HIV/AIDS policy have revolved around Western donors and their influence over aid recipient countries. However, these dialogues are increasingly less relevant due to a plateau in HIV funding from the West, and growing financial ownership of the epidemic within Africa. This project tests the hypothesis that this shift in HIV financing has prompted African countries to move their National Strategic Plans (NSPs) on HIV/AIDS away from global policies, in favour of domestically developed approaches.

Methods: Data was collected by analyzing the NSPs of the eight highest-burden African countries (i.e. HIV prevalence rates greater than 10 per cent). Based on 34 policies from the Global Fund's 2009 Monitoring and Evaluation (M&E) Toolkit, each NSP was evaluated on the basis of its compliance with the Global Fund's policies, measured on a 5-point scale. This was carried out for three successive policies in each country, to also enable me to search for change in Global Fund policy compliance over time.

Results: Overall, countries in Southern Africa are shifting their National Strategic Plans towards greater alignment with Global Fund policies. However, Botswana and South Africa are exceptions, as they have moved their NSPs away from Global Fund policies in the last five years. These differences can be explained by each country's structural and institutional context; wealthier countries with better governments comply less with Global Fund policies. In addition, idiosyncratic variables such as political culture and the Global Fund Country Team also help explain how strongly a country complies with Global Fund policies.

Conclusions: The practical application of this research is well-timed with the abandonment of the Global Fund's previous Round-based grant system and the design of its New Funding Mechanism. In particular, my results submit three major recommendations for this process. First, the "country bands" formula ought to take into account the economic development of a country, since this variable helps to explain why some countries have more country owned policies than others. Second, the New Funding Mechanism should allow for health systems strengthening concept notes to be submitted independently of disease-specific applications, since my results suggest that general health spending leads to more country owned policy and program design, but that AIDS-specific spending does not. Lastly, the Global Fund's Country Coordinating Mechanisms should be encouraged to have fewer donor and international non-governmental seats, since these elements are connected with stronger external influence over domestic HIV/AIDS policy. If these three recommendations are heeded, the New Funding Mechanism should promote better country ownership over HIV/AIDS policy and programming. There may also be implications that are relevant to epidemiological outcomes. HIV prevalence is falling in the countries examined in this study, and this decrease is logically linked to fewer new infections, since HIV incidence is also falling. While it is necessary to also examine behaviour change interventions and their impact, there is a possible relationship between the policy findings of this study and these changes in infection rates which warrants further research.

Chapter One

The New Global Politics of HIV/AIDS

"Donors are either flat-lining or decreasing their involvement in HIV/AIDS. Some donors are steadily moving away from treating HIV/AIDS as an emergency, with dedicated flows of funds, to more indirect interventions" (Médecins Sans Frontières, 2010, p. 15).

Introduction

The number of new HIV infections has fallen by an estimated 19 per cent across the world since 1999, when the epidemic peaked (UNAIDS, 2010). At the same time, there has also been a 19 per cent decrease in AIDS-related deaths. That said, prevalence rates remain at catastrophic levels in many countries in Southern Africa, with one in four people infected in Botswana, Lesotho and Swaziland. Additionally, while new infections have declined in Botswana, South Africa, Swaziland and Zimbabwe, in other countries such as Zambia and Malawi, incidence rates appear to have remained steady, thereby sustaining the current epidemic. In the midst of fragile progress in the global fight against HIV/AIDS there has been a recent shift in financial and political circumstances. While African domestic contributions to funding for HIV/AIDS are increasing, Western donor money is much smaller in relative terms. Further, Western priorities are moving away from an HIV-specific focus, towards a broader objective to strengthen health systems more generally. What is more, there is preliminary evidence in some countries of a divergence in policy between internationally designed best practices and recent "African-owned" strategies. Why do some countries in the region continue to align their policies with global norms, while others seem to challenge them? And what are the potential health consequences of these trends?

Background and Context

In the 1990s and early 2000s, the debate about "who governs" policy on HIV/AIDS prevention and treatment centered on the relationship between Western donors and their grantees in the Global South. There were three main themes to this debate: aid-recipient countries were incentivized to be more accountable to their donors than to their citizens, international HIV/AIDS policies were argued to be culturally irrelevant to African realities, and the significant amount of money attached to them was said to lead countries to adopt imported and ineffective Western interventions.

Firstly, critics charge that the demands of large international development partners for "upward accountability" diverted state responsibility away from the actual needs of their citizens, towards satisfying the agendas of donor institutions (Hulme & Edwards, 1997). This was referred to as "confused accountability", as states toe the political line of the donor, and become accountable to the donors instead of their own citizens, also dubbed the "franchising out" of state responsibilities (Wood, 1997; Bendaña, 2006). Others have argued that public health non-governmental organizations (NGOs) marginalized local governments since the apparent neutrality of donors masked their agenda and allow them to carry out their own aid policies, performing the same function of control as imperial colonial powers (Ainsworth & Teokul, 2000; Howell & Pearce, 2001; Petra & Veltmeyer, 2001; Agg, 2006).

Secondly, there was widespread condemnation in the early 2000s of Western HIV/AIDS policies that were said to be culturally irrelevant in African settings. Discussions around blanket policies, or what Elizabeth Pisani (2008) called 'UN cookbooks', refered to international policies (which were connected to funding) that were supposed to be equally useful in the Middle East and in Southern Africa. For Pisani, this meant that anything specific or useful got deleted. Helen Epstein (2007) put forward a similar contention, noting how donors with multi-billion dollars and international consultants offered domestic Ministries of Health in affected countries a set menu of HIV/AIDS prevention and treatment programs. In her opinion, if health officials in high burden countries had more time and money, they would have been able to refuse these donors and create HIV/AIDS policies and programs that were better suited to their specific cultural histories and realities.

Lastly, critics suggested that African countries were pressured to alter their domestic policies in order to please their international donors. Scholars often referred to Uganda, where the national government initially believed that the HIV policy-making apparatus in the country should predominantly be comprised of individuals appointed by foreign institutions such as the World Health Organization (Parkhurst, 2005). Similarly, Helen Epstein (2007) noted that few African leaders seemed interested in HIV/AIDS and preferred to leave policy-making to foreign consultants.

Foreign control seemed particularly dangerous to some critics who warned that the emphasis on abstinence in Uganda might have been motivated by a desire to please the Bush Administration in the United States, particularly in light of the $US 1 billion President's

Emergency Plan for AIDS Relief (PEPFAR) (with one third of prevention funds earmarked for abstinence and faithfulness programs) (Pisani, 2008). In particular, the United States stood accused of working through specific types of civil society groups such as faith-based organizations, to achieve American economic and political policy goals (Hulme & Edwards, 1997). As such, the main characteristic of the 1990s debate on Uganda was that foreign donors created enabling environments for free market capitalism and economic growth, allowing the United States to sidestep the Ugandan state to achieve American goals abroad (Igoe & Kelsall, 2005). With American political ideals and economic gains at the forefront of PEPFAR-funded initiatives, donor-recipient relationships were heavily criticized for their tendency to focus on donor-identified problems, instead of locally acknowledged needs (Dicklitch, 1998).

In light of the new global politics of HIV/AIDS, with changing financial and political realities, these kinds of debates may no longer be as relevant.

The Research Problem: Funding Plateaus and Shifting Priorities

The criticisms, however relevant at the time, have now been overtaken by new developments that began to emerge roughly five years ago. First, there have been significant shifts in financial priorities, with stagnant amounts money for HIV/AIDS coming from the Global North, despite increasing needs in African countries. To fill this gap, more funding is being generated domestically within affected countries. Second, there have also been political changes, with policy agendas in the North shifting away from an HIV/AIDS specific focus and towards a broader emphasis on strengthening health systems more generally. Within this context, there are several examples in Africa where local policies have begun to diverge from the strategies of international donors.

Funding Plateaus

Around 2008, global donors began re-constituting their financial contributions to HIV and AIDS. This was the result of many factors, including the global economic crisis, evidence of more effective health spending options (such as childhood immunization and malaria bed nets) and UNAIDS' statement that "global HIV incidence likely peaked in the late 1990s" (UNAIDS & WHO, 2007, p. 6). Consequently, in many Southern African countries fiscal assistance from donors for HIV/AIDS programs either decreased or reached a plateau (Médecins Sans Frontières, 2010; PlusNews, 2011, December 1; Gonzalez, 2012).

International funding for HIV rose from 2002 to 2008, but after that it began to plateau. To put this shift in perspective, HIV/AID funding was six times higher in 2008 than it was in 2002, before it levelled off in 2009. The drop of available HIV funding from US$ 7.6 billion in 2009 to US$ 6.9 billion in 2010 represents a 10 per cent drop, which was the first time funding decreased in more than a decade (Kates et al., 2011). UNAIDS and the Kaiser Family Foundation (KFF) attribute this decline in HIV funding to reductions in development assistance, which they said was primarily result of a slower disbursement rates from donor governments in 2010 (Figure 1.1). For example, US HIV/AIDS funding fell from US$ 4.4 billion in 2009 to US$ 3.7 billion in 2010. Evidently, Congress applied new restrictions to PEPFAR with regard to eligibility for funding during the 2008 reauthorization process. While it is true that the US makes up the vast majority of international HIV/AIDS funding, it is not the only country involved in this global funding plateau; Australia, Germany, the Netherlands, Norway, Spain and Sweden have also cut levels of HIV/AIDS disbursements (PlusNews, 2011, August 17). The most recent data available on financial commitments (from 2012) show a slight increase in disbursements, but a decrease in commitments. According to The Henry J. Kaiser Foundation and UNAIDS (Kates, Wexler & Lief, 2013, p. 13), "donor funding has plateaued since the onset of the global economic turndown in 2008, and does not show signs of increasing."

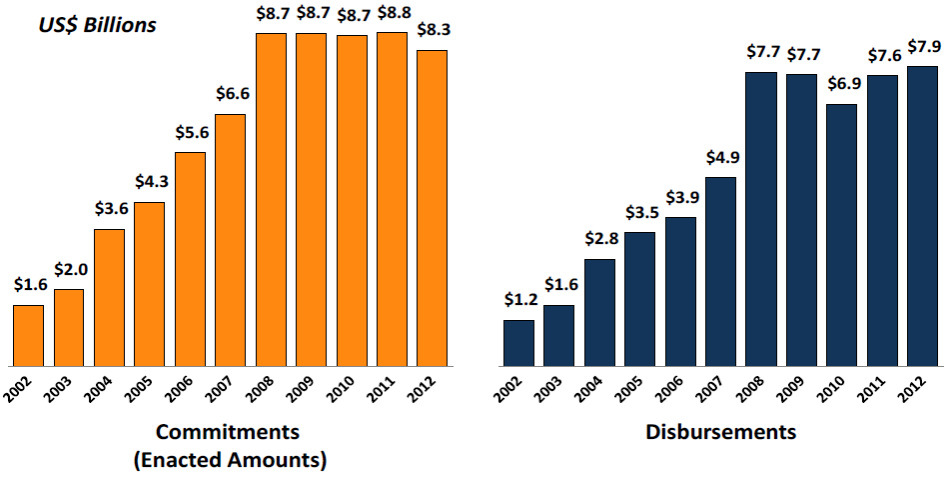


Figure 1.1: Total International AIDS Disbursements 2002-2012 (Kates, Wexler & Lief, 2013)

UNITAID, World Bank and European Union

One of the more significant global donor institutions curtailing its HIV/AIDS support is UNITAID, an initiative housed within the WHO which raises money through levies on airline tickets for increasing treatment coverage. UNITAID is ending funding for second-line

antiretrovirals[1] (ARVs) in Zimbabwe, Mozambique, the Democratic Republic of Congo (DRC) and Malawi by 2012 (Médecins Sans Frontières, 2010). Moreover, via the Clinton Health Access Initiative (CHAI), UNITAID has been trying to redirect the 1,100 patients it financially supports for second line treatment to the Global Fund since 2009. At the same time, UNITAID/CHAI financing for paediatric medical supplies, which supports 5000 treatment initiation slots, was not renewed for 2011.

Similarly, the World Bank's Treatment Acceleration Project (TAP) program ended in 2008, and its Multi-country HIV/AIDS Program for Africa (MAP) has been discontinued in several countries, with no realistic opportunities for host governments to sustain the programs. Consequently, 11 per cent of UNAIDS, World Bank and World Health Organization staff surveyed in 71 countries in March 2008 experienced cutbacks for their HIV/AIDS projects on the ground. Additionally, 31 per cent expected to face funding challenges in the coming year (Wenner, 2009). Most of these cost cut-backs are related to funding for ARVs, which can be the most expensive component of HIV/AIDS programs in many countries. For instance, in Malawi, 65 per cent of overall HIV/AIDS program costs go towards drug procurement (Jouquet et al., 2009). For this reason, cessation of funding for HIV/AIDS - and for treatment especially – has profound consequences for high-burden countries.

While responsibility for some World Bank programs has been shifted to other sources of funding, this is not the case for all donor initiatives. For instance, several European Union (EU) member state aid agencies have raised the alarm on the depleted number of European donors in Mozambique, with no one stepping in to fill their place.

PEPFAR

Since funding from the American government makes up more than half of the total global money available for HIV/AIDS (Figure 1.2), the leveling off of funding commitments from PEPFAR has one of the most severe effects on the global financial politics of HIV/AIDS. The program began in 2003, promising US$ 15 billion over 5 years, making it the largest financial commitment for public health by any one country in history (Denny & Emanuel, 2008). PEPFAR's founding principles emphasized treatment, with programs supporting more than 2.5 million people with ARV treatment; these 2.5 million on PEPFAR-funded treatment

[1] Second-line treatment is the regimen that people require once they become resistant to first-line drugs. This can occur as a result of inconsistencies in treatment administration or re-infection with another strain of HIV.

programs represent more than half of *all* people on treatment, globally (Dickinson, 2010, June 25). In addition, one quarter of all PEPFAR funding was dedicated to prevention programs (abstinence, faithfulness and condom use). Given this, the fact that PEPFAR reduced its funding for ARVs in 2009 and 2010[2] and froze its overall HIV and AIDS budget for 2009-2014 holds enormous consequences (Médecins Sans Frontières, 2010). The 2009 PEPFAR budget of US$ 1.38 billion was a US$ 180 million decrease from 2008's US$ 1.56 billion pledge. Of that US$ 180 million decrease, US$ 83 million of it was a cut in ARV funding. What this means is that there will be a significant number of new patients that need ARVs who will not be able to receive their medicines through PEPFAR. With 2.4 million new patients put on PEPFAR treatment from 2006-2008, only 1.6 million will be added to the program from 2009-2014.

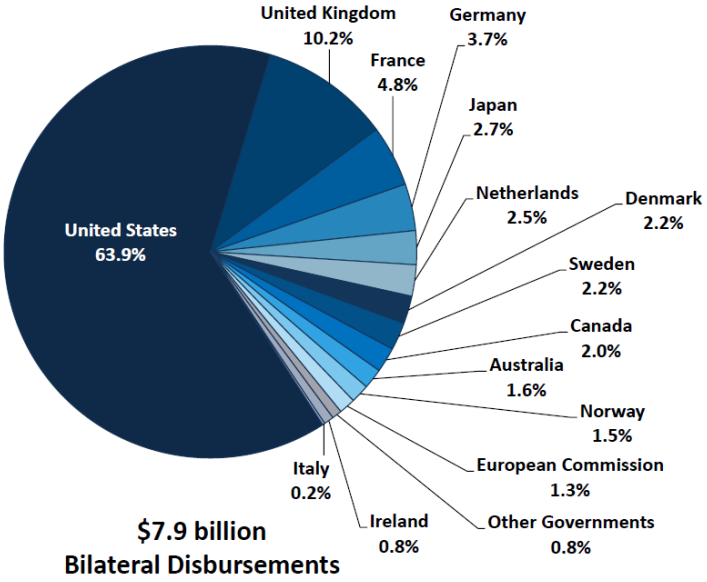


Figure 1.2: International HIV/AIDS Disbursements in 2012, by Donor Governments (Kates, Wexler & Lief, 2013).

More recently, the 2013 budget from the Obama Administration contains further PEPFAR cuts. Since the program has been included into the broader Global Health Initiative (total budget of US$ 880 million in 2012), PEPFAR's 2012 funding has fallen (Kaiser Family Foundation, 2012, February 13). The White House's budget request for fiscal year 2013 shows a 10.8 per cent drop in PEPFAR funding, budgeting for only US$ 453 million. For its African beneficiaries, these cuts drastically alter the financial realities for planning and implementing HIV/AIDS policies and programs. In Mozambique, PEPFAR has announced that it will slash ARV supplies by 10-15 per cent each year from 2010-2014 (Médecins Sans Frontières, 2010). In South Africa, PEPFAR-funded programs have been ceasing initiating new patients for treatment, with more than 240 patients refused treatment in Mpumalanga

[2]With the exception of Uganda, where recent appeals from healthcare providers has prompted the fund to increase its support for ARV programs.

province between November 2009 and February 2010. Similarly, in Uganda, the American Centers for Disease Control (CDC) sent a letter to PEPFAR-supported facilities warning them not to initiate new patients on treatment unless they were sure they could continue the regimen without further donor support in the future (PEPFAR, 2009). For this reason, treatment opportunities at some sites in Zimbabwe, Uganda and South Africa are only available for pregnant women or young children (Médecins Sans Frontières, 2010).

It should be noted that in some contexts, PEPFAR's funding cuts for HIV/AIDS should not be strictly characterized as donor abandonment. In South Africa, the US government has entered into a five-year (2012-2017) transition agreement with the South African government to make sure that PEPFAR's funding reductions can lead to an effective hand-over of the response through dialogue and increased technical support (Brundage, 2011). Similar (though less financially significant) transitions are also underway with PEPFAR in Botswana and Namibia. Though these transition periods are preferable to some of the more drastic funding cuts that are happening elsewhere from other donors, this still represents uncharted territory for PEPFAR; South Africa has been its biggest portfolio with over US$ 3.1 billion spent there since 2004. Both partners are also aware of the complexity of such a transition and the potential threats it holds for interrupted service delivery, civil society backlash and damage to South Africa-US relations (Brundage, 2011).

The Global Fund to Fight AIDS, Tuberculosis and Malaria

If the shrinking HIV/AIDS budgets from UNITAID, the World Bank, the European Union and PEPFAR are regarded as significant funding cuts, no public health austerity measure compares in size and impact to that of the Global Fund to fight AIDS, Tuberculosis and Malaria (hereafter referred to as the Global Fund). The Global Fund is most commonly a financing organization which makes on-budget donations (multi-lateral aid channelled directly to governments, rather than to non-state entities such as NGOs or faith based organizations). Launched in 2002, the Global Fund is one of the world's largest funders of HIV, totalling 864 grants, worth US$ 21.9 billion (Global Fund, 2011). Of this amount, approximately half (over US$10 billion) was granted to African governments. Resources available for the Global Fund grew by approximately 8 per cent per year between 2008 and 2010, reaching a peak of nearly US$ 3.6 billion in 2010 (Usher, 2011). Since then, however, major donor countries to the Global Fund have severely cut their contributions. For Round

10, the US contribution to the Global Fund was frozen and the White House proposed a US$ 50 million reduction of the US Global Fund contribution in future years (Médecins Sans Frontières, 2010).[3]

In addition, Ireland and the Netherlands reduced their financial involvement in the Global Fund, while donations from France and Italy fell behind schedule. This means that the amount originally promised to the Global Fund was not met by actual donation. In the past, donors honoured 100 per cent of their commitments to the Global Fund. From 2001 to 2005, every single pledge to the Global Fund was paid. Since then, from 2006 to 2011 US$ 645 million in pledges was not paid (Rivers, 2012). For instance, in 2010, countries only gave 80 per cent of the amount they originally promised. In 2011, the number of confirmed pledges from donor countries for the period of 2011-2012 shrunk from US$ 9.7 billion to US$ 8.2 billion (Rivers, 2011, November 21).

Donor	2011 pledge US$ millions
Germany	142·9*
European Commission	185·7
Denmark	33·5

*Germany has released 50% of its US$285·7 million pledge for 2011, frozen in January, following publication of the interim report of the independent panel.

Table 1: Donors that have frozen funds to the Global Fund in 2011

Country	2010 pledge US$ millions
Spain	250·0
Italy	185·7
Sweden	74·0
Ireland	48·5

Table 2: Countries that have not committed funds to the Global Fund in 2011

Figure 1.3: Frozen & Decreasing Global Fund Contributions (Usher, 2011).

As a result of unconfirmed contributions or those dispersed behind schedule, the Global Fund's Round 11 available budget declined from US$ 1.6 billion (in May 2011), to US$0.8 billion (in September), to US$ 0.6 billion (in November). Consequently, in November 2011 the Global Fund announced that round 11 of grant approvals would be cancelled (Zumla, 2012). The next opportunity for countries to apply for Global Fund grants will not be until the next replenishment period, in 2014-2016. According to Jeffrey Sachs, the Global Fund Board decision to postpone Round 11 marks the sharpest setback to the Millennium Development Goals since their adoption in September 2000 (Donnelly, 2011).

[3] See the next page for countries' re-commitment to the Global Fund leading up to the fourth replenishment meeting in the last quarter of 2013. These contributions have helped to stabilize global spending on HIV/AIDS since the initial decline. However, the spending cuts which occurred from 2008-2010 are still highly significant in how they changed the landscape of the new global politics of HIV/AIDS. As a result, many countries have now heavily increased domestic public spending on HIV/AIDS.

This funding decline (and subsequent Round 11 cancellation) is partly due to the global economic downturn. After the markets crashed in September 2008, countries have had fewer resources available to contribute to the Global Fund. However, the decrease in commitments to the Global Fund could also be the result of a loss of confidence in grant oversight, since investigations revealed that millions of dollars were mismanaged by recipient countries (Rivers, 2011).[4] Additionally, there have been internal management conflicts. In January 2012, Global Fund Executive Director Michel Kazatchkine announced that he would be stepping down after a disagreement with the Board's decision to appoint a new General Manager (Cohen, 2012, January 24).

Third, decreases in commitments to the Global Fund may also be seen as a result of large quantities of unspent money, both from the Global Fund and from other partners. For example, in 2008 the Reserve Bank of Zimbabwe released US$ 7.3 million in unspent Global Fund money that it had been holding during the country's economic collapse (Punitha, 2008, November 8). Similarly, in Kenya, nearly US$ 500 million of PEPFAR money went unspent, due to inefficient bureaucracies and reductions in the cost of ARVs (Chonghaile, 2012, April 27). In Namibia, too, US$ 57 million of PEPFAR money has recently been found to have gone unspent (Ashipala, 2012, April 27). In the last fiscal year in South Africa, too, there have been reports of ZAR 31.7 million (~US $ 4.2 million) of unspent funds, which were earmarked for NGOs working in the field of HIV prevention and support of vulnerable families (Brown, 2012, December 4). This is certainly a relevant factor in why countries may be cutting back on their contributions to the Global Fund, taken in combination with the financial crisis in 2008 and with widespread reports from the Global Fund's Office of the Inspector General (OIG) on mismanagement of Global Fund recourses in country.

It should be mentioned that since the cancellation of Round 11, the international community has tried to increase its Global Fund support. In January 2012, the Bill and Melinda Gates Foundation contributed US$ 750 million to the Global Fund, which was more than the total amount that the foundation had pledged since the Global Fund was begun 10 years ago (US$ 650 million) (Rundle, 2012, January 26). Moreover, the White House has requested a budget increase for 2013 for Global Fund contributions, from both the Global Health Initiative (+US$ 350 million/+26.9 per cent) and the State Department (also +US$ 350 million/ +26.9 per cent) (Kaiser Family Foundation, 2012). In addition to the American efforts to re-charge

[4] While the dollar amount of corruption is only about 1 per cent of total Global Fund money dispersed, the barrage of media attention and the shake to contributing countries' confidence indicates the implied severity of any kind of lack of transparency surrounding donor institutions.

the Global Fund, on 13 March 2012 Japan made a US$ 340 million contribution, the highest amount Japan has ever pledged to the fund (Hurst, 2012, March 13). Sweden, Norway, Finland, Denmark and Iceland also pledge a combined US$ 750 million, which is $150 million more than they have previously donated (Garmaise, 2013, September 6). Most recently, the UK pledged US$ 1.6 billion to the Global Fund (Faison, 2013, September 23).

These pledges are encouraging and are contributing towards the stabilizing of international HIV/AIDS funding. However, the gap between what has been committed and what is needed remains large. The future of the Global Fund is still uncertain and the cancellation of Round 11 marked a significant turning point in the financial and political realities facing HIV/AIDS programs in Africa. It is a wake-up call for many governments in high-burden countries, and will certainly effect budgeting and policy-making in the near future. Indeed, some leaders have noted that the cancellation of Round 11 might have come at the right time, prompting countries to step up and begin acting on their promises about the financial sustainability of their own HIV/AIDS programs (Muleshe, 2012, March 12). As a result, financial commitments from affected countries are increasing.

Increased Domestic African HIV/AIDS Funding

Given the growing gap between in-country needs and the available donor funds, the onus is on African governments to fill the gap. Responding to the need for more resources for HIV/AIDS, there has been a dramatic increase in financial contributions for HIV/AIDS programs from within Southern Africa (Figure 1.4). African domestic spending (defined as public spending independent of Global Fund aid, bi-lateral aid or multi-lateral aid) on HIV and AIDS efforts in affected countries rose from $500 million in 2000 to $2.5 billion in 2004 and $4.3 billion in 2008 (Bonnel, 2009). Lesotho is a prime example, where domestic funding for HIV/AIDS programs made up only 18.7 per cent of total available funds in 2006-2007. Then, in 2007-2008, Lesotho's domestic contribution rose to 37.2 per cent of the total amount of HIV/AIDS funding. Lesotho's domestic financing continued to rise in fiscal year 2008-2009, when for the first time domestic contributions made up the majority of HIV/AIDS program funding in the country, reaching 56.9 per cent of total funding (Lesotho National AIDS Commission, 2008). Similar upward trends are evident in Zimbabwe, where domestic funding leapt from 16.4 per cent in 2005 to 49.0 per cent in 2006. More recently, Kenya's 2010/2011 national budget has - for the first time ever - allocated money for local ARV programs (PlusNews, 2010, June 14).

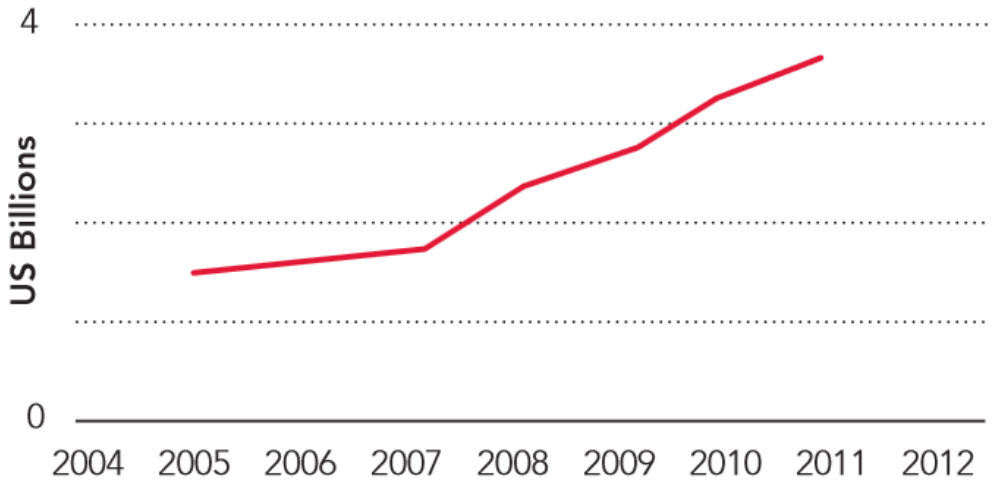


Figure 1.4: Domestic African Resources for HIV/AIDS (US$ billions) (UNAIDS, 2013b)

These changes in domestic African spending are often based on an imperative for African countries to begin making up the shortfalls in donor money by reallocating public funds (Bodibe, 2010, October 28). Jeremy Youde (2010) suggests increases in foreign aid for HIV/AIDS, frees up domestic resources and allows them to be spent on other health care needs. By the same logic, decreases in foreign aid for HIV/AIDS will move national treasuries to re-allocate funds from other areas of health back towards HIV/AIDS to fill the donor gap. For example, in 2010, South Africa's budget included an increase of ZAR 8.4 billion (~US$ 1 billion) for ARVs, which should add an extra 100,000 people to treatment regimens (Odendal, 2010, February 26; Langa, 2010, March 11). There was also an additional ZAR 100 million (~US$ 12 million) included in the Medium Term Expenditure Framework for HIV prevention in 2010, which forms part of a larger commitment from the South African government of ZAR 1.5 billion (~US$ 18.5 million) for HIV programs from 2010 to 2013.

Additionally, in the wake of Swaziland's funding crisis which resulted from Global Fund rejection of its Round 10 application, South Africa stepped in to support the Swazi government with a US$ 313 million loan, the first US$ 104 million infusion to go directly to health and education (PlusNews, 2011, November 15). This loan represents substantial financial ownership of the HIV epidemic coming from within Southern Africa, especially when compared PEPFAR's US$7 million emergency funding for Swaziland, which was only to go towards first-line ARVs (PlusNews, 2011, November 15).

Rwanda has also increased its financial contributions to global HIV/AIDS efforts, by pledging US$ 1 million to the Global Fund in 2010 (The New Times, 2010, September 30). The donation came from the Rwandese financial institution, Access Bank, demonstrating the mounting commitment of the African private sector to filling the gap left by stagnant Western donor funding. Along with South Africa and Rwanda, Tanzania has also increased its domestic spending on HIV/AIDS. In December 2010, Vice President Dr. Mohammed Gharib Bilali announced that Mbeya, Iringa and Dar es Salam regions (those with prevalence rates of five per cent or higher) would be allocated more money from the federal government, through the Medium Term Expenditure Framework (MTEF) for HIV programming (Lucas, 2010, December 1).

In addition to increased African financial commitments for HIV/AID programs, there is also a movement towards producing ARV pharmaceuticals locally, which is another form of HIV/AIDS domestic investment. In Uganda, Quality Chemical Industries has partnered with Indian generic drug manufacturer, Cipla, to produce ARVs locally. Carel IJsselmuiden, director of the Council on Health Research for Development (COHRED), notes how African countries increasingly are electing to take charge of their own public health situation (McColl, 2010). McColl (2010) also indicates that local pharmaceutical production is an example of the momentum behind Africans increasingly driving the HIV/AIDS agenda. Similarly, Tanzania's first locally manufactured ARVs began to be produced midway through 2012, at the country's new pharmaceutical plant in Arusha. While the plant was built using a grant from the European Union of about US$ 6.6 million, it is significant that the Tanzania Pharmaceuticals Industry (40 per cent government owned) has contributed US$ 963,000 to the project (PlusNews, 2012, March 6). A similar investment is occurring in South Africa, where the government is investing ZAR 1 billion (~US$ 113 million) to build a pharmaceuticals plant, which will locally produce ARV ingredients by 2016 (Aboobaker, 2012, February 13).

Broader Donor Policies and Diverging African Strategies

While the cuts in HIV/AIDS financial support from Western donors have been widely covered by the news media, there has also been significant political change in Western donor policies that may be equally important. International policies on health from donors like PEPFAR and The World Bank used to speak in a straightforward way, specifically about HIV/AIDS prevention and treatment. However, these organizations have more recently begun

to refer to broader strategies of health systems strengthening (HSS) or capacity building. One by one, major international donors have changed their policy frameworks to focus on broader issues of health development, rather than HIV/AIDS. In particular, this has come to include more indirect interventions, commonly referred to as 'efficiency improvements' (Médecins Sans Frontières, 2010; Jouquet et al., 2009).

Another example of the changing environment of HIV/AIDS is the recommendation from the Institute of Medicine, in which it was urged that PEPFAR should move from emergency relief for HIV towards capacity building for sustainability (Institute of Medicine, 2007). Following these recommendations, discussions within the White House on reauthorizing PEPFAR progressively revolved around expanding human resources, improving labs, increasing patient information and making procurement more efficient, instead of targeted HIV interventions (Moore & Morrison, 2007). These rhetorical changes in health development were confirmed in January 2010 when US Secretary of State, Hilary Clinton, consolidated the shift in focus from HIV/AIDS towards broader health priorities with a US$ 63 billion commitment to health systems strengthening over six years (Clinton, 2010, January 6). Bongaarts and Over (2010, p. 10) have called this a "significant shift from the previous administration's approach." As a result, under PEPFAR II, HSS and improvements to human resources for health are a much stronger focus area. Pursuant to this diverted emphasis away from HIV/AIDS, towards other interventions, PEPFAR treatment for 3,000 adults in Zimbabwe was re-channelled to reach only mothers in 2011 (Médecins Sans Frontières, 2010).

In the same manner as the World Bank and PEPFAR, in April 2007, the board of the Global Fund began considering funding comprehensive country health programs (Ooms et al., 2008). As a result, the new International Health Partnership Plus was launched in September 2007, which some speculate will lead the Global Fund to embark on a much broader health mandate as well. Many donor countries to the Global Fund, along with several grant-recipient countries, have echoed these sentiments, asking that Global Fund money also be used for HSS and maternal, newborn and child health (MNCH). It seems that Millennium Development Goal #6 (HIV/AIDS, malaria, and other major diseases) is increasingly losing political favor to Millennium Development Goal #4 (child mortality) and Millennium Development Goal #5 (maternal health) (Médecins Sans Frontières, 2010).

An important reason for this this change in the political focus of public health aid may have arisen out of the 2005 Paris Declaration, where donors committed to improve effectiveness of their development aid. Following this, and fuelled mounting exposure about the disproportionately high cost of funding HIV/AIDS, there is a growing tendency to donate money towards health more generally, rather than HIV/AIDS specific projects or programs. For instance, The Lancet published an article disclosing that the financial assistance for HIV/AIDS was 23 per cent of total health aid in 2007, when the percentage of AIDS deaths in the world was less than 5 per cent (Bongaarts & Over, 2010). Further, in some African countries, foreign donor funding for HIV/AIDS was greater than the total budget of the Ministry of Health (Shiffman, 2008). Based on this evidence, it may be that allocating fewer foreign resources for HIV/AIDS might be a very reasonable step.[5]

Emerging out of such aid-effectiveness questions, the costs of HIV/AIDS programs were increasingly compared to other life-saving interventions. In 2008, scholars began urging that cost-effectiveness (lives saved per dollar spent) was an ethical responsibility of public health development partners (Denny & Emmanuel, 2008). The Disease Control Priorities Project released a list of the most cost effective medical public health interventions (defined in terms of dollars per year of life saved) (Jamison et al., 2006). This report made it clear that bed nets for malaria prevention were the most cost effective initiative, with aspirin or beta-blockers for myocardial infarction, household spraying for malaria, tax for tobacco and Bacillus Calmette-Guérin (BCG) vaccine for tuberculosis (TB) were among the most cost-effective (Bongaarts & Over, 2010). These programs are all more cost-effective than condom distribution for HIV/AIDS prevention. Further, antiretroviral therapy was, in some cases, the least cost-effective life-saving measure, with short-course chemotherapy for TB, family planning for unwanted pregnancies, improved care for maternal health and basic sanitation for diarrheal disease all proving to be more cost-effective interventions. These data, published by Ezekiel Emanuel, a senior advisor in the White House, were used to make the point that extending funding for PEPFAR should be discouraged, since more lives could be saved by spending money on other issues, such as respiratory and diarrheal illnesses (Denny & Emmanuel, 2008). Bongaarts and Over (2010) agree, arguing that donors should focus more on childhood immunization, malaria, tuberculosis, maternal mortality and family planning, since these interventions save many more lives per dollar spent than anti-retroviral drugs do.

[5] It is not the objective of this introduction to comment on the normative implications of the financial and political changes in the donor landscape for HIV/AIDS. Rather, my aim is to describe the context within which African countries now write their HIV/AIDS policies and implement programs.

Growing Policy Divergence

There also appear to be growing a divergence in the policy-making process between African governments and international donors. For example, Swaziland's 2000-2005 National Strategic Plan, excludes any policies aimed at commercial sex workers (CSWs), in line with PEPFAR's long-standing refusal to fund any HIV/AIDS proposal seen to provide support for prostitution. However, in Swaziland's more recent national strategic plans (2006-2008, as well as 2009-2014) the policy diverges politically from PEPFAR regulations and includes CSWs as a target at-risk group (Mathabela & Odido, 2010). Additionally, in line with UNAIDS' top target populations, in its newly reviewed (March 2009) list of indicators, men who have sex with men (MSM) were identified as a group that is particularly vulnerable to infection in Zimbabwe's 2006-2010 NSP (UNAIDS, 2009). In another move away from UNAIDS protocol, the 2011-2015 Zimbabwean NSP mentions only that no surveillance of MSM exists, because the government of Zimbabwe expressly refuses to plan HIV prevention programs for these populations since "these groups have no legal status in Zimbabwe" (Government of Zimbabwe, 2010, p. 15).

A third example of divergence between African policies and global norms is Uganda's 2010 draft policy on when children ought to be informed of their HIV positive status. While the international policy (according to Human Rights Watch and the UNHCR [UN Refugee Agency]) is that children as young as age six may be informed of their status, Uganda's age remains higher than that (Human Rights Watch, 2010). The previous policy in Uganda legislated that children must be 12 years old, and this policy review is only lowering that age to 10, not 6 as international policy stipulates. Kenya is also politically divergent from this global norm, remaining steadfast that it must be the responsibility of the legal guardian to inform the child, whenever the parent sees fit.

In sum, there are three main elements that make up the new global politics of HIV/AIDS: First, relatively declining levels of international donor support is coupled with increasing resources coming from within affected countries; Second, the political focus of international heath agendas is shifting away from HIV/AIDS specific interventions, towards broader health systems policies; Third, there is at least some evidence of policy divergence, as some African HIV/AIDS policies are beginning to move away from international policy norms.

Research Questions

Given the previous discussion, the first major research question that I ask in this study is *who governs HIV/AIDS policy in Southern Africa?*[6] With the recently changing financial and political realities of the new global politics of HIV/AIDS, will African governments react by pursuing policies that may respond to local imperatives and diverge from global protocol?

In addition, I ask a second major question which follows from the first. After investigating *who governs*, I am also driven to know *why*. Specifically, are there predictable institutional or structural factors which make one country more likely than another to comply with or diverge from global HIV/AIDS policy than another? Exploring this trend sheds light on why certain countries may comply more with global HIV policy than others.

At this point, the next obvious question would be 'so what'? Do HIV/AIDS policies make any difference in terms of actual health outcomes? If African countries diverge from global policy, or comply with it, do these policy decisions affect HIV infection rates? The mainstream argument in the literature is that domestically designed policies are more effective because they are more contextually informed than those developed in the Global North. However, there is a tendency for the literature to argue anecdotally that locally designed policy is *always* more effective, without much scientific evidence for this claim. As such, given the lack of evidence it could just as reasonably be true that policies put forward at the global level – by leading experts at UNAIDS, WHO or the Global Fund – might be more effective and should therefore be adopted. Based on this uncertainty, the 'so what' question is important. But, showing that policy is related to epidemiological outcomes is a difficult endeavor. Justin Parkhurst (2008) suggests a five-step model that requires evidence in the following order: (1) falling HIV prevalence, due to (2) falling HIV incidence, due to (3) changes in behavior, due to (4) behavior change interventions, due to (5) HIV prevention policies. Within the scope of this study I am able to provide evidence for step 1, step 2 and step 5, but not for steps 3 or 4. As a result, my objective is to offer some initial tentative observations about which type of policies might be better, in order to inspire future research into the debate about global versus domestic HIV/AIDS policy efficacy.

[6] It should be stated at the outset that this question was operationalized by focusing on the influence of the Global Fund and its influence over domestic National Strategic Plans in Africa. The methodology behind why the Global Fund was selected as the independent variable is detailed in Chapter 2. My model for measuring donor influence could be subsequently applied to the other donors discussed in this chapter. It could also be a useful tool for other researchers, or for donor organizations themselves, to assess the influence they have over African domestic policy-making.

Propositions

In answering my first question I expect to find that after 2008, African national HIV/AIDS policies will be less likely to be aligned with donor policy. The logic behind this hypothesis is based on the new global politics of HIV/AIDS, where money from Western donors is leveling off while in-country needs continue to grow. As African governments commit more and more domestic resources to fill this gap, it is logical that they will have greater ability to direct policy-making in their countries. Before the new global policies of HIV/AIDS, African governments were much more dependent on global donors, and therefore less able to control their own policy and program agenda.

For my second question, I anticipate finding variation across countries in the degree to which African governments move their strategies away from global policies, and that this variance can be accounted for by both structural and institutional variables. First, with respect to structural economic variables, I expect to find that wealthier countries who spend more domestic public funds on HIV/AIDS and accept less foreign aid will diverge to a greater degree from international policy protocols than those countries that depend on donors. A country's economic independence is connected with its ability to design locally relevant policies (Parker et al., 2000; Epstein; 2007; Pisani, 2008). As such, it follows that wealthier countries will diverge from global HIV/AIDS policies more than poorer ones. Second, with respect to institutional variables, I expect to find that greater policy divergence will be exhibited by better-governed, more democratic states with greater political accountability and political stability. Stronger governance is connected to more domestically designed health policy-making, since effective states are more likely to demonstrate greater political commitment to issues such as HIV/AIDS (Parker et al., 2000; Baldwin, 2005; Menon-Johansson, 2005; Heald, 2006; Biesma et al., 2009; Altman & Buse, 2012).

For the question of 'so what' (which I offer some interesting initial evidence for in the implications section of Chapter 7) I hypothesize that divergence from global policy norms will be associated with better epidemiological outcomes. This reasoning comes from the mainstream logic that local policies are more effective than imported ones because they are more culturally relevant (Green, 1988; Asiimwe-Okiror et al., 1997; Ahmed et al., 2001; Campbell, 2003; Hogle, 2002; Low-Beer and Stoneburner, 2004; Cohen & Tate, 2005; Halperin et al., 2011; Timberg & Halperin, 2012).

Significance of Study: Democracy and HIV/AIDS Policy Effectiveness

Aside from an academic rationale based on Alex De Waal's (2003) view that the political science of HIV and AIDS policies is intellectually under-capitalized, this study deals with a significant real-world problem. There are two main grounds for justifying the value of this project: First, the implications for democracy and development and; Second, new ways of measuring political commitment and AIDS governance.

Democracy and Development

If I find that global institutions continue to heavily influence local HIV/AIDS policies in Africa, this will have significant implications for democracy, especially in contexts of a developing country. Milton Friedman (1958) argues that donor funding obstructs democracy and civil liberties since funding economic productivity in the public sector is not helpful in fostering democracy and freedom. Similarly, according to Adam Przeworski's (1991) research in Eastern Europe and Latin America, economic reform policies are generally forced on developing country governments by international organizations that control the finances, such as the World Bank or the International Monetary Fund. More broadly speaking, policy changes are generally a strategy of control from above, not from broad consensus and participation from domestic stakeholders. As such, governments resort to ruling by decree to meet international deadlines, as evidenced by economic reforms in Argentina, Bolivia, Ecuador and Peru. Democracy is thus potentially substantially weakened as people seem to get a regular chance to vote, but not choose.

In addition, if I find that HIV/AIDS policies in Africa remain heavily compliant with global agendas then this top-down process renders African governments less responsive to the wants and needs of their citizens. According to Mick Moore (1998), foreign aid has a negative impact on state responsiveness to its citizens by weakening democratic systems of taxation and service provision. Moore says that foreign assistance comes between governments and the demands on their citizens since donor money is an 'unearned' source of state income. As a result, he argues African governments never develop the capacity to raise public funds through taxation and provide good public services in return. Without developing this democratic tradition, government responsiveness to its internal constituencies is significantly weakened. Putzel (2004) follows the same logic with respect to HIV/AIDS donor funds. He suggests that it has undermined the state's leadership role in the political response. This same

argument has been made, generally, about how democracy evolved in the West. With England as the prime example, political shifts from monarchies to democracies were chiefly fuelled by the state's need for tax revenues, often for fighting wars (Tilly, 1990; North, 1990). As foreign aid stunts this precondition for democracy, if I find donors to be continuing to exert control then the significance for democratic development is that African states will continue to be accountable to Western donors, and not to their citizens.

Indeed survey research has shown that Africans consistently rank HIV/AIDS very low on their list of priorities they want their elected governments to address, choosing rather to see government action on employment, food security and crime (Whiteside, Mattes, Willan & Manning, 2004).

Donor influence also retards the development of a strong and healthy civil society. Without a strong civil society as external watchdogs, government accountability is weakened. Julie Hearn (2001) argues that Western donor support to African policy-oriented non-governmental organizations weakens democracy by creating a false 'partnership' whereby civil society has very little power since it is dependent on outside funding. The result is a system where civil society and citizens are incentivized to accept the status quo, rather than challenge it.

However, if I find the opposite – that donors are exerting less control over HIV/AIDS policy-making in African states then the opposite result may be true. It could signify the development of a more accountable and democratic state system emerging in Southern Africa.

Political Commitment and AIDS Governance

The results of this study are also significant for measuring political commitment. On July 3, 2004, the lead editorial of the Lancet observed that when it comes to fighting the HIV/AIDS epidemic, "Perhaps the most important factor is the willingness of political leaders to acknowledge the crisis and implement needed interventions" ("HIV/AIDS: not one epidemic but many", 2004, p. 1). Similarly, Patterson (2001) notes that for the last two decades, International AIDS Conferences have been dominated by call for stronger political commitment and bolder political will.

But defining political commitment and good AIDS governance is a challenge. Bor (2007, p. 1586) defines political commitment as "the extent to which top-level government leaders (viz. heads of state and their appointees) support AIDS as a priority on the national agenda." Others prefer a broader understanding which includes the private sector, civil society, and local government.

To assess political commitment there are some measurement tools available. Bor (2007) uses the 'political support' component of the 2003 AIDS Program Effort Index (API). There are also other suggested measures of political commitment such as the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment Indicators and the AIDS Policy Aggressiveness Indicators (Lieberman, 2011). Furthermore, there is a literature that uses expressed commitment, institutional commitment and budgetary commitment as other measure of AIDS leadership (Fox et al., 2011).

Building on existing efforts, this study develops a new indicator – the level of domestic AIDS policy compliance with global protocol. I have developed a new measurement tool for assessing political commitment, which may contribute towards research efforts to understand what good AIDS governance is, and what contextual factors make certain types of governance more likely. Based on the literature (Bor, 2007; Fox et al., 2011; Lieberman, 2011) there is a need for more tools which can measure political commitment in ways that are empirically testable. Therefore, one of the key contributions of this study is the creation of a new statistical measurement of AIDS governance.

In addition to developing indicators on AIDS policy compliance, this thesis also contributes significantly to debates about which contextual factors inspire or impede different types of political responses. In answering my second question, about *why* certain countries comply more with international HIV/AIDS policy than others, I test a number of structural and institutional variables which have previously been posited to affect political decision making. The results of these tests are significant because they help us to understand which contexts will beget certain kinds of political commitment to AIDS.

Why does measuring political commitment and AIDS governance matter? Strand (2007, p. 219) says a comparative research agenda will be able to answer such questions as "which type of AIDS governance is more successful with prevention?, or which type is better at

sustaining a treatment programme?" It is difficult to say whether compliance with global policy, or divergence from it, represents better political commitment or stronger AIDS governance. Without being able to definitively connect policy compliance with epidemiological outcomes in this study, I cannot conclusively say which is better for health outcomes. However, the section in Chapter 7 on "Policy Efficacy" implications offers some intriguing initial and tentative evidence. My aim here is to provide a platform and an incentive for future researchers to investigate the potential relationship between AIDS policy compliance and infection rates.

Concluding Remarks

It is clear from the preceding chapter that since 2008, there have been significant shifts in the global politics of HIV/AIDS. These shifts include financial changes, such as less donor money available compared to the relative need, met by increased African domestic spending. There is also a change in the political focus of Western donors, with priorities moving away from HIV/AIDS-specific discussions towards broader health systems strengthening and capacity building. Lastly, there is preliminary evidence of diverging HIV/AIDS policy agendas of African governments and global institutions. These financial and political shifts (referred to collectively in this project as *the new global politics of HIV/AIDS*) are hypothesized to lead to changes in African domestic policy-making.

In Chapter 2 of this dissertation I will provide more detail on exactly how the term 'global policy' was operationalized by selecting the Global Fund's 2009 Monitoring and Evaluation Toolkit as the independent variable. In this chapter I will also discuss precisely how I measured policy change, so that this method can be easily replicated by other researchers who may be interested to measure the influence of other donors in the HIV/AIDS or public health field.

Next, in Chapter 3 I will present the first part of my results. Here, I will highlight the aggregate trends in policy compliance in the region, revealing which countries comply with global policy and how this changes (or does not change) over time. In this chapter I will also reflect on how these findings contribute new knowledge and understanding, as well as relate to the debates in the literature.

In Chapter 4 I illustrate how and why this aggregate policy change happens by examining in detail individual policy changes over time in the written policy documents.

In Chapter 5 I investigate the potential causes of policy by examining relationships between HIV/AIDS policy change and contributing contextual factors. Specifically, I look at two sets of explanatory variables – structural economic variables and institutional political variables.

In Chapter 6, I present qualitative data from 82 key informant interviews conducted in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, as well as the Global Fund Secretariat in Geneva. Data from these interviews help to illustrate the causal mechanisms suggested by the statistical analysis in Chapter 5.

Lastly, in Chapter 7 I finish with a number of recommendations for the Global Fund's New Funding Mechanism, based on the results of this research. The New Funding Mechanism is set to be fully implemented in late 2013, once the Global Fund ascertains availability of funds for the 2014-2016 cycle. For each of these recommendations, I also suggest how the change makes sense in the context of the new UNAIDS (2011) Investment Framework.

I then inspect potential consequences of changes in policy compliance. I do this by measuring the association between change in HIV/AIDS policy and change in epidemiological trends. Due to the difficulties in demonstrating the impact of policy on HIV infection rates, as well as the small number of cases in this project, the results of this analysis are not conclusive or definitive. Instead, they are meant to provide direction for future research into the relationship between HIV policy change and its impact on the epidemic.

Chapter Two

Evaluating National Strategic Plans based on Global Policy Indicators: Methodology and Research Design

"There is no such thing as a logical method of having new ideas. [...] Discovery contains an irrational element or a creative intuition" (Popper, 1968, p. 32).

Introduction

As the purpose of this study is to measure HIV/AIDS policy and policy change quite closely, a quantitative methodology was selected to achieve this. The methodology and research design was chosen based on the three fundamental research goals of this study: first, to determine the level of influence global policy has over HIV/AIDS strategies in Southern Africa; second, to explain why some countries might comply more heavily with global policy than others; and third, to see what associations changes in compliance or divergence with global policy may have on changes in the HIV/AIDS epidemic in each country.

Study Population

Since my intention is to understand the politics of HIV/AIDS policy-making in countries significantly affected by the epidemic, the criterion for inclusion is a high level HIV prevalence. I have set HIV/AIDS prevalence of greater than 10 per cent as the rule for the inclusion of a country. Table 2.1 displays all the Anglophone countries with HIV/AIDS prevalence rates higher than 10 per cent (I am not proficient in Portuguese). Countries with HIV/AIDS prevalence rates lower than 10 per cent were excluded for two reasons. First, there is a natural cluster of countries with prevalence rates above 10 per cent, since prevalence rates drop off quite steeply after that with the next highest rates found in Uganda (6.5 per cent) and Kenya (6.3 per cent). Secondly, there is also a logical geographical grouping since the epidemic and policy landscape in East Africa is at a very different point in its life cycle than Southern Africa. For instance, when Uganda was faced with a wide-spread generalized epidemic in the early 1980s, HIV/AIDS was only starting to appear along truck routes and in mining communities in Southern Africa. For this reason, comparing the contemporary epidemic and policy response in Eastern African and Southern Africa would ignore significant chronological differences.

Table 2.1: Adult (15-24) HIV/AIDS Prevalence (%) Estimates (UNAIDS, 2010)

Country	HIV Prevalence
Swaziland	**25.9%**
Botswana	**24.8%**
Lesotho	**23.6%**
South Africa	**17.8%**
Zimbabwe	**14.3%**
Zambia	**13.5%**
Namibia	**13.1%**
Malawi	**11.0%**
Uganda	6.5%
Kenya	6.3%
Tanzania	5.6%
Cameroon	5.3%

Data Collection

Operationalizing the Concept of 'Global Policy'

I understand the concept of 'Global Policy' as the policy of the largest donor that channels its funds through the national government of a recipient country (sometimes termed "on-budget" funding).[7] I look at donors which give money to national governments because I am measuring the effect of donor money on national policy. Money given to governments would have a larger influence over national policy than money that goes directly to non-governmental organization (such as funds from USAID, which do not go to governments).

The UNAIDS 2010 Global Report disaggregates external HIV/AIDS funding into five categories: Bilaterals, Global Fund, the UN, all other multilaterals and all other international sources.[8] Before 2010, the UN and other multilaterals where grouped together in the same category. Then, in the most recent UNAIDS Global Report (2012), spending is only disaggregated into Public, Bilaterals, Development Banks, Global Fund, Multilaterals and all other (multilaterals and international).

[7] This excludes PEPFAR, since it only funds non-governmental organizations.

[8] I have chosen to use The UNAIDS 2010 Global Report as the source for spending data because its disaggregation of data into five categories is the most useful. The 2011 UNAIDS Epidemic Update does not include AIDS spending data by country and the UNAIDS 2012 Global Report only disaggregates spending data into three categories (public, bilateral and development banks).

In order to achieve the most even and effective funding breakdown, I used the 2010 report breakdown categories and the data from the UNAIDS 2010 report. However, there is data missing for both Namibia and Zambia. For Namibia, I used the 2010 National AIDS Spending Assessment (Government of Namibia, 2010) and for Zambia, I used the data available in the 2008 UNAIDS Global Report.

Based on this spending data, the Global Fund is clearly the largest *individual* donor across the countries in this study. A complete chart of Global Fund disbursements to the countries in my study, as well as the total amount of funding to date, may be found in Appendix A and B.

Table 2.2: AIDS Spending by Financial Sources (UNAIDS, 2010)

Country	Domestic Public Resources	Bilaterals	Global Fund	UN and all other Multilaterals	All other international sources or not specified
Botswana (2008)	67.4%	21.3%	0%	0.4%	10.9%
Lesotho (2007)	56.9%	18.5%	8.9%	5.1%	10.6%
Malawi (2009)	1.4%	26.4%	54.7%	8.5%	8.9%
Namibia (2009)[9]	48.3%	33.1%	14.7%	2.5%	1.4%
S. Africa (2007)	72.7%	26.3%	0.2%	0.5%	0.3%
Swaziland (2006)	39.6%	5.8%	31.0%	9.7%	13.6%
Zambia (2006)[10]	15.3%	60.9%	12.9%	7.0%	3.9%
Zimbabwe (2009)	19.5%	21.4%	17.1%	1.1%	40.9%

[9] **Source:** Government of Namibia, Health Systems 20/20 Project, World Health Organization, and UNAIDS. (2010). *Namibia Health Resource Tracking: 2007/08 & 2008/09*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
[10] **Source:** UNAIDS (2008). *Report on the Global AIDS Epidemic*. Geneva, Switzerland.

The Global Fund clearly represents the largest individual donor which supports government in each of the countries in the study population (Table 2.2). Since the Global Fund is the largest individual donor, I use the most recent edition (Third Edition, February 2009) of the Global Fund HIV Monitoring and Evaluation Toolkit as the basis for data on 'Global Policy'. The Toolkit includes "25 indicators related to the United Nations General Assembly Special Session on HIV/AIDS required for monitoring the Declaration of Commitment on HIV/AIDS and 15 additional recommended indicators" (Global Fund, 2009, p.67). The way the Global Fund selects these policies is based on a collaborative process which includes international organizations, bilateral agencies, nongovernmental and private organizations and other major partners. In particular, the following organizations are acknowledged with providing input into the Global Fund's 2009 M&E Toolkit: The United States Centers for Disease Control and Prevention, the Global Fund, the Health Metrics Network, the Roll Back Malaria Partnership, the Stop TB Partnership, UNAIDS, WHO (including the Global Malaria Programme, the HIV/AIDS Department and the Stop TB Department), the World Bank, the United States President's Emergency Plan for AIDS Relief (Office of the United States Global AIDS Coordinator) and the United States Agency for International Development, the President's Malaria Initiative and MEASURE Evaluation. This collaborative effort means that the Global Fund's selection of policies is based on "those used across organizations, promoting a common understanding of M&E within and among the three diseases and health systems strengthening as well as the use of a common set of indicators" (Global Fund, 2009, p. 5).

Since this Third Edition (2009) Toolkit will be used to measure compliance of policies written before 2009, it is relevant to mention that the Third Edition does not differ dramatically from its earlier versions: "the third edition of the M&E toolkit does not introduce a new reporting framework but rather fine-tunes and enhances the second edition of the toolkit. The toolkit uses the same measurement framework as developed in the first two editions (published in June 2004 and January 2006)" (Global Fund, 2009, p.7).

The Global Fund says that it supports existing national strategies of recipient countries, but it also emphasizes the fact that grant negotiation and management will occur "in a way that allows for optimal alignment with national processes while maintaining the principle of performance-based funding" (Global Fund, 2011, p. 126). What this means it that while the Global Fund says it supports domestic policies, this is only the case if those national policies

adequately reflects the Global Fund's policy agenda. It is clearer that national strategies must be favourable for the joint assessment, which will only occur if the "national strategy is based on a sound situational and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, and institutional determinants)" (Global Fund, 2011, p. 128). The national policy must also contain a "plan for monitoring and evaluation that includes clearly-described output and outcome/impact indicators, with related multi-year targets that can be used to measure progress and make performance based decisions" (Global Fund, 2011, p. 129). So, in other words, the Global Fund says that they will support locally devised programs and national strategies, but only if those national strategies are in line with *their* policy principles and involve *their* M&E indicator-based outcomes. Therefore, it is reasonable to assume that there is a significant amount of pressure placed on recipient countries to oblige to these Global Fund policies.

While the Toolkit says it has 40 policies (25 UNGASS and 15 other) is actually contains 54 policies if one also counts the sub-sections of policies which often refer to difference populations. For instance, under the policy on prevention, there are four sub-policies including injecting drug users, sex workers, men who have sex with men and youth. The Toolkit has a range of different policies on prevention, treatment, care and support, collaboration between TB and HIV, supportive environments, impacts and outcomes. Of these 54, many of the indicators are strictly epidemiological, such as Global Fund Indicator HIV-I1 "Young women and men aged 15–24 years who are HIV infected (percentage) (HIV-I1)" (Global Fund, 2009, p. 75). These were excluded from use in this study, because these indicators do not tell you anything about policy compliance or divergence, only about epidemiological realities. Indicators that *were* included had to do with a specific policy objective. For instance, Indicator HIV-O3, "Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months (percentage)" (Global Fund, 2009, p. 75) was included, because adherence to this suggests a policy focus on promoting faithfulness and deterring multiple concurrent partnerships. After careful review of the 54 indicators, 34 were selected for inclusion in this project's framework. Therefore, the operationalization of Global Policy was narrowed down to mean 34 specific indicators from the Global Fund's 2009 HIV M&E Toolkit. The table below lists all 34 policies selected for the independent variable in this project, which policy compliance was measured against.

Table 2.3: List of Global Fund Indicators Used to Measure Policy Compliance (Global Fund, 2009)

Policy Code	Global Fund M&E Indicator (2009)
Prevention	
HIV-P1	Young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission (percentage)
HIV-P4a	Most-at-risk populations reached with HIV prevention programs (percentage) *injecting drug users*
HIV-P4a	Most-at-risk populations reached with HIV prevention programs (percentage) *men who have sex with men*
HIV-P4a	Most-at-risk populations reached with HIV prevention programs (percentage) *sex workers*
HIV-P4a	Most-at-risk populations reached with HIV prevention programs (percentage) *young people aged 10–24 years*
HIV-P5	Schools that provided life skills–based HIV education in the last academic year (percentage)
HIV-P7	Condoms available for distribution nationwide during the last 12 months (number) *male condoms*
HIV-P7	Condoms available for distribution nationwide during the last 12 months (number) *female condoms*
HIV-P7	Condoms available for distribution nationwide during the last 12 months (number) *private sector*
HIV-P7	Condoms available for distribution nationwide during the last 12 months (number) *those distributed free of charge*
HIV-P8b	People who received testing and counseling services for HIV and received their test results (number) Testing and Counceling for Women and Men (15-49)
HIV-P8b	People who received testing and counseling services for HIV and received their test results (number). Testing and Counceling for Most-at-risk populations
HIV-P8b	People who received testing and counseling services for HIV and received their test results (number). Testing and Counceling for Young women and men aged 15–24
HIV-P11	Pregnant women who were tested for HIV and who know their results (percentage)
HIV-P12	HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (percentage)
HIV-P13	Infants born to HIV-infected women who receive an HIV test within 12 months of birth (percentage)
HIV-P14	Infants born to HIV-infected women starting on co-trimoxazole prophylaxis within 2 months of birth (percentage)
HIV-P15	Health facilities with post-exposure prophylaxis available (percentage)
HIV-P16	Cases of sexually transmitted infections treated (number)
HIV-P17	Donated blood units screened for HIV in a quality assured manner (percentage)
Treatment	
HIV-T1	Adults and children with advanced HIV infection (currently) receiving antiretroviral therapy (percentage)
HIV-T2	Health facilities that offer antiretroviral therapy (prescribe and/or provide clinical follow-up) (percentage)
HIV-T4	Facilities providing antiretroviral therapy using CD4 monitoring in accordance with national guidelines or policies, on site or through referral (percentage)
Care and Support	

HIV-CS1	Adults and children enrolled in HIV care and eligible for co-trimoxazole prophylaxis (according to national guidelines) currently receiving co-trimoxazole prophylaxis (number and percentage)
HIV-CS2	Adults and children living with HIV who receive care and support services outside facilities (number)
HIV-CS3	Orphaned and vulnerable children aged 0–17 years whose households received free basic external support in caring for the child (percentage)
Collaborative Activities	
TB/HIV-1	Adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting period (number and percentage)
Supportive Environment	
HIV-SE1	National Composite Policy Index
HIV-SE2	Enterprises implementing an HIV workplace program (number and percentage)
HIV-SE3	Municipalities with at least one human rights network functioning (number and percentage)
Outcome Indicators	
HIV-O1	Young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years (percentage)
HIV-O3	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months (percentage)
HIV-O8	Injecting drug users reporting the use of sterile injecting equipment the last time they injected (percentage)
HIV-O9	Current school attendance among orphans and among non-orphans (percentage)

Based on these 34 indicators, a number of clarifying points need to be made. First, the categories for the indicators are those listed in the Global Fund Toolkit; I did not change or reorganize indicator names, categories or codes. The reason for this was to make this methodology more straightforward for other researchers to use in future. The Global Fund's headings such as "Collaborate Activities" or "Outcome Indicators" are not very clear, but by way of Table 2.3 I aim to be transparent about which specific indicators they contain. Third, compliance with these indicators was measured strictly by adherence as stated in national policies, not on implementation or on any other factor. Ideally, measuring roll-out of policies would provide a better picture of policy compliance, but that is beyond the scope of this study. Fourth, I made a number of logical inferences about how certain indicators speak to policies and policy objectives. For instance, indicator HIV-PI4 logically suggests that testing for infants who are born to HIV positive mothers is a policy priority of the Global Fund. Some indicators are a little less intuitive; indicator HIV-O1 is taken to mean that abstinence is an encouraged area of policy focus, just as indicator HIV-O3 suggests partner reduction or faithfulness as policy proprieties. The benchmarks for compliance are detailed in the following section on how policy compliance was measured.

Measuring Policy Compliance, Divergence and Change

I measure policy compliance, divergence and change by looking at how similar National HIV/AIDS Strategic Plans are to the Global Fund policies. Since I want to measure donor influence on African governments, National Strategic Plans were chosen as data sources for the dependent variable because they are published by the National AIDS Commission of each country, which is a government body sometimes housed under the office of the President or Prime Minister.

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Table 2.4: Scale for Measuring Policy Change

I then use an ordinal rank-order scale to measure compliance. Put simply, each policy indicator receives a 0, 1, 2, 3 or 4. A ranking of "0" means that the National Strategic Plan does not, in my judgement, comply with the Global Fund policy at all. If the indicator receives a "1", it means that the National Strategic Plan promotes the Global Fund policy just a little. A ranking value of "2" means the Global Fund policy is followed to a moderate degree. A ranking of "3" denotes that the Global Fund policy has been adhered to quite a lot. Lastly, the highest indicator code – a "4" – represents indicators that comply with Global Fund policy very heavily (Table 2.4).

In order to minimize the subjective element of this scale, I employ a systematic set of decisive rules, and define them here to promote transparency. This is critical to enable future researchers to replicate or expand this research.

The lowest ranking – 0 – is the most straightforward. There are two instances in which an policy can receive this value. First, if there is no mention of the Global Fund policy, a 0 is clearly appropriate (Table 2.5). The second instance is when the country's policy states that it *does not* follow international policy protocol. This is sometimes the case for policies concerning groups that are illegal in the context, such as men who have sex with men.

Table 2.5: Example of a 0 Value ('not at all')

Indicator	Indicator Code	Global Fund Policy	NAMIBIA HIV Medium Term Plan II (1999-2004)	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	n/a	**0**	This indicator receives a 0 because the NSP does not mention the global policy at all.

In order to receive a 1, the indicator must only be mentioned once, or twice, and must not contain age brackets, time lines or other data to go with it. If any one of those three is included, the country received a ranking of 2. An example of a ranking of 1 can be seen in Swaziland's first National Strategic Plan (2000-2005) under indicator HIV-O3, Multiple Partners. The Global Fund policy stipulates inclusion of "Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months" (Global Fund, 2009, p. 75). A little bit in line with this, Swaziland's NSP policy says it will "Strengthen advocacy on [...] fidelity" (Swaziland HIV/AIDS Crisis Management and Technical Committee, 2000, p. 26). The value explanation here is clear; there is a mention of the policy, but no age bracket, no time-line and no data on how many people this speaks to in the country. This is important since many of the Global Fund policies express the need for age brackets, timelines and baseline data, which are later used for M&E purposes. Table 2.6 is an example of how a 1 ranking was coded.

Table 2.6: Example of a 1 Value ("just a little")

Indicator	Indicator Code	Global Fund Policy	SWAZILAND National Strategic Plan (2000-2005)	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	"Strengthen advocacy on [...] fidelity" (Page 26).	**1**	This indicator receives a 1 because there is a little mention of the global policy (once) but the age bracket, time-line and supporting data are absent.

A policy receives a 2 if that policy is mentioned once or twice and has an age bracket but no time-line or data. It also receives a 2 if a policy is mentioned more heavily (mentioned many times, or has a paragraph dedicated to it) but does not possess any more specific

characteristics. A 2 may also indicate that the National Strategic Plan mentions the Global Fund policy once or twice and provides an age bracket, but not in the same way as the Global Fund. The broad nature of this ranking means it could be described as a default ranking between what I *know* is a 1, and what I *know* is a 3. Between these two definitions, large variation among the 2s necessarily exists. As you can see below in Table 2.7, the local policy is clearly more compliant with the global policy than the example in Table 2.6, but there are still a number of significant components missing, such as the age bracket, the time window and supporting data.

Table 2.7: **Example of a 2 Value ('to a moderate degree')**

Indicator	Indicator Code	Global Fund Policy	National Policy on HIV/AIDS for Zimbabwe 1999	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	"Promote sexual and family responsibility by integrating it into all programmes, particularly those targeting men and adolescent boys. Discuss consequences of multiple sexual partnerships and high-risk sexual behaviour" (Page 29). And "Educate individuals to refrain from high-risk behaviour such as multiple partners, unprotected sex, alcohol and drug abuse" (Page 30).	**2**	This indicator receives a 2 because the policy does mention the idea of the policy to a moderate degree, but there is no age bracket or time window and no data to support the policy.

A country's policy receives a 3 if it contains the language of the Global Fund policy, but is missing just one element of data. The missing data can range from neglecting to include an age bracket, neglecting to include outcome data, or omitting the time frame that should be specified. For example, a lot of the Global Fund policies require that a policy target youth (15-24) or children (0-17) or the general population (15-49). Additionally, some Global Fund policies specify outcome data, such as the percentage or number of people reached with an intervention. Lastly, timeframe data is often expressed by the Global Fund policy, wanting the policy to reflect the last 12 months. If any one of these three is missing, or augmented, the indicator will receive a 3 (instead of a 4). In some instances, indicators show an expanded age bracket or timeframe that is larger or smaller than the Global Fund policy.

The example below (Table 2.8) shows how a 3 is assigned to an indicator which matched the policy language, provides the time frame and the supporting data, but is missing only one element. In this case, the indicator received a 3 and not a 4 because the age bracket was missing from the policy.

Table 2.8: **Example of a 3 Value ("quite a lot")**

Indicator	Indicator Code	Global Fund Policy	Lesotho National HIV Strategic Plan (2000-2003)	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	"To reduce the percentage of young men and women who have had two or more sexual partners in the last 12 months to 20% by 2011 among men, and to 15% by 2011 among women" (Page 51-52).	**3**	This indicator receives a 3 since the strategy does promote the policy quite a lot, but there is no age bracket specified.

A score of 4 is given when African policies have the Global Fund policy language, along with all of the age, time and data components. If any one of these is missing, it is a 3 and not a 4. Below is an example of a 4 value, where the policy language is there, along with the age bracket, time frame and supporting performance data.

Table 2.9: **Example of a 4 Value ("very heavily")**

Indicator	Indicator Code	Global Fund Policy	Zambia National HIV Strategic Framework (2011-2015)	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	"Percentage of adults aged 15–49 years who had more than one sexual partner in the past 12 months" at Male: 19.7% and Female: 1.6% at baseline 2007 (Page 68).	**4**	This indicator gets a 4 since the global policy is emphasized very heavily; there is an age bracket, a time frame and supporting data to go with it.

I should note that there were minor exceptions made to this rule for policies that came out before the first Global Fund M&E framework in 2004. That is to say that when analyzing a policy from the 1990s, if multiple partnerships were emphasized very heavily in language, they could still potentially be awarded a 4 (since there is no way they could match a global policy perfectly that had yet to be written). In the example below (Table 2.10), the indicator was given a 4 even though there was no age bracket specified. This is because this policy came out in Botswana before the Global Fund M&E Toolkit was written, and before the UNAIDS Declaration of Commitment (where the global indicator comes from). For this reason, Botswana is clearly quite in line with global policy to have all of the elements of the policy, including language time frame and performance data, even before global policy from the Global Fund was officially codified.

Table 2.10: **Example of a 4 Value under other circumstances (pre-2009 Global Fund M&E Toolkit)**

Indicator	Indicator Code	Global Policy	BOTSWANA HIV Policy (1993)	Score	Value Rationale
Multiple Partners	**HIV-O3**	Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	"Several factors are thought to have contributed to the rapid spread of HIV in Botswana. Among them are [...] sexual behaviour patterns which include having multiple partners" (Page 2). Additionally, "40 to 50% of interviewed young men reported having had more than one sexual partner in the previous 12 months, and multi-partner behaviour among males was significantly more frequent than among females" (Page 2).	**4**	This indicator receives a 4 since the strategy emphasizes this intervention and collects measurable data for it.

In sum, I have set clear guidelines for assigning ranks to how compliant a country's policy is with the Global Fund Toolkit. This ranking method can easily be replicated to a reasonable degree of consistency by other researchers, either in the same study population or in another.

National Strategic Plans

With the dependent variable defined (the 34 indicators selected from the Third Edition [February 2009] of the Global Fund HIV Monitoring and Evaluation Toolkit), and the measurement of policy compliance clearly delineated, the next methodological step is deciding which policies to analyze. According to King, Keohane and Verba, disciplined qualitative researchers carefully attempt to analyze concrete documents such as constitutions, laws and policies, rather than merely reporting what observers say about them (King, Keohane & Verba, 1994, p.44). For this reason, this dissertation will rely heavily on a first-hand primary document evaluation of formal written government policy, rather than using secondary sources which assess policy. All civil society policy or policy designed by other government branches (other than the National AIDS Councils), were excluded from consideration. This means that only National Strategic Plans, Frameworks, or Policies that come from the federal government's National AIDS Councils were measured.

It is important to recognize the importance of who actually writes national policies and strategic plans on HIV. In many cases, foreign consultants are hired to do the majority of the writing and funding partners are called in to review parts or all of the policy. For instance, in Botswana's 2010-2016 National Strategic Framework on HIV/AIDS Peter Stegman is

acknowledged as the lead strategic planning consultant hired by the Botswana National AIDS Coordinating Agency. In addition, partners such as PSI and PEPFAR are credited with making key contributions to drafts. In Swaziland's National Strategic Framework for HIV and AIDS (2009-2014) the lead consultant writing the document was Simon Muchiru, and the World Bank is credited with conducting the final edit. Namibia's National HIV Strategic Framework (2010-2015) is the only policy in this study that gives credit the Global Fund for financial and technical support in its acknowledgments. While some countries are transparent in their NSPs about who wrote and contributed to them, others are not. This is true of the most recent NSPs from Malawi and Lesotho where no names are listed. While the National Strategic Plans are ultimately owned by the National AIDS Councils – a government body – it is important to recognize the various influences that come into play during the writing process. For the most part, the design of a National Strategic Plan is government led and highly consultative (Namibia's most recent NSP indicates that approximately 6000 people deserve credit for contributing to the policy), so individual influence from the personal viewpoints of hired consultants or the advocacy agendas of other contributors tend to be limited. However, it is still a relevant factor, and one that will be included in the analysis later in this thesis.

Measuring Policy Changes

Next, in order to show change, or an observable trend, at least three points in time needed to be analyzed. Governments release new National HIV/AIDS Strategic Plans every five or six years. To measure change, I selected three National Strategic Plans[11] from each country. The process of measuring policies against the 34 indicators in Appendix C, using the 5-point scale in Table 2.2, was carried out for two successive national policies *before* the 2008, when I argue the new global politics of HIV/AIDS roughly began, and one *after*. These points in time will henceforth be described as **T1** (before 2003), **T2** (between 2003 and 2008) and **T3** (after 2008).

Looking at change between two policies before this event helps to control for policy changes that might have been occurring anyway. For instance, it would be wrong to suggest that the global HIV/AIDS politics in 2008 caused African policy divergence if that country had been slowly moving away from global policy for a decade before. Put differently, to conclude that the new global politics of HIV/AIDS had an effect on policy in Zimbabwe would not be

[11] In the absence of available National Strategic Plans (some countries do not yet have 3 that satisfy the time frame required here) Medium Term Plans or National HIV/AIDS Policies were used as a substitute.

accurate unless Zimbabwe actually conformed to Global Fund policy until 2008, after which it began to diverge. Therefore, in order to confirm the hypothesis of this project (that policy-making agendas of global donors and institutions exert less influence over domestic HIV/AIDS policies post-2008), countries will have to become increasingly compliant, or remain constant, with global policy from T1 to T2, then move away from T2 to T3. Otherwise, the hypothesis will be rejected.

Most National Strategic Plans are available online, with some coming directly from the National AIDS Councils if they were not yet available or not publicly posted. A complete list of the policy documents analyzed in this project can be found in Appendix D.

Explanatory Variables

This process outlined above describes how I answer my first question asked in this project. But, I also ask: *what political and economic factors make a country more or less likely to follow or move away from international protocol?* In order to answer this second question, I collect data for two specific sets of explanatory variables – structural economic variables and institutional political variables. These two sets of variables are then plotted against policy compliance data to test for any significant relationships between them. A complete list of variables examined can be found in Appendix E.

My rationale for selecting these specific kinds of variables to test the causes of HIV/AIDS policy is based on a body of literature that debates the relationships among these factors. To further explain the selection of these explanatory variables, I will give a brief overview of the literature which discusses the effects of economic and political factors on HIV/AIDS and HIV/AIDS policy-making, followed by the literature which debates the impact of different policies on epidemiological outcomes.

Structural Economic Variables

The first set of variables that I examine largely has to do with a country's economic situation. These include indicators of overall wealth (such as gross national product per capita, gross domestic product per capita, government revenue, etc.) and spending or budgetary patterns (such as resource allocations for health and donor funding). There is a tradition in AIDS literature of testing the connection between economic factors and the variation among HIV/AIDS policy responses in Africa.

One frequently tested economic variable is the way which donor aid affects HIV policy-making. James Putzel (2004) posits that donor dependency is a highly significant economic variable which affects how countries respond politically to HIV. He suggests that donor pressure to establish National AIDS Councils compromised the effectiveness of previous state-led responses. Similarly, Jacob Bor (2007), who examines economic explanations for HIV policy-making, finds that official development assistance (ODA) as a percentage of gross domestic product (GDP) was the most significant economic variable for explaining trends in the 2003 AIDS Programme Effort Index. The way in which donor aid impacts HIV/AIDS policy-making has also been explored by Suzette Heald (2006, p. 6), who points out that the change in policy in Botswana from the mid-1980s to the late1990s was largely a result of "all the major donors pull[ing] out after 1995, on the grounds that the relative wealth of Botswana allowed it to underwrite its own programmes." Per Strand (2007) also suggests that donor dependency is a logical economic variable which may help explain governance responses to HIV in Africa. Parkhurst and Lush (2004) also find that dependency on donors may be a factor which affects the way in which HIV/AIDS policy is developed. They seek to explain the differing HIV/AIDS policy responses in Uganda and South Africa, arguing that weaker ties with the international donor community allowed the South African government more control in the development of HIV prevention policy.

In addition to donor aid, other economic factors such as GDP, foreign direct investment and government expenditure have also been shown by Bor (2007) to be significant predictors of how a country will devise HIV policy responses. Nicoli Natrass (2006) also finds that per capita income is a significant predictor of political commitment, particularly with respect to treatment policies. Strand (2007), too, indicates that the availability of resources, particularly resource constraints in Southern Africa, are logical predictors of AIDS governance decisions.

Along with wealth in general, the distribution of wealth has also been posited as a relevant economic variable which can help to explain HIV policy decisions. Bor (2007) finds that income inequality (as measured by gini coefficients) stands out as one of the stronger determinants of political commitment to HIV. He says that the "Distribution of economic resources is linked to the distribution of political resources, and thus to policy outcomes" (Bor, 2007, p. 1592). Similarly, Nattrass (2006) also examines whether income inequality is related to political commitment to treatment policies, though she finds that it is not statistically significant.

Epstein (2007) notes how economic factors play a role in the efficacy of fidelity policies. She says that Uganda's fertile land and farming economy means that people are more likely to live with their families than those in South Africa, where the mining industry leads to fractured families where men work far from their wives and the family homestead. She calls this the "social cohesion" factor where economic (and political and historical) factors are linked with government policy choice. Epstein (2007, p. 198) also suggests that levels of economic underdevelopment in Africa also affect the degree to which countries policies may pander to global donor policies:

> Now that AIDS is a multibillion-dollar enterprise, donors with vast budgets and highly articulate consultants offer health departments in impoverished developing countries a set menu of HIV prevention programs, which consists of either abstinence education or condom social marketing or HIV testing and other services. Beleaguered health officials have no time, money, or will to devise programs that might better suit their cultures.

Another perspective on the connection between economic drivers and the choices a country makes in terms of its HIV/AIDS policy is offered by Anthony Butler. Looking to explain South African AIDS policy, Butler (2005, p. 607) argues that South Africa's early HIV/AIDS policies, which he calls a "cautious approach", can be partially explained by the government's economic calculations of the costs of scaling up their policies.

It is clear that there is rich scholarship of tracing the pathways between the economic development of a country and its HIV/AIDS epidemic and/or the nature of the policy response. Using this work as a platform, this project extends the nature of the debate to test whether indicators of a country's economic situation can predict whether it will align its national strategic plan with Global Fund policies.

Institutional Political Variables

The second set of variables that might help to explain trends in HIV/AIDS policy trends are political variables. As with economic variables, many other scholars have demonstrated the relationship between governance variables and HIV/AIDS policy-making. Alex de Waal (2003, p. 255) says that "the AIDS industry is a prisoner of political circumstance", arguing that power dynamics among political actors largely dictate which policies gain legitimacy and when. Similarly, Suzette Heald (2006) delineates three distinct 'phases' in Botswana's HIV/AIDS policy over time, which evolved in large part due to institutional factors such as the erosion of the power of the chiefs and increasing government effectiveness.

Anatole S. Menon-Johansson (2005) suggests that stability in a political regime is linked with the kinds of HIV/AIDS policies in the country. He points to Cuba as an example of a country that was one of the first in the Americas to launch policies around care and support for those living with HIV, attributing this to the strong political commitment to health by the government. He contrasts this with Haiti, where he indicates that political instability along with other governance factors are related to a lacking health policy response. Allen and Heald (2004) also assert that political stability is related to HIV/AIDS policy-making tendencies. In comparing HIV/AIDS policies from Uganda and Botswana, they argue that political upheaval in the former versus decades of stable governance in the latter contributed to which policies prevailed and how well they worked. Contrary to those arguments, Bor (2007) findings show that political stability (as measured by the World Bank Governance Indicators) has a very low and statistically insignificant correlation with HIV policy-making.

Others debate what kinds of governance regimes produce the best HIV/AIDS policies. Kondwani Chirambo (2008) suggests that authoritarian regimes, or those that are nominally democratic, tend to demonstrate better responses to HIV/AIDS epidemics. In agreement, there are also those who indicate how democracies are not necessarily effective HIV/AIDS policy-makers especially if they are fledgling regimes. Wouters et al. (2010) show how the slow development of program infrastructure, along with inexperienced new public officials can render younger democracies as ineffective HIV/AIDS policy-makers. These sentiments are echoed by Schneider and Stein (2001), Ngwena and Van Rensburg (2002), Butler (2005) and Pelser et al. (2004). Strand (2007) also makes the argument that the type of governance model is a key explanatory variable for understanding differing AIDS policy responses in Africa. He looks at three types of AIDS governance he posits to be the most important factors in shaping the HIV policy response, two democratic (idealistic, authoritative) and one non-democratic (authoritarian). Lastly, Parkhurst and Lush (2004) indicate that institutional variables such as the existing bureaucratic system and health care infrastructure help to explain the differing HIV/AIDS policy responses in Uganda and South Africa.

Also testing how governance models affect HIV/AIDS policy making is Kim Yi Dionne (2011). She argues that the leaders' expected length of time in office is a relevant variable that helps to explain which countries have more comprehensive HIV/AIDS policies than others. According to Dionne, leaders with shorter time horizons have more comprehensive HIV/AIDS policies than those with longer foreseeable years in office. This is connected to the arguments above about democratic vs. authoritarian systems of government, since it is

logically to believe democratic regimes to have shorter time horizons for leaders than authoritarian ones. It is also related to political incentives, which others have shown to be a relevant explanatory factor in HIV policy decisions. Evan Lieberman (2009) says the desire for political survival has often led to less comprehensive HIV policy responses. He says governments introduce policies on sex, sexuality and drugs at their peril, as there is likelihood that many of their constituents will not like the messages received, and therefore dislike the messenger. Putzel (2004) agrees that political incentives matter. He suggests that more comprehensive HIV policy responses are more likely where taking political action on AIDS is a positive-sum game, where action is less costly than inaction.

Variation in political histories has also been examined to try and explain differing HIV/AIDS policies. Baldwin (2005) argues that path dependency is an important factor, suggesting that the best predictor of how a country will respond to HIV/AIDS is to look at the way it responded to previous infectious diseases, such as syphilis. Also examining political histories, Parkhurst and Lush (2004) find that the way in which a country experiences a liberation struggle and transitions to democracy leads to important distinction in its HIV/AIDS policy implementation structures.

Another study that is related to types of government was done by Bor (2007), where he finds press freedom to be one of his most significant predictors of good HIV political responses. Press freedom may also be logically associated with more democratic systems of government.

In addition to those who argue democracies are better policy-making regimes, and those who argue that authoritarian systems are, Amy Patterson (2006) argues that variables in state governance and their HIV/AIDS policies show no clear connection – one way or the other – at all. She recognizes that the effectiveness of states varies greatly across the Africa continent, saying that "the development of multiparty elections, legislatures, judiciaries, and sub-national governments has had an uneven impact on state actions on AIDS. The underdevelopment of these institutions has facilitated inconsistent representation and accountability in AIDS policymaking in Africa's new democracies" (Patterson, 2006, p. 21). However, after examining the potential connection between governance variables and HIV/AIDS policies in studies of Zimbabwe, Uganda, Swaziland and South Africa, Patterson (2006, p. 21) argues that "there is no clear pattern of state institutions that leads to AIDS policies."

In terms of governance models, there has also been a significant body of work done looking into how political decentralization affects HIV responses (Blaauw et al., 2003; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Lieberman, 2011; McIntyre & Klugman, 2003; Schneider, Blaauw, Gilson, Chabikuli, & Goudge, 2006; Schneider, Coetzee, Dingie, and Gilson, 2010). These authors suggest that issues of coordination, as well as the rise of non-state service providers in this context play a role in how HIV policy is designed and implemented.

Others have looked at more nuanced governance factors, delving deeper than testing the relationship between democracy and AIDS. UNAIDS and the International AIDS Society have a 'Thinking Politically about HIV' mantra aimed at better understanding the political circumstances that affect HIV policy and health outcomes. Under the auspices of this initiative, Lieberman's (2011) research in South Africa shows that the personal views of those in power are a stronger driver in favor of one policy over another, than are the epidemiological realities of their constituents. This seems to suggest that politics is much more important than epidemiology in determining AIDS policies, and that the previous slogan from UNAIDS to 'know your epidemic, know your response' is not really the way policy-making works. The political factors that guide the HIV response are also emphasized by Altman and Buse (2012), who argue that we need better political scaffolding of how governance factors are related to HIV/AIDS.

Lieberman (2009) also further unpacks concepts of political variables and how they may help to explain variation among HIV policies. He says says that political and social boundaries that divide groups have impacted HIV policy-making; if a country has strong boundaries that divide people, the epidemic is understood in ethnic terms, which creates a certain kind of policy response. Lieberman also indicates that culture is an important variable to examine.

Both the lack of consensus and the call from others to further develop the understanding of this structural variable strongly justify the need to continue testing the extent to which political variants can help explain or predict different HIV/AIDS policy responses and infection rate outcomes. In addition, in the past, others have made connections between governance and HIV prevalence, but very little evidence exists for a connection between governance and HIV *policy-making* (Menon-Johansson, 2005; Chirambo, 2008; Patterson, 2006). This is further rationale for selecting political institutional variables as an explanatory variable category.

Epidemiological Trends

While impact of policy on infection rates is not one of my main questions, it is still an important implication of this research which deserves a brief literature review. Though I cannot conclusively show that policy compliance is connected to epidemiological changes, I do provide intriguing initial tentative evidence in Chapter 7 that aims to inspire future research. For this reason, it is necessary to provide literary background for this implication.

There is a vast literature which debates which policies have, or have had, greater impact on reducing the HIV prevalence and/or incidence, with little conclusive evidence. HIV prevalence in the general population is a measure of the estimated number of people (15-49) living with HIV divided by the adult population of that year. HIV incidence in the general population is a measure of the estimated number of people (15-49) newly infected with HIV in that year, divided by the adult population of that year (UNAIDS, 2010). Often, this data is collected from women attending antenatal clinics (UNAIDS, 2013). In measuring the impact of policy on HIV prevalence and incidence, there is also uncertainty about what kind of time lags to include. In other words, how long does it take for a new policy to start having an impact on infection rates? The debate around how to measure policy impact and the importance of accounting for time lags is discussed in Chapter 7. Here, I will present a brief literature review on those who have previously measured the impact of HIV policy on epidemiological trends to demonstrate why it was important to include a discussion around policy's relationship with HIV infection rates in this thesis.

Ades et al. (1999) investigated the connection between HIV prevalence rates and the policy on HIV screening in pregnant women. While they concluded that there is no link, their work provides a basis for further investigation in the possible links between epidemiological trends and corresponding HIV/AIDS policies. However, most studies examine the causality in the opposite way. Instead of testing how epidemiological factors affect policy, most work looks at how certain policies affect infection rates. Many of studies have attempted to draw connections between the emphasis of certain HIV/AIDS policies and the subsequent (or simultaneous) changes in incidence or prevalence rates. Asiimwe-Okiror et al. (1997) strongly indicate that the declining rates of prevalence in HIV in Uganda in the mid-1990s correspond to policies for an increase in condom use, especially among young people. The same conclusion was reached by Ahmed et al. (2001) in a study conducted in Rakai district of Uganda. They argue that increased condom use is directly associated with lower HIV

infection rates and that the implication for policy is clear: "Programs must emphasize consistent condom use for HIV and STD prevention" (Ahmed et al., 2001, p. 2171). Cohen and Tate (2005) also firmly argue that condom promotion is a far superior policy than abstinence or delayed first sex programs in Uganda.

On the other side of the debate about how policy affects epidemiological outcomes are those that think policies on partner reduction are much more efficacious than condom promotion. While Halperin et al. (2011) recognize that Thailand's 100 percent condom policy was the main driver responsible for that country's success in combating the spread of HIV, they also strongly believe that these kinds of policies would likely prove less effective in the more generalized epidemics of Southern Africa. Similar arguments have been made by Feder and Kerrison (1992), who feel condom promotion is not an effective policy for combating HIV since condoms are not one hundred per cent effective, and giving them out implies that you can do whatever you want so long as you use one. Even Dr. Malcolm Potts, one of the inventors of the lubricated condom, has said that advising a person who engages in high-risk behaviour to use a condom "is like telling someone who is driving drunk to use a seat belt" (Feder & Kerrison, 1992, p. 126).

Low-Beer and Stoneburner (2004) are chief among those in the camp that find partner reduction to be a much more effective policy than condoms for reducing HIV infection rates. Contrary to the findings of Asiimwe-Okiror et al. (1997) and Ahmed et al. (2001), they find that that partner reduction, and the 'Zero Grazing' policy was responsible for this epidemiological change in Uganda. Epstein (2007) also makes this argument, faulting those who believe condoms policies were responsible for the prevalence decline, since the timelines of policy and epidemiological effects do not line up, according to the time-lags employed. Timberg and Halperin (2012) concur, citing arguments that support the idea that partner reduction in Uganda was equivalent to a social vaccine of around 80 per cent efficacy.

The debate about the effects on policy of infection rates goes beyond the condoms vs. partner reduction dispute in Uganda. Halperin et al. (2011) draw a direct connection between Zimbabwe's prevention policies helping achieve the country's 13 per cent decline in HIV prevalence. Specifically, they note that the Zimbabwean government's early emphasis on a policy for home-based care accelerated behavior change which helped curb the epidemic. The logic behind this contention is that if people see relatives and loved ones die at home, they are forced to confront death in a way that is more likely to influence their own future risk-taking

(Low-Beer & Stoneburner, 2004). Informed by these conflicting contentions, the objective of this project is to contribute towards the debate about which policies are more effective in combating HIV prevalence. However, most research focuses on one policy or intervention to demonstrate efficacy. More narrowly still, the bulk of the research on policy efficacy is on what happened in Uganda (Hogle, 2002; Parkhurst, 2005; Green, 1988). Despite this narrow focus of the research, there is a large consensus that locally devised policies (as opposed to those coming from Washington and Geneva) are more effective, yet there is very little scientific mapping that examines this mainstream idea. As such, the contribution of this study's systematic policy data analysis to the debate on how HIV/AIDS policy affects disease outcomes is of critical value.

Semi-Structured Interviews

To complement and inform the quantitative data on the degree to which countries comply with or diverge from Global Fund Policy, I conducted 82 key informant interviews. Interviews were conducted in person in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, as well as with the Global Fund Secretariat in Geneva, Switzerland. In each of the African countries, interviews were conducted with key informants who sit on the respective Country Coordinating Mechanisms (CCM) for the Global Fund, as well as some other key stakeholders such as Global Fund principal and sub-recipients.

CCMs vary in size, with 19 members in Botswana, 23 in Malawi and Namibia, 29 in Zambia, 37 in Swaziland and 40 in Zimbabwe. The South African CCM is currently not functional as it is undergoing a re-structuring. These members are mandated by the Global Fund to be representative, and must include members from local civil society, government, international NGOs, multi-lateral and bi-lateral organizations, the private sector and key affected populations. They are elected by their various constituencies and meet four times a year (usually) to review proposals from in-country applicants for Global Fund grants. CCM members were selected as key informants, since they have the closest first-hand experience with the way Global Fund policies operate in terms of granting funding, steering discussion and affecting local HIV policy. I selected a cross section of CCM representation, too, so that I could compare the perceptions of each interest group (civil society, government, international institutions, etc.). The interviews were very semi-structured, with a few guiding questions to steer the discussion:

- How influential is the Global Fund in your policy-making process?
- Do you think the Global Fund's policies are effective?
- How would you describe civil society strength in your country?
- How would you describe the leadership of the Government in the HIV/AIDS response?
- Do you think the wealth of your country plays a role in the kinds of HIV/AIDS policies that are developed?
- Who writes your National Strategic Plans (government, consultants, etc.)?
- In the past five years, with donor retreat, do you feel more or less freedom to create locally informed HIV/AIDS policy?
- What do you think will happen as a result of the New Funding Mechanism of the Global Fund? Will this result in more or less local-decision making?

Interviews were recorded using a digital voice recorder and transcribed at a later date. Verbal consent was requested at the beginning of the interview, and signed formal consent was given after the meeting. This was so ensure that informants had two opportunities - one before and one after - to opt out of having their insights used in the dissertation. A list of all the key informants can be found in Appendix G.

Reliability and Validity of Data

The research methodology employed here is based on King, Keohane and Verba's (1994) *Designing Social Inquiry*. In their book, they make a case for how studies of a relatively small number of cases can be designed in such a way so that principals of scientific inference are met. In other words, research questions about a small number of cases, such as the one I ask in this project, can achieve the same scientific standard as more quantitative research if statistical logic is applied to qualitative problems. While applying an ordinal scale of evaluation helps to increase the precision of my measurement and robustness of my conclusions, there are still certain limitations to the data and analysis.

Coding Subjectivity

Even though each value has a relatively strict set of criteria, it is still a somewhat subjective measurement upon which this project rests quite heavily. In order to combat this limitation, two mitigating tactics were employed. Firstly, King, Keohane and Verba recommend to "check reliability ourselves by measuring the same quantity twice and seeing whether the measures are the same" (King, Keohane & Verba, 1994, p.25). In order to judge the reliability of my coding, I followed King, Keohane and Verba's advice and repeated the coding myself. The initial policy coding was done between March and October 2011, and

was repeated 6 months later in April 2012. Any discrepancy between the two rounds of coding was then reconciled and reflected in the final values. This reliability rate was higher than 90%. In addition, I also utilized multi-coder reliability tests for one policy. The National Strategic Framework for HIV and AIDS Response in Namibia (2010/11 – 2015/16) was also coded by an academic peer. The result yielded a reliability coefficient of 85 per cent, which is deemed acceptable (Krippendorff, 1980; Miles & Huberman, 1994; Riffe, Lacy & Fico, 1998).

Limitations of Correlation Analysis

In this project, I use scatterplots and bivariate correlations as my principal method to test for relationships between variables. Linear correlation is limited in that it cannot reflect certain non-linear dependencies that undoubtedly exist between many variables in the real world (Blyth, 1996; Shaw, 1997). For instance, perhaps HIV/AIDS policy compliance and wealth do not correlate in a linear fashion, but rather that there is a wealth threshold that a county has to reach before it is able to exercise freedom over its domestic policies. A linear *r* value tends to obscure this relationship. As such, it is important to recognize this limitation in linear correlations (Embrechts, McNeil & Straumann, 1999). However, it is a standard to test for linear relationships unless there is a good theoretical reason to look for a non-linear relationship. Quite often, this occurs in follow-up studies that build upon the initial studies that demonstrate the linear relationships.

Data Reliability

UNAIDS data is collected based on guidelines in the UNAIDS Estimation and Projection Package (EPP). This package helps with the estimation and short-term projection of the HIV epidemic. The trouble with this is there have been five versions of the EPP (2001, 2003, 2005, 2007 and 2009), with each subsequent version adapting its data collection methodology based on previous experience (Brown et al., 2007). As a result of these frequent adjustments to the way HIV prevalence is estimated, it is understood that early prevalence data, especially in Africa, were likely to be gross over-estimates (Cameron, 2005; Epstein, 2007). Some suggest prevalence estimates were twice as high as the reality of the epidemic. As such, it is difficult to make a logical case for comparing UNAIDS prevalence data from 2001, with data from 2009, since estimations were made based on different projection methodologies.

Another very relevant factor to consider when comparing earlier estimates of incidence and prevalence data is the introduction of ARVs. Along with using different EPPs, ARVs also likely had a large impact on changes in infection rates. The availability of anti-retroviral treatment in a country means that more people with HIV will be able to live much longer and healthier lives. This can influence HIV prevalence levels since prevalence is calculated as the number of people living with HIV divided by the total population. With treatment, the numerator becomes larger than it otherwise would be, as people living with HIV do not fall sick or die. The advent of ARV treatment also has an effect on HIV incidence. When an HIV positive person is on treatment, they are much less infectious as their viral load is supressed, often to undetectable levels. This means that those on treatment are less likely to pass HIV to their partners. In addition, using ARVs for post-exposure prophylaxis can also prevent new infections. Therefore, the availability of ARVs likely contributed to changes in incidence and prevalence rates in a very significant way, which is worthy of consideration when analysing epidemiological trends.

A third limitation with UNAIDS data is that the EPPs are designed to work for all epidemics across the globe. There are data reliability issues with this, especially in four types of epidemics where country data does not fit well with the EPP: (1) countries where prevalence falls to zero in the near future; (2) countries which show a steep decline in prevalence, followed by a levelling off; (3) countries with a long and steady decline in prevalence; and (4) countries with prevalence rates that steadily rise for many years on end (Brown et al., 2007).

Fourthly, this model is somewhat unreliable because it assumes all parameters are constant over time. In other words, things like behavior change are not adequately accounted for in UNAIDS' data collection model (Brown et al., 2007).

Fifthly, independent of the UNAIDS EPP method, the very availability of data that UNAIDS has to work with in order to generate these numbers is often very problematic. In many cases, data for generalized epidemics is extrapolated from surveillance data on pregnant women, collected from antenatal clinics. This clearly entails a number of assumptions which further cloud the reliability of UNAIDS epidemiological data. For instance, testing pregnant women means you are starting with a sample population that is having unprotected sex. This means measurements of prevalence are taken from a high-risk group, which might inflate the resulting estimates of HIV prevalence in the general population.

In addition to the reliability of HIV prevalence rates, there are also limitations with HIV incidence data, too. UNAIDS (2013) is open about the fact that estimates of HIV incidence (new infections) are difficult to make. UNAIDS says that "In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available" (UNAIDS, 2013, p. 38). What this means is that it is extremely difficult to capture reliable data on how many people became newly infected in the last year, but that fairly accurate estimates can be drawn using annual prevalence data among certain populations. Often, incidence data is projected based on anti-natal testing among 15-24-year-old women.

Concluding Remarks

In sum, I tried to be as systematic as possible in categorizing, ranking and measuring the key concepts of HIV/AIDS policy influence and change. My method aims to uphold what Alexander George calls a method of 'structured, focused comparison', whereby the same information is collected systematically, using the same variables, across decisively selected units (King, Keohane & Verba, 1994, p. 45). The ordinal rankings of policy compliance are then measured against two sets of explanatory variables, which help explain whether a certain set of qualities indicate the degree of freedom or constraint that a country feels in designing its policies. Lastly, policy changes are measured against epidemiological change, making causal inferences about policy efficacy.

This data is complemented by a series of semi-structured interviews, conducted face-to-face in Southern Africa and telephonically with Geneva. The information gathered from these key stakeholders serves to uncover the more idiosyncratic elements of HIV/AIDS policy compliance. The interview information also helps to distinguish between systemic and random phenomena. Contradictions between policy compliance datasets and informant responses may also reflect a disjuncture between *perceived* and *actual* Global Fund policy influence. As such, while I cannot say with absolute certainty why policies change and the effects that that might have had on the epidemic, I can offer important arguments about which countries comply with Global Fund policies and which do not, and why this might be the case. I also make a reasonable inference about whether my data show domestic or international HIV/AIS policy to be more effective.

Chapter Three

Findings Part I: Aggregate Trends in Policy Compliance

"Disease is neither global nor merely a local phenomenon.
It is located in between these processes" (Seckinelgin, 2008, p. 19)

Introduction

The location of HIV/AIDS strategies between the global and the local, as Seckinelgin (2008) suggests, is the main objective of this dissertation. The lack of consensus on this subject makes the findings in this chapter all the more relevant in their contribution to the discourse on HIV/AIDS governance.

Recall that one group of scholars finds that global institutions and Western financial aid is what governs HIV/AIDS policy in Southern Africa (Ainsworth & Teokul, 2000; Howell & Pearce, 2001; Agg, 2006; Bendaña, 2006; Petra & Veltmeyer, 2001; Wood, 1997; Cohen & Tate, 2005). On the other hand, there is an equal and opposite school of thought that argues that domestic dynamics and national governments play important roles in the HIV/AIDS policy-making processes in affected countries (Parkhurst, 2005; Baldwin, 2005; Epstein, 2007; Low-Beer & Stoneburner, 2004). Most of the policies promoted by the Global Fund are extracted from the UNAIDS core indicators (15 UNGASS indicators and 25 additional recommended indicators) and thus represent internationally accepted policies. Compliance or divergence with these policies will therefore indicate whether the global or the local has more influence over HIV/AIDS policy-making in Africa.

In light of the new global politics of HIV/AIDS detailed in Chapter 1, the Methodology in Chapter 2 was employed to answer the question of *who governs*? In an effort to contribute to the debate on whether global institutions or domestic dynamics are more important in the HIV policy-making process, this chapter illustrates the findings of this project. I will begin by presenting some aggregate results, including overall trends in policy compliance, as well as overall compliance by policy domain (prevention, treatment, etc.) and policy indicator. Next, I will outline the major patterns and observations that these aggregate results reveal, followed by the relationships and generalizations they uncover as well as the exceptions or anomalies. I will then briefly discuss how these findings show agreement or disagreement with previous

work. Lastly, I will revisit my original hypothesis and detail the new knowledge and understanding that my findings contribute to the field.

Aggregate Result

The aggregate results of scores – averaged across all 34 policies in this project's framework – are displayed below in Table 3.1. To restate, these scores represent rankings on a scale of 0 to 4, with higher numbers indicating greater Global Fund policy compliance. The findings show that while Botswana and South Africa have shifted their National Strategic Plans away from Global Fund compliance since 2008, the rest of the countries in the Southern African region continue to move their National Strategic Plans more closely in line with Global Fund policies.

Table 3.1 Total Aggregate Global Fund Policy Compliance Scores

Country	Before 2003	Between 2003 and 2008	After 2008
Botswana	**1.412**	**2.588**	**1.676**
South Africa	**1.059**	**3.118**	**2.353**
Zambia	**1.588**	**2.441**	**2.529**
Zimbabwe	**1.353**	**2.206**	**2.618**
Swaziland	**1.059**	**2.235**	**2.765**
Lesotho	**1.265**	**2.147**	**3.088**
Malawi	**1.265**	**1.912**	**3.118**
Namibia	**1.382**	**2.147**	**3.382**
TOTAL	**1.298**	**2.349**	**2.691**

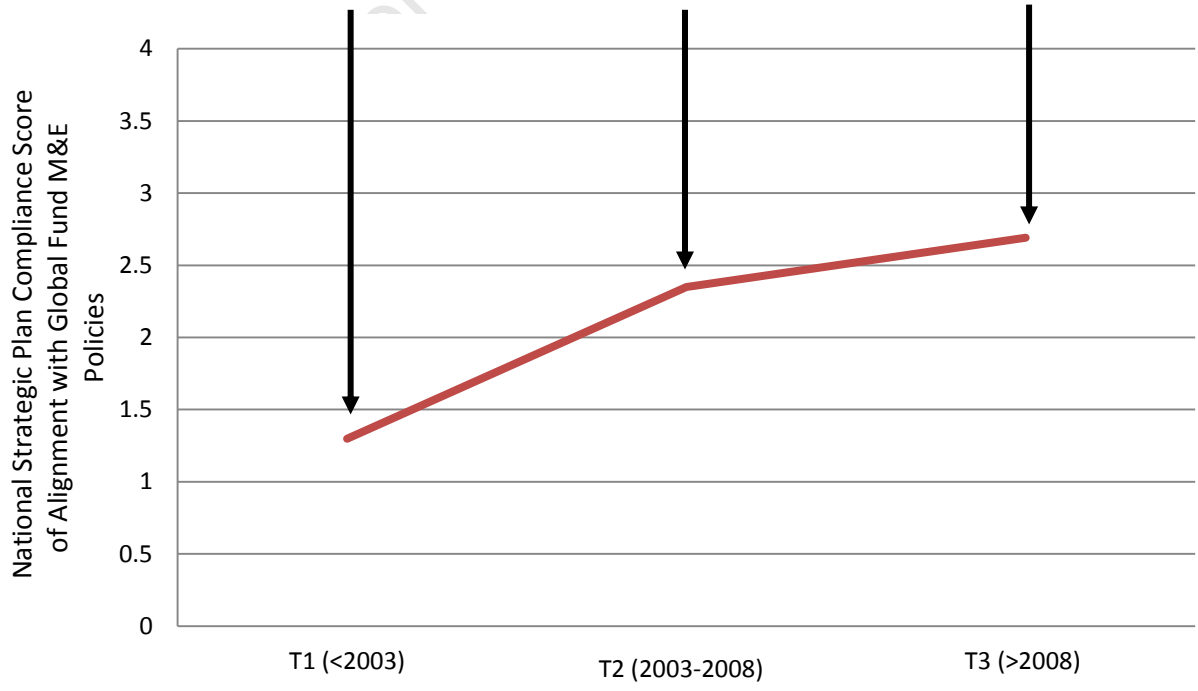


Figure 3.1 Total Aggregate Policy Compliance Scores over Time

It is clear from these results that the average policy compliance in high burden countries is increasing. Table 3.1 and Figure 3.1 show the average scores for all eight countries over time. It is also clear that the change in compliance before 2003 to the period between 2003 and 2008 (T1 to T2) was a steeper change in compliance than the change from before 2008 to after (T2 to T3).

From this aggregate data, there are two initial major conclusions: (1) There is an overall increase in the compliance of Southern African HIV/AIDS National Strategic Plans with Global Fund policies, from before 2003 to after 2008, and (2) there is large country variation around the mean. Following this, it is then worthwhile to look at what is happening in each individual country, to see which areas are driving this regional policy alignment.

After 2008, (at T3), Botswana's National Strategic Plan is the least compliant with Global Fund policies, and Namibia's is the most compliant. There are also three relatively distinct clusters of countries at T3. First, since 2008, Botswana and South Africa have clearly moved their National Strategic Plans away from the Global Fund's policy framework, focusing more on locally informed objectives and less on the international policy priorities of the Global Fund. Second, Zambia, Zimbabwe and Swaziland have moved further towards greater compliance with Global Fund policies, though not drastically. Lastly, Lesotho, Malawi and Namibia have made more significant movements to align their NSPs with Global Fund policies since 2008. These clusters are easily identifiable in Figure 3.2.

It is also telling that some of the largest policy shifts occurred in the countries at the richest and poorest ends of the country spectrum. During the period between 2003 and 2008 (T2), the NSPs out of Botswana and South Africa – the two richest countries in the region - were the *most* compliant with Global Fund policies. This information is particularly clear in Figure 3.1. These two countries also exhibit some of the biggest changes in alignment from before 2003, to period between 2003 and 2008. This may be partially explained, at least in South Africa, by political circumstances before 2003. At this time, President Thabo Mbeki's rule involved some very unorthodox policies on HIV/AIDS, originating a denialist standpoint. His personal dissident views were very much are engrained in the NSP of the time, and are clearly at odds with the Global Fund's policies. However, in the period between 2003 and 2008, it is quite intriguing to see that South Africa had the most heavily Global Fund-aligned NSP, while Malawi (the poorest country in the region) had the least. The movement for these two countries, especially, from T2 to T3 is particularly drastic.

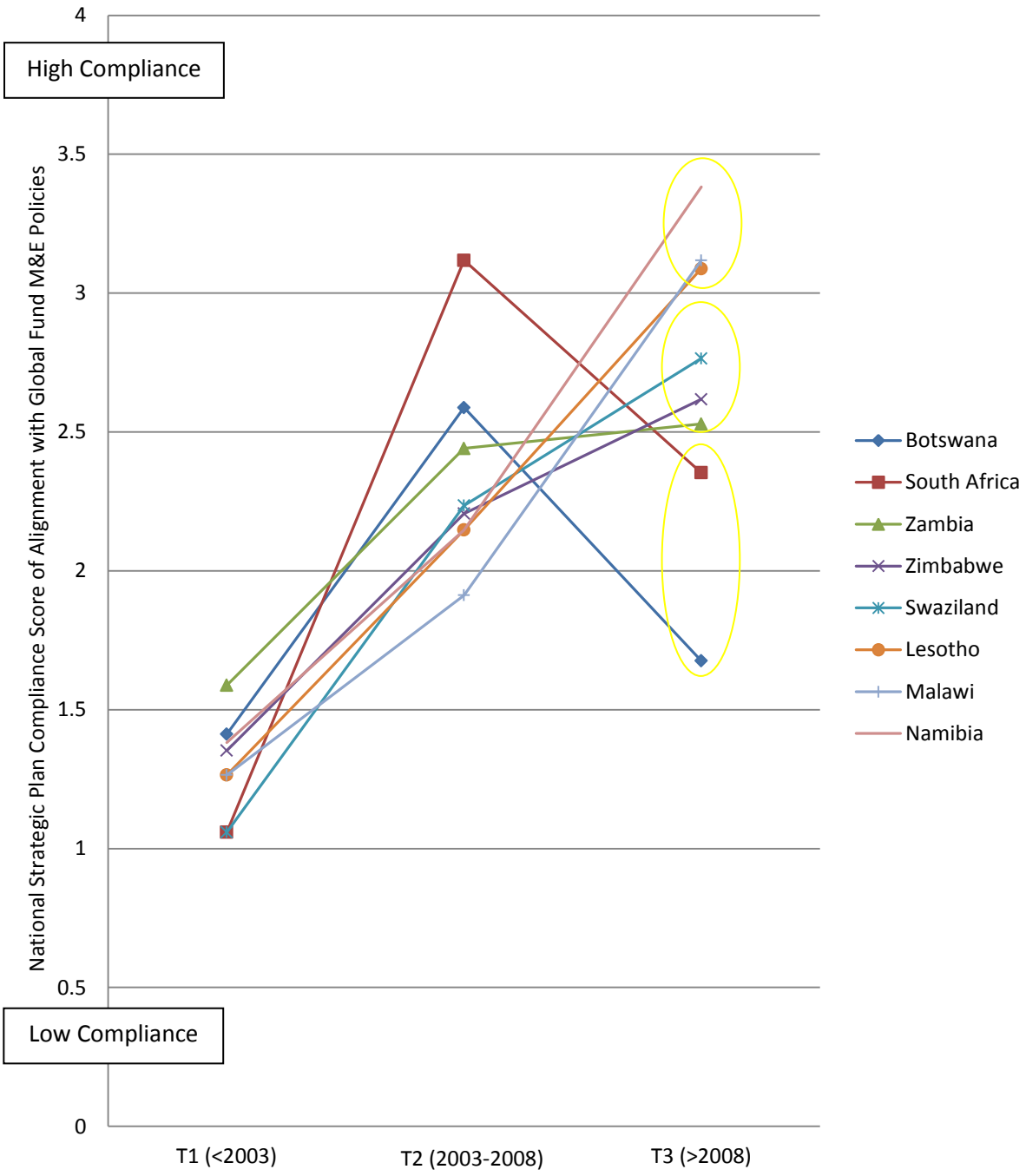


Figure 3.2 Total Aggregate Global Fund Policy Compliance Scores for NSPs

As Figure 3.2 shows, most of the high prevalence countries in the Southern African region (six out of the eight) have moved their HIV/AIDS policies further in line with Global Fund objectives, during the time periods above. Given these extreme policy compliance swings, it is useful to further disaggregate the country-specific scores, delving into the individual policy categories, as well as individual policies, themselves. The Global Fund M&E Toolkit groups indicators into six categories: Prevention, (2) Treatment, (3) Care and Support, (4)

Collaborative Activities, (5) Supportive Environment and (6) Outcome Indicators.[12] While a full list of the Global Fund indicators used as the independent variables in this study can be found in Table 2.3, it is useful to briefly explain how these M&E indicators relate to HIV/AIDS policies and how the National Strategic Plans of African countries can therefore be assessed based on their compliance with these indicators.

The indicators in each of these six categories are associated with certain HIV/AIDS policies. For instance, Prevention indicators on the number of condoms available for distribution are related to policies that promote condom use. Further, since the Global Fund M&E toolkit has indicators for both procurement of male and female condoms, policies that promote female condoms are also measured in this study. For Treatment, indicators on the number of people receiving ARVs are related to policies on universal access. Collaborative Activities indicators measure the number of people who are tested and treated for HIV/TB co-infection, which are related to policies for integrated service provision for these two diseases.

The indicators which fall under the Global Fund's category termed Outcome Indicators are perhaps the most unclear. While the Global Fund calls this category "Outcome Indicators" these indicators are primarily related to policies of behavior change. For instance, Outcome Indicators on the number of women and men who had more than one sexual partner in the last year are related to faithfulness policies. Other Outcome Indicators measure the number of youths that have had intercourse before they were 15 years old, which are related to policies on abstinence.

Measuring trends in country policy compliance with these individual categories sheds more light on how policies are changing overall. A good example is shown in Figure 3.3, where policies movements connected to indicators from the Collaborative Activities category and the Supportive Environment category are really driving the overall increases in regional compliance levels, especially since 2008 when compliance with these policies rose dramatically. Compliance of African NSPs with other Global Fund indicator categories, such as Care and Support, Prevention and Outcome Indicators have not changed much since 2008 and are therefore not the key policy areas that are changing in recent years.

[12] There is a seventh category called "Impact Indicators", but these were excluded from this project since they are all epidemiological in nature. In other words, where all the other indicators in the M&E Toolkit are related to certain policies, the Impact Indicators are just measures of HIV prevalence in certain populations.

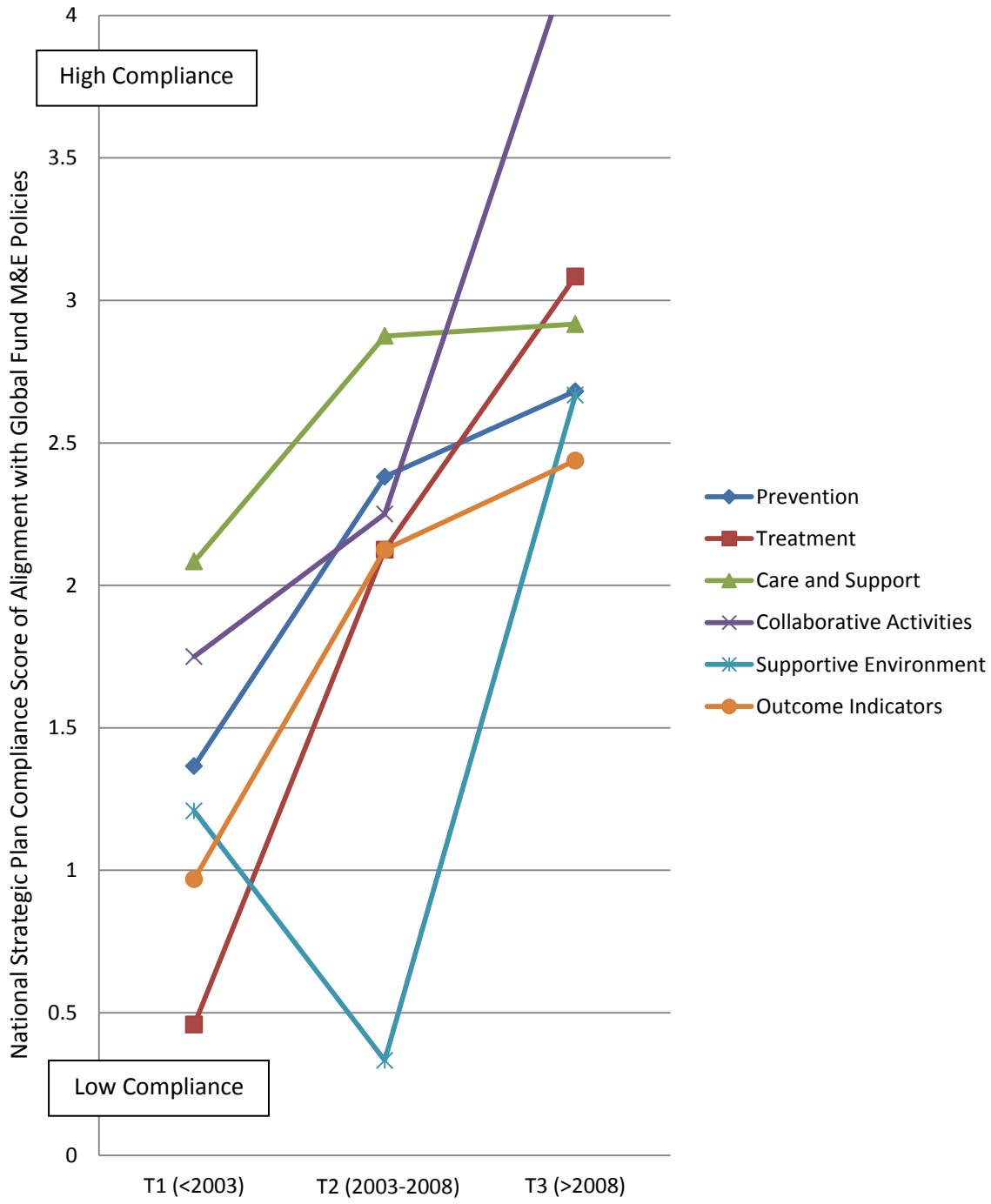


Figure 3.3 Aggregate Policy Compliance Scores for Categories of Policy

It is also useful to disaggregate policy compliance by country for individual indicators. In terms of treatment (Figure 3.4) Botswana was the only country to have shifted away from Global Fund treatment policies after 2008. It also emerges that Lesotho has always been one of the least compliance high prevalence countries with Global Fund treatment guidelines, and that Zimbabwe has been one of the most compliant.

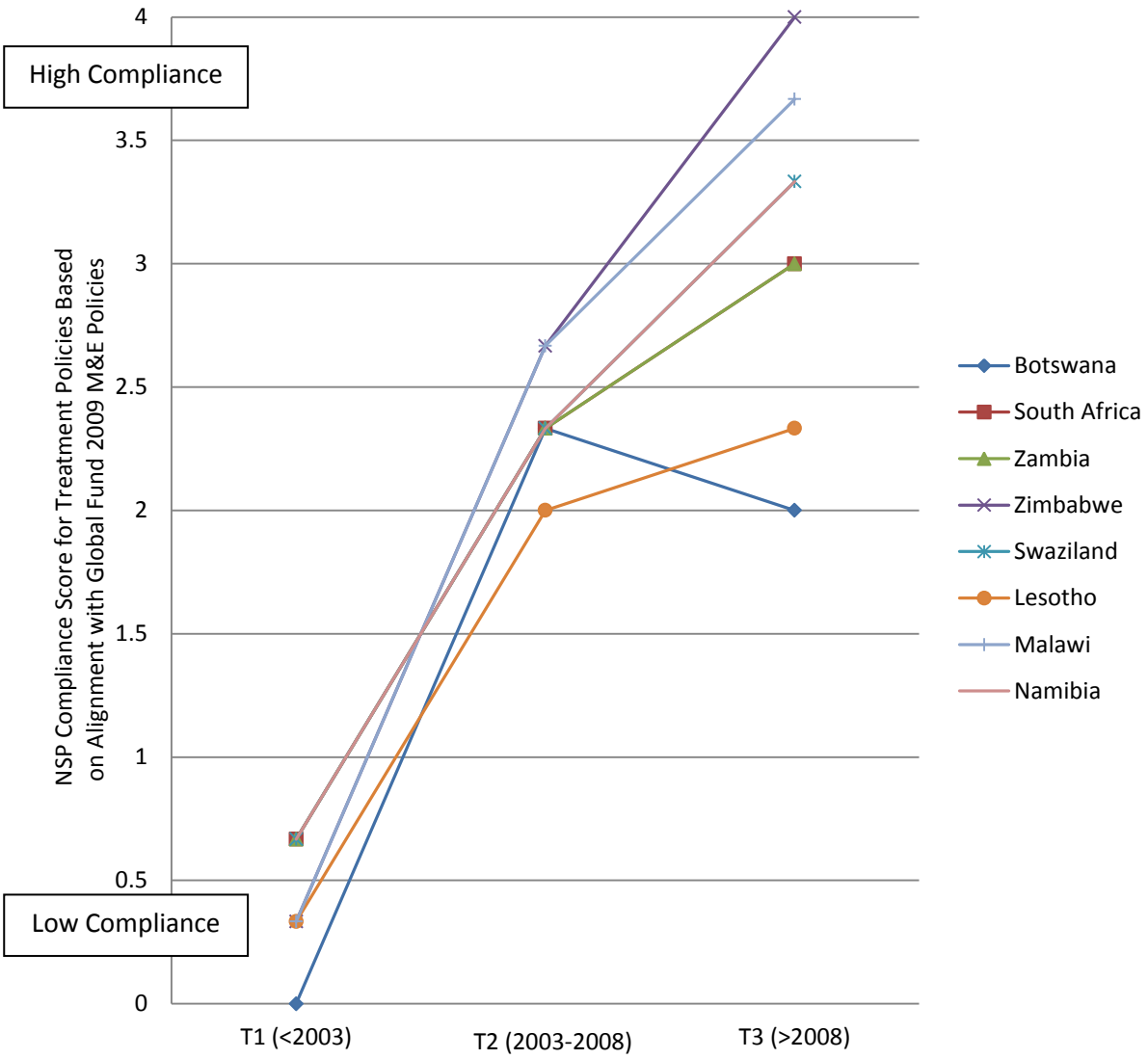
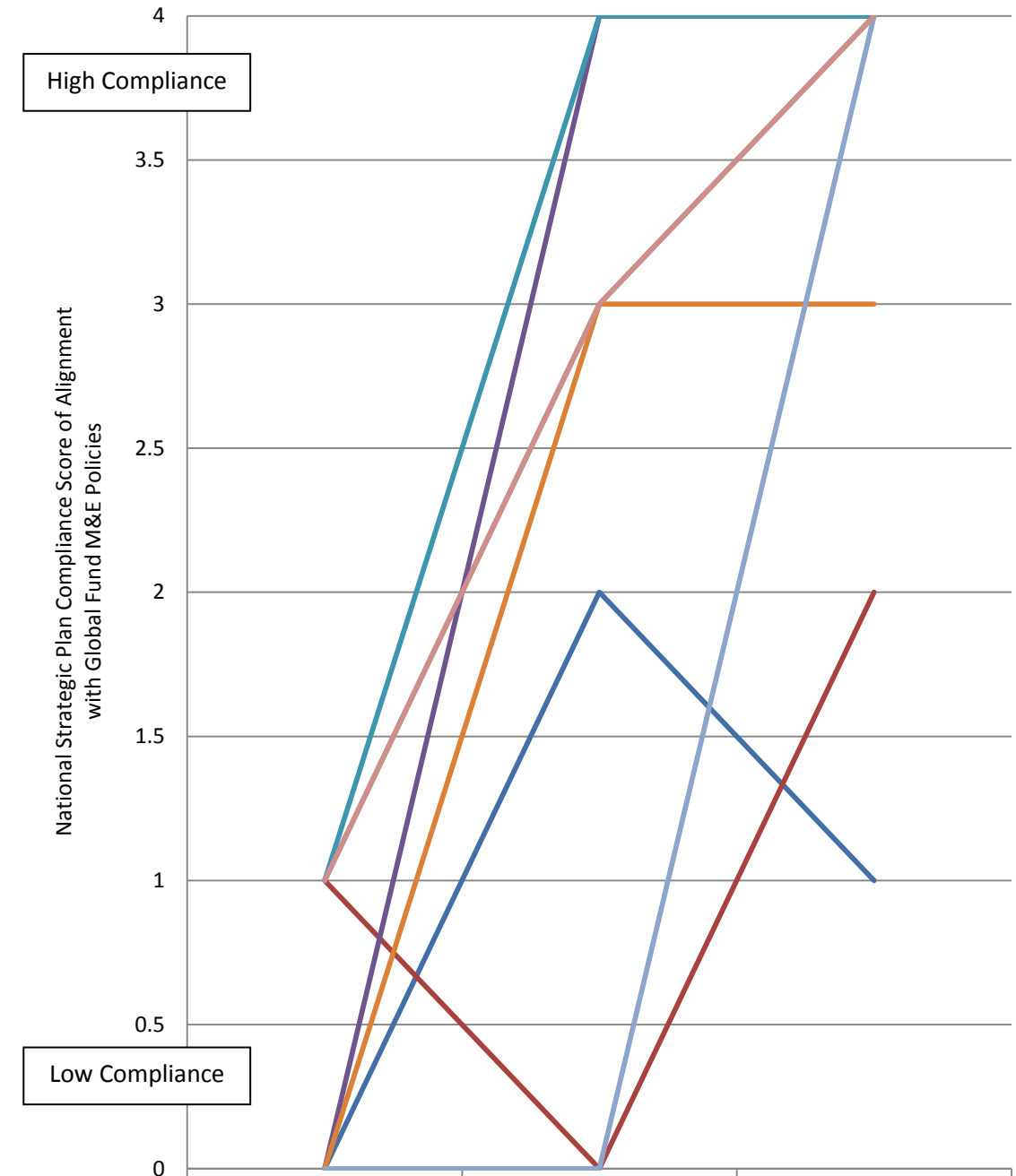


Figure 3.4 Global Fund Policy Compliance Scores for Treatment Policies in NSPs

When we further disaggregate the treatment policy category further, one of the Global Fund policies is to state the percentage of Health facilities that offer prescriptions and/or provide clinical follow-up for antiretroviral therapy (HIV-T2) (Global Fund, 2009). Here, in Figure 3.5, it is apparent that with individual policies, the trends are not at all linear, as they appear with the aggregate compliance scores in Figure 3.1. There are some countries like Botswana, whose national policy moved towards Global Fund policy on health facilities providing treatment from T1 to T2, and then moved away from T2 to T3. On the other hand, South Africa's national policies did exactly the opposite, moving away from Global Fund policy from T1 to T2, then sharply complying from T2 to T3. Differently still, some countries have been steadily moving in line with Global Fund policy on health center, like Namibia and Zambia.



	T1 (<2003)	T2 (2003-2008)	T3 (>2008)
Botswana	0	2	1
South Africa	1	0	2
Zambia	1	3	4
Zimbabwe	0	4	4
Swaziland	1	4	4
Lesotho	0	3	3
Malawi	0	0	4
Namibia	1	3	4

Figure 3.5 Compliance Scores for Global Fund Policy (HIV-T2) on Health Facilities Providing Antiretroviral Treatment

Major Patterns and Observations

To summarize once more, the broadest pattern suggested in this data is that National Strategic Plans of all high burden countries moved towards compliance with Global Fund policies from pre-2003 (T1) to pre-2008 (T2). In six of these countries (Malawi, Zambia, Zimbabwe, Swaziland, Lesotho and Namibia) policy compliance levels continued to increase even after 2008 (T3). However, since 2008 (T3), Botswana and South Africa moved away from the Global Fund's policy paradigm. Instead, these countries elected to design more locally informed National Strategic Plans which focus on policies like pre-teen sex education, alcohol abuse and intergenerational sex, for which there are no Global Fund policies.

When looking at which countries were complying with which policies and when, it is important to contextualize the time periods. At T1, before 2003, many of these National Strategic Plans were written long before ARV treatment was a realistic option in their countries. For obvious reasons, African policy compliance with the Global Fund's treatment indicators during this time is low. In the same vein, without viable treatment options, the focus of donors and African governments during T1 was on prevention programs as well as care and support. During T2, between 2003 and 2008, there were massive increases in funding available for HIV in Africa. The Global Fund was established in 2002 and PEPFAR began in 2003, two massive global funding institutions which created a very different time period for African HIV/AIDS responses. There was a great deal of debate during this time about what kinds of prevention strategies worked better than others, as donors and governments analyse the successes and failures of T1. Then, in 2008 (T3) things shifted significantly. The financial crisis hit and priorities of donors changed. Funding for HIV decreased dramatically before slowly stabilizing again. During this time, the focus of donors moved towards biomedical interventions (male circumcision, CD4 count tests) that can more easily show results, partly as African implementing partners feel added pressure to demonstrate successful results to donors. With these three different time periods in mind, it is interesting to see how country policies changed and adapted to these shifting circumstances.

Recall that the Global Fund's HIV/AIDS M&E Toolkit has six policy domains: (1) Prevention, (2) Treatment, (3) Care and Support, (4) Collaborative Activities, (5) Supportive Environment and (6) Outcome Indicators. The degree of compliance or divergence within these categories varied greatly across countries. I will now highlight some interesting results

on which policy domains influence countries to comply more than others. For a complete dataset on all country compliance levels per policy domain over time, see Appendix F.

Firstly, over time, prevention policies are most closely aligned with Global Fund policy language in South African NSPs. Secondly, treatment indicators in Swaziland are the most aligned with Global Fund policies in this domain. Thirdly, the NSPs from Botswana, Malawi, Zambia and Zimbabwe are most closely aligned with Global Fund policy on Care and Support indicators. Fourthly, averaged over time, the Global Fund's collaborative activity policies (combined HIV and TB programming) have had the most heavily influence over the NSPs in Lesotho and Namibia. Fifthly, supportive environment policies from the Global Fund were the least influential in all countries in the period from 2003 to 2008, yet countries moved towards greater compliance after this period. Lastly, outcome indicators (recall, these speak to abstinence and faithfulness) from the Global Fund have had the most impact on the NSPs from Zambia and Lesotho. These country-based policy domain results may point towards a variation in which kinds of donors are funding certain country programs, or differences in local priorities or absorptive capacities.

Another way to draw out trends in policy influence, instead of looking at influence by policy category, is to look at what certain time periods reveal about the degree to which the Global Fund's policies exert influence over Southern African NSPs. Before 2003 (at T1), Global Fund's care and support policies exercised the most influence over National Strategic Plans in Botswana, Malawi, Zambia and Zimbabwe. This is the same set of countries that align with Care and Support indicators averaged over time (T1 to T3), which suggests that this prioritization is not symptomatic of the new politics of HIV/AIDS, but rather, a longer-standing relationship between African policy makers and objectives in this area. The same is true of Namibia and Lesotho, which also most heavily align with collaborative activities at T1, as well as over time. However, at T1 collaborate activities is also South Africa's most strongly aligned group of indicators, which shifts towards prevention when we look at the average influence across time. In the same vein, Swaziland's chief policy alignment at T1 is different from its average alignment over time. At T1 in Swaziland, Supportive Environment policies (workplace programs, human rights networks for anti-stigma) are the most parallel with Global Fund M&E indicators, whereas treatment indicators are the most heavily influenced if you look across time.

During the period from 2003 to 2008 (T2), Botswana, Malawi and South Africa and Zimbabwe were most closely aligned with the Global Fund's policies on care and support. This represents stability for Botswana, Malawi and Zimbabwe who were in this same position at T1, but a shift for South Africa, which was more aligned with collaborative activities at T1. Additionally, treatment indicators are equally well-aligned as care and support indicators at T2 for Zimbabwe, which is another shift. At T2, Namibia and Lesotho also remain as they were at T1, aligning most strongly with collaborative activities. Both Zambia and Swaziland have shifted at T2 in terms of which category of policies are most closely aligned with Global Fund objectives. At T2, Zambia shifts from care and support indicators to outcome indicators as its most influenced set of policies, where previously it was care and support. Swaziland also moves its most focused alignment from supportive environment indicators to prevention.

By T3, most countries are aligning with either treatment indicators or collaborative activities. This is a significant policy influence shift, beginning at T3 in during the New Global Politics of HIV/AIDS. The only countries that are aligning with other sets of indicators at this point, post-2008, are Lesotho which focuses on Outcome indicators, and Zambia which is split between Care and Support and Supportive Environment.

What this all suggests is that policy emphasis, or put differently – policy *influence* from the Global Fund – shifts over time, with some groups of policies gaining traction at certain points in time compared to others. These variations indicate the need to better understand the contextual factors that may be leading to these different policy influence levels.

There are clearly structural and institutional explanations for these disparate levels of policy influence, since trends have emerged with respect to which countries internalize Global Fund policies more than other. It is also useful to disaggregate these policy influences to trace *when* countries are influenced by different objectives at different times, since this may also help point to which policies are working and when. For instance, if a country witnesses large drops in incidence during an era of heavily aligned Prevention policies, this could provide insight into the causal mechanisms behind these epidemiological outcomes.

Relationships and Generalizations

In addition to the major patterns and observations, there are also some more general relationships - between and among countries - that emerge from the data. More specifically,

there are certain clusters of countries that emerge out of the results. Three clusters emerge, in particular, in terms of overall policy alignment behaviour:

CLUSTER 1	Botswana and South Africa are clearly in one group, as the only two countries to diverge from Global Fund policies after 2008 (T3).
CLUSTER 2	Swaziland, Zambia and Zimbabwe form the second cluster, since these three countries continuously align with Global Fund policies over time, but at a relatively flat and steady rate. In other words, the difference between compliance scores at before 2003 (T1) and after 2008 (T3) are not that great.
CLUSTER 3	The third cluster is made up of Lesotho, Malawi and Namibia. These three countries have increased very steeply in terms of their National Strategic Plan alignment with Global Fund policies from T1 to T2.

Initial speculation suggests that structural, institutional and social variables may help to explain these clusters of policy compliance. Botswana and South Africa are the two richest, most democratic, countries in the project and they are the ones who deviate from Global Fund policy.

In addition, the two countries which comply the most with Global Fund policy – Namibia and Malawi – have the lowest HIV prevalence rates. Further, countries with similar levels of freedom and democracy seem to behave similarly, on both ends of the spectrum. As stated, South Africa and Botswana have the two highest levels of freedom, according to Freedom House International (2010). The middle cluster – Zambia, Zimbabwe and Swaziland – have the lowest levels of freedom, and all behave similarly in terms of their policy compliance. Other trends, clusters and outliers might also be logical explained by sets of explanatory variables, which will be explored in detail in Chapter 5.

Exceptions

For the most part, these clusters initially seem to correspond with shared characteristics. However, the one extreme outlier in this whole analysis is Namibia. This is a fairly rich and well-governed country that does not behave like its peers, Botswana and South Africa. In fact, it behaves exactly the opposite, by being the country that is *most* compliant Global Fund policies. Since variables in economic and political circumstance do not seem to shed light on this case, on the face of it, I expect to find other social determinants at play in this country to

explain its anomalistic behaviour. These kinds of variables will be explored through key informant interviews, which are discussed in Chapter 6.

In the same sense, while not necessarily an exception, Botswana is also a rather extreme outlier. Referring back to Table 3.1, Botswana behaves radically differently than other countries in the region after 2008. This was not previously the case, as its NSP compliance scores before 2003 (T1), and between 2003 and 2008 (T2) are fairly similar to the rest of its neighbours. However, Botswana shifts its policy focus quite drastically after that. Therefore, while most countries behave in a similar fashion, the two major outliers are Namibia and Botswana:

Agreement and Disagreement with Previous Work

The emerging results of this study presented in this chapter appear to confirm some previous research in the field, but also contest and dispute the findings of others. The fact that most countries in the region continue to align their policies closely with Global Fund polices (save Botswana and South Africa) corroborates the previous mainstream idea that donor agendas shape local policy to a large extent in Southern Africa. However, one could argue that the two exceptions also work to refute these arguments. For instance, Colleen O'Manique (2004) broadly suggests that neo-liberalism has created a top-down approach to AIDS policy-making in, which leaves African governments relatively irrelevant in the decision-making process:

> [T]he main institutions involved in formulating policy take as a given that states should have a minimal role in the provision of health services, and that the private and voluntary sectors are best equipped to mount the proper response (O'Manique, 2004, p. 9).

Some of the data in this study suggests the opposite. Certainly, before the new global politics of HIV/AIDS there was a high degree of external control over HIV/AIDS policy making in the region, as all countries moved their policies further in line with Global Fund policies from T1 (before 2003) to T2 (between 2003 and 2008). However, with substantial shifts in the political and economic climate of HIV/AIDS funding and policy-making, this is no longer true. Additionally, the low levels of Global Fund policy compliance at T1 in most Southern African countries might be explained by what Attaran and Sachs argued in 2001. They put forward that the World Health Organization's Global Programme on AIDS endeavoured to provide technical and organizational assistance to national aids programs in the mid-1980s, but that this funding was cut in 1990 and the initiative never really reached its potential (Attaran & Sachs, 2001). In addition, the establishment of UNAIDS in 1996 is a likely cause

of the large increase in policy compliance – in all countries in this study – which takes place during T2 (after 2003 and before 2008).

The results can also be brought to bear on the research literature within each country. For instance, in Botswana, some others accurately traced the circumstances which led to a movement away from Global Fund Policy influence over National Strategic Plans. Allen and Heald suggest that the Government of Botswana was following a fairly exclusive Western model, with respect to its AIDS policy, in the early decades of the epidemic (Allen & Heald, 2004; Heald, 2006). This is indeed confirmed by my data. Botswana's 1993 National Policy on HIV/AIDS was one of the most compliant in the region at the time, second only to Zambia.

However, Allen and Heald (2004) suggest that by the mid-1990s, most international donors had pulled out of Botswana, with the understanding that the wealth of the country would self-sustain its AIDS programming. At the same time, they point to the changes in government policy accompanying the beginning of President Mogae's first term in 1997, citing reasons such as increased engagement from the executive office. According to my hypothesis laid out in Chapter 1, I would have expected these changes to result in a movement away from Global Fund policies. This was not the case. In 2003, Botswana had become more aligned with Global Fund policies, despite donor withdrawal and increased in-country political ownership. But, Allen and Heald argue that the real leadership shift, with Mogae's self-stated aim 'to make Batswana face up to the disease' did not really begin until 2003/2004, which might corroborate why the increased domestic policy influence, as compared to Global Fund M&E influence, only began to show up in Botswana's policy at T3, in the country's Second National Strategic Framework released 2010. Allen and Heald also conclude at the end of their piece that Botswana used to follow a more accepted line in HIV intervention which more closely mirrored global norms, which has now changed. They suggest that now (after T2, when the article was written), the country is following a different set of HIV/AIDS protocols that are facing intense opposition from international organizations.

The results of this research also speak to previous work on specific policies. Allen and Heald (2004) argue that condom promotion in Botswana was a heavy policy focus in the early days of the AIDS response, but that this initiative was not well-received by the community and was largely ineffective. My policy analysis of Botswana's 1993 National Policy in HIV/AIDS corroborates this heavy emphasis on condoms, with male condoms and free

public condoms both scoring 4/4 for alignment with the Global Fund policy, and the notion of private sector condoms scoring a 3/4. Since 1993, the emphasis on condom promotion across the four condom policies has decreased. Heald (2006) points to ARVs, as well, as a policy that gained traction at the turn of the millennium in Botswana. My results also corroborate this notion, since at T2 Botswana's HIV Strategic Framework for 2003-2009 scored 4/4 for the antiretroviral policy. It was also one of the few countries at T2 to include mention of CD4 count machines in its National Strategic Plan. My data also corroborates previous work from other countries, including Malawi. Ngwira, Bota and Loevinsohn (2001) suggest that the government in Malawi has a tendency to leave grassroots programs and activities to NGOs. This argument is supported by my data which show a high level of external influence of Global Fund M&E policies on Malawi's local HIV policy.

In 2004, Jones (2004) writes that international policy influences skew local agendas towards the prevention side of HIV/AIDS programming, with much less focus on treatment and care (which, in his view, is a more effective approach). This seems initially true, when you see that out of the 34 Global Fund policies used in this project's framework, 20 are prevention policies and only 3 are treatment policies. However, the data findings of Part 1 of this thesis do not entirely support Jones' contention. For instance, at T2, when Jones wrote this article "When 'development' devastates", Zambia's 2006-2010 HIV Strategic Framework was much more compliant with Global Fund policies on treatment than it was on Global Fund policies on prevention. This indicates that international donors were influencing treatment policies to a greater degree than they were influencing prevention policies, in Zambia at the time. The same is true of Zimbabwe, Botswana and Namibia, which were also more strongly influenced by Global Fund policy prescriptions in terms of treatment policies than they were for prevention policies, at T2.

It should be mentioned that certain countries do follow Jones' assertion about Global Fund influences that favour prevention. In the era before the new global politics of HIV/AIDS (pre-2008), Lesotho, Swaziland, Malawi and South Africa were all heavily weighted towards prevention policy alignment in their National Strategic Plans much more strongly than compliance with treatment policies. For instance, at T2 in Malawi, the 2003 National HIV and AIDS Policy scored a 2.150/4 for its average over prevention policies. There are quite a few sections that emphasize behavior change communication and PMTCT. By contrast, its treatment policies were almost non-existent, with no mention of health centres that carry

ARVs, no mention of facilities for CD4 count, and only one sentence mentioning of ARV treatment programs in the whole policy.

Jones (2005) wrote another article a year later, on South African HIV/AIDS policy and its influencing factors. In his piece "A Test of Governance: rights-based struggles and the politics of HIV/AIDS policy in South Africa", he cites commonly held criticisms of South African policy at T1 (HIV/AIDS/STD Strategic Plan for South Africa 2000-2005) for not living up to expectations. He says that a lack of consideration for training NGO involvement is a key error of omission. McKerrow (2002) also critiques this policy for lacking treatment guidelines. The findings of this project do support these ideas, with an overall score of 1.059/4 for alignment with Global Fund policy. McKerrow is also accurate, since treatment policies in this policy scored 0.667/4 in terms of cooperation with Global Fund precedent at the time. Anthony Butler's work on South African HIV/AIDS policy is also bolstered by the results of this project. Similar to McKerrow, Butler (2005) says that South Africa's first Strategic Plan in 2000 left out the specifics on timeframes and commitments, though it was based on a United Nations policy template. This is evidenced in the data from the policy analysis, which shows most of the Global Fund policies in South Africa are adhered to on a base level, but very few score higher than a 2/4 since, for the most part, they are missing age ranges, timeframes and percentage data.

The New Global Politics of HIV/AIDS: Revisited

Now that the major patterns and trends in the data have been identified, and their relevance for previous work has been outlined, it is important to return to the original question presented in Chapter 1: *Who Governs? Have the recent financial, rhetorical and political changes in the global politics of HIV/AIDS resulted in African policy movements away from global influence?*

The answer is a partial yes. Since 2008, HIV/AIDS policies in Botswana and South Africa are less compliant with Global Fund policies. For the rest of the countries in this study, (Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe) this is not the case, and they continue to further align their national plans with Global Fund objectives. These changes may be related to many different political and/or economic factors, which will be explored in Chapter 5. The implications for the epidemic are tentatively explored in Chapter 7, with an aim to inspire future research into the question of policy efficacy.

The data outlined in this chapter might be the very beginning of a new emerging trend away from Global Fund protocols. On the other hand, the tightening of resources from the West could also just be having the opposite effect. For poorer countries, like Malawi and Zambia, a decrease in available funding from the West might incentivize policy-makers to vie even harder for the affection of international donors, dressing up their policies in Global Fund M&E language even more intensively than before.

Nevertheless, we do not as of yet why some countries diverged and others complied with Global Fund policies. Nor do we know what the consequences of such policy-making decisions are or will be. These two questions will be answered in next chapters of this thesis. These questions, answered in the second half, will explore potential causes of the patterns identified in this chapter. The initial hypothesis for the explanatory variables was that richer, better governed countries might be in a better position to break from Global Fund policy-based policies in pursuit of more culturally-tailored approaches. From the results of this chapter, it seems that this may be confirmed. However, it will take mapping against data sets of explanatory variables to say, more robustly, that this is true across the entire project. The question about the impacts that policy has on disease outcomes was hypothesized in a fairly mainstream manner. The consensus among most scholars is that locally devised, culturally relevant, policies are more effective at combating infection. From the literature, I have also adopted this line of reasoning. However, it will be interesting to see if there is an association between trends in policy change and trends in infection rates, which could follow a trajectory that supports this thinking.

New Knowledge and Understanding

There are five major discussion points to take away from the findings in this overview chapter on aggregate results. First, the most recent National Strategic Plans from Botswana and South Africa show a movement away from compliance with Global Fund policies.

Second, the countries in this study appear to behave in three distinct clusters: (1) Botswana and South Africa diverge from Global Fund policies at T3; (2) Swaziland, Zambia and Zimbabwe continuously align with Global Fund policies over time, but at a relatively flat and steady rate; and (3) Lesotho, Malawi and Namibia have increased very steeply in terms of their national policy alignment with Global Fund policies from T1 to T3.

Third, overall, from before 2003 to after 2008, Global Fund policies concerning care and support have had the most influence over Southern African National Strategic Plans. These Global Fund policies had the greatest influence in Botswana, Malawi, Zambia and Zimbabwe. However, Lesotho and Namibia have always been more closely aligned with Global Fund policies on Collaborative Activity policies (combined HIV and TB programming). South Africa's alignment has always been Prevention and Swaziland's most heavily influenced policy area has been Treatment.

Fourth, while the Global Fund's care and support policies have had the greatest *average* impact, since 2008 other policy focus areas have taken the spot of having the greatest influence over Southern African National Strategic Plans. After 2008, most Southern African countries shifted the focus of their National Strategic Plans to be aligned most heavily with either treatment policies or collaborative activities (combined HIV and TB programming).

Fifth, these findings disrupt previous arguments that all African countries are tightly bound by global policies and agendas, since some countries are beginning to demonstrate movements away from compliance with Global Fund policies. Particularly, previously held ideas about the large impact of Western donors' "imperialistic" control over the design of HIV prevention programs (Cohen & Tate, 2005; Epstein, 2007; Pisani, 2008) are challenged since Global Fund prevention policies have not been overwhelmingly influential in the countries in this study (except in South Africa).

Concluding Remarks

These aggregate trends reveal that my original hypothesis was incorrect: countries have not been moving away from Global Fund policy compliance in the post-2008 period. In fact, overall, high burden countries continue to align their policies with Global Fund agendas, even after the new global politics of HIV/AIDS, particularly in the face of reduced political and financial influence coming from Western donors. When we disaggregate overall policy compliance, it also becomes clear that different global policies (i.e. prevention, treatment, care and support, etc.) have different levels of influence over African National Strategic Plans. Further, individual policies from these categories can further illuminate the subtleties of policy change in the region. The next chapter delves one level deeper to illustrate the actual written changes from one policy to the next in individual countries.

Chapter Four

Findings Part II: Illustrating Individual Policy Changes

"The language of international [HIV/AIDS] policy frameworks has an important impact on the people who are targeted by these policies" (Seckinelgin, 2006, p. 1).

Introduction

In addition to looking trends in the aggregate policy compliance in high burden countries, it is equally important to focus on the more micro-level elements of policy making, that is, how and why the specific shifts of individual policies occur within countries. Seckinelgin (2006) has shown that examining language is important for understanding how people identify themselves in relation to policies, which in turn affects policy implementation. Others have demonstrated that health policy language is heavily connected to dominant meanings and assumptions, which is highly significant for the way in which policy is operationalized by the implementers (Iannantuono & Eyles, 1997). In this chapter, I examine a selection of interesting examples which highlight what policy change looks like, and how shifts in compliance with Global Fund policies are often the result of subtle written changes over time. This chapter is organized differently from the last, as it aims to display a different element of the policy compliance results. While Chapter 3 looked at aggregate trends, highlighting limited examples of compliance within a certain policy, this chapter will lay out what compliance looks like within each of the Global Fund's six policy categories that are examined in this project: (1) Prevention, (2) Treatment, (3) Care and Support, (4) Collaborative Activities, (5) Supportive Environment and (6) Outcome Indicators.

Prevention

Of the 34 policies analyzed in the framework used in this project, 20 are related to prevention. Yet, HIV prevention policies are perhaps the most widely contested in terms of their political motivations and epidemiological efficacy. Where few would dispute that support for orphaned children is a beneficial AIDS policy, prevention strategies such as behavior change communication and voluntary testing and counselling have been hotly debated by doctors, policy-makers and academics alike.[13]

[13] This project's policy framework (the Global Fund 2009 M&E Toolkit) categorizes abstinence and faithfulness as outcome policies, not prevention policies. A full list of the policies and policy categories, see Appendix C.

Justin Parkhurst (2008) notes that in order to show that certain prevention policies were responsible for declining HIV prevalence, a chain of different types of evidence are required: first, prevalence decline must connected to incidence decline, which must also be connected to behavior change, intervention, and finally, policy. However, he suggests that in many cases, there is no conclusive data for these various linkages, citing the example of the continuing debates over which prevention policies were responsible for HIV prevalence declines in Uganda. Parkhurst says prevention policies are usually the subject of intense debate because people often misunderstand the evidence required. Despite these challenges, rigorous understanding of HIV prevention policies (and policy changes) is an important first step towards satisfying the evidence needed to measure policy impact.

Behavior Change Communication

According to the Global Fund, behavior change communication (BCC), focuses on "Young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission" (Global Fund, 2009, p. 72). The Global Fund's policy framework also targets "Most-at-risk populations reached with HIV prevention programs (percentage)." To track performance, the data is disaggregated into different most-at-risk population, such as (1) Young women and men aged 15-24, (2) injecting drug users, (3) men who have sex with men, (4) sex workers and (5) young people aged 10–24 years. As a result, there are five BCC-related policies measured in this study (HIV-PI and the four sub-categories of HIV-P4a).

Table 4.1 Botswana's Behavior Change Policies

Policy	Code	T1	T2	T3	TREND
BCC Mass Media	**HIV-P1**	**3**	**4**	**3**	Towards Then Away
BCC Community Outreach for Injecting Drug Users	**HIV-P4a**	**0**	**2**	**1**	Towards Then Away
BCC Community Outreach for Men Who Have Sex With Men	**HIV-P4a**	**0**	**1**	**1**	Towards Then Static
BCC Community Outreach for Sex Workers	**HIV-P4a**	**0**	**3**	**2**	Towards Then Away
BCC Community Outreach for Young People (10-24)	**HIV-P4a**	**2**	**3**	**1**	Towards Then Away

The majority of Botswana's BCC policies have become less compliant with the Global Fund's policies in their latest National Strategic Plan. At T2, the National Strategic Framework for HIV/AIDS (2003-2009) cites the objective to "Design and provide airtime for appropriate HIV/AIDS programmes targeting [...] drug users" (Government of Botswana, 2003, p. 69). However, in 2010, this language becomes slightly less conspicuous. The

"Proportion of MARPS [most-at-risk populations] utilizing HIV Prevention services" remains the relevant indicator, yet the definition of MARPS is "sex workers, truck drivers, seasonal farm workers, and construction workers but can be expanded" (Government of Botswana, 2010, p. 37). There is no outright mention of drug users – injecting or otherwise – in this NSP, as there was in the previous policy.[14]

The same trend is true for sex workers. In 2003, the NSP said that the Department of Information and Broadcasting (DIB) should "Design and provide airtime for appropriate HIV/AIDS programmes targeting [...] commercial sex workers" (Government of Botswana, 2003, p. 69). Additionally, there was a whole section devoted to "Mobile populations [such as] Commercial Sex Workers" (Government of Botswana, 2003, p. 33). In 2010, however, all of this language disappears and the only attention given to sex workers is the inclusion into the current definition of MARPS.

Lesotho's emphasis on BCC mass media prevention in youth provides a good example of increasing Global Fund policy compliance over time. Recall that the Global Fund policy language is "Young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission" (Global Fund, 2009, p. 72). In 2000, the Lesotho policy read that there would be "Television and radio air-time slot for HIV/AIDS increased to at least 3 times a week for 15 minutes by August 2000" (Government of Lesotho, 2000, p. 23). In the 2006 NSP, Lesotho's national policy became more compliant with the Global Fund, including a target age-bracket and providing baseline data, as the Global Fund indicator requests: "To increase the percentage of men and women who have correct knowledge about the prevention of sexual transmission of HIV infection to 80% by 2011" with "98 % of population aged 15-49 exposed to HIV/AIDS media" (Government of Lesotho, 2006, p. 51). Yet, the policy was not completely compliant with the Global Fund policy, since it measures knowledge for the general population (15-49) instead of youth (15-24). By 2009, Lesotho's policy reads "% of

[14] It is important to note that in some settings there is no significant population of injecting drug users and hence this may not be related to the epidemic. However, the Global Fund does suggest that countries with generalized heterosexual epidemics may want to consider collecting data on this indicator: "Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, calculating and reporting on this indicator for these populations would be valuable" (Global Fund, 2009, p. 86). They also include "countries with concentrated sub-epidemics within a generalized epidemic" in the applicability for the injecting drug use policy. However, in this chapter, it is not the aim to suggest which policies should and shouldn't be included in African NSPs. Instead, it is discusses changes in the policies in so far as they comply or deviate from the Global Fund M&E Toolkit (2009). Potential causes and consequences of this are explored in Chapter 5.

key populations at risk who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from X in 2009 to 50% in 2011" (Government of Lesotho, 2009, p. 40). It also says "The % of men and women who have correct knowledge of HIV prevention increased from 23% in 2005 to 80% by 2011" as well (Government of Lesotho, 2009, p. 67). Lesotho's policy shift on BCC mass media from 2006 to 2009 represents a further move towards compliance with Global Fund policy, since there is added language about the rejection of major misconceptions about HIV transmission, which matches the Global Fund indicator.

Malawi also exhibits similar trends in its youth BCC policy. In its most recent NSP, its policy is essentially a cut-and-paste of the Global Fund policy: "% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV" (Government of Malawi, 2010, p. 47). However, what is more interesting here is the increased alignment with policies for drug users and men who have sex with men. The first mention of injecting drug users only appears in the most recent NSP, where it is stated that ""Injecting drug users" are in the resource needs budget, but there is no money specified for them (Government of Malawi, 2010, p. 50). Further, the increasing emphasis on men who have sex with men is a noteworthy point. In 2000 there was no mention of this population. In 2003 this changes, with one slight mention to suggest that "Vulnerable populations include [...] persons engaged in same sex relations" (Government of Malawi, 2003, p. 19). Moving further in line still, in 2010 the NSP includes men who have sex with men in the resource needs budget, with up to US$ 0.7 million specified for them (Government of Malawi, 2010). Additionally, the policy aims at "Targeting most-at-risk groups: sex workers, MSM and prisoners" (Government of Malawi, 2010, p. 21).

Zambia is also moving in line with the Global Fund policy on BCC for men who have sex with men, admittedly in very small steps. At T2, in 2006, the NSP says that men who have sex with men are not a priority for the country because "It is estimated that less than 1% [of HIV infection] is through [...] sex between men" (Government of Zambia, 2006, p. 10). Then, in 2011, the policy indicates a sudden alignment with Global Fund priorities, noting that "Policies and programmes are, also, inadequate to address the specific needs of MSM" (Government of Zambia, 2011, p. 16) and that the country needs to "Create research environment that support evidence generation for vulnerable and marginalized populations (e.g. MSM)" (Government of Zambia, 2011, p. 17). The same is true for sex workers. In 2006

Zambia's policy notes that "Despite some of the success that has been demonstrated with HIV prevention efforts with small populations, like sex workers, many of these lessons have not been taken to scale for the general population to have an impact on overall incidence" (Government of Zambia, 2006, p. 23-24). There is also one mention of the "the Corridors of Hope Programme [which] targets truck drivers and sex workers" (Government of Zambia, 2006, p. 37). Then - again in a minor way - the 2011 NSP seems to suggest that sex workers are more of a priority than they were at T2. The language moves from saying that programs have not been expanded, to suggest that they *should* be: "Brothels and MSM are illegal, and as a result hidden and largely inaccessible to mainstream prevention programmes. The number and size of prevention activities addressing sex work is insufficient and most do not include clients of sex workers" (Government of Zambia, 2011, p. 16). (Page 16) and "Of these categories the informal sector and illegal activities such as sex work are targeted by a few implementing organisations for HIV interventions but not to the degree occurring in the formal sector. The majority of workers are not reached" (Government of Zambia, 2011, p. 47).

In Namibia, almost all BCC policies are moving in line with Global Fund language, with four out of the five policy areas receiving a value of 4 (out of 4) in terms of compliance.

Table 4.2 Namibia's Behaviour Change Policies

Policy	Code	T1	T2	T3	TREND
BCC Mass Media	**HIV-P1**	**3**	**1**	**4**	Away Then Towards
BCC Community Outreach for Injecting Drug Users	**HIV-P4a**	**1**	**0**	**4**	Away Then Towards
BCC Community Outreach for Men Who Have Sex With Men	**HIV-P4a**	**1**	**0**	**4**	Away Then Towards
BCC Community Outreach for Sex Workers	**HIV-P4a**	**1**	**4**	**4**	Towards Then Static
BCC Community Outreach for Young People (10-24)	**HIV-P4a**	**1**	**2**	**3**	Towards Then Towards

The difference between policy compliance from T1 (1999) to T3 (2010) is stark. Admittedly, the Global Fund was not around at in1999, but certainly was in T2 – 2004 – and there are very low levels of policy compliance there too. For injecting drug users, men who have sex with men and sex workers, Namibia's policy moves from one very indirect mention of 'vulnerable groups' in 1999 (Government of Namibia, 1999, Appendix B, p.2), the following in 2010: "% of Most at Risk Populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major OC16: misconceptions about HIV

transmission increases by 20% between FY [Fiscal Year] 2010/11 and FY2012/13 and by 50% between FY2010/11 and FY2015/16" (Government of Namibia, 2010, p. 36). This policy includes injecting drug users, men who have sex with men and sex workers because the NSP later states that "Most at risk populations (MARPS) [...] include mobile and migrant populations such as long-distance truck drivers, sex workers, men who have sex with men, disciplined forces (Army, Police, and Prison officers), inmates (prisoners) and injecting drug users" (Government of Namibia, 2010, p. 33).

Swaziland's BCC policies mirror Namibia's, with all five areas (Recall: (1) Young women and men aged 15-24, (2) injecting drug users, (3) men who have sex with men, (4) sex workers and (5) young people aged 10–24 years) becoming more closely aligned with Global Fund policy language in each subsequent NSP. The most notable alignment occurs with the young people aged 10–24 years policy. In 2000, the NSP says there is an objective "To teach young people about human sexuality including HIV/STI/AIDS by Empower young Swazis (both male and female) with knowledge and skills that will enhance their self-esteem [...] so as to make informed decision on important areas of their lives and positively influence their peers" (Government of Swaziland, 2000, p. 82). This becomes more compliant with the Global Fund language in 2006, since it begins to include some age brackets: This policy identifies that "In terms of age group patterns, youth aged 20-24 and 25-29 have experienced the highest prevalence since 1996, followed by people aged 40 years and above" (Government of Swaziland, 2006, p. 4).

There is also a focus on the "Improvement of the capacity of all health facilities in public and private sectors to deliver child and youth friendly sexual and reproductive health services" (Government of Swaziland, 2006, p. 22). Finally, at T3 in 2009, the policy is entirely in line with the Global Find policy for knowledge outreach in 10-24-year-olds, providing the same priority age bracket, and data to support the policy: "With regard to focusing on young people, prevention will target programmes that keep children in school, and address out of school youth where no formal opportunities exist to provide life skills" (Government of Swaziland, 2009, p. 29) and "More young people get information about HIV from their family members, as opposed to in the media or from friends: % of young people aged 10-24 who cite a member of the family as a source of HIV and AIDS information is increased from 39.2% in 2006 to 60% by 2014" (Government of Swaziland, 2009, p. 44).

For South Africa, the emphasis on BCC for youth and injecting drug users is moving in the opposite direction, away from strict compliance with Global Fund policy language. In 2007, it was stated that the country would "Investigate the extent of HIV risk from injecting drug use (IDUs) and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices" with goals to "Continuously research and monitor the extent of IDU use and the relationship with HIV infection, Develop policy and guidelines for HIV prevention in IDUs and review annually [and] Establish public sector drug rehabilitation programs in all provinces" (Government of South Africa, 2007, p. 80). From there, in the most recent NSP in 2012 it is just noted that "Although Injecting drug use has not been identified as a key driver of HIV transmission, a pro-active stance will contain the emergence of IDU challenges in the context of HIV transmission" (Government of South Africa, 2012, p. 75). This might indicate a move responsive policy for South Africa's needs, so should not necessarily be ill regarded, but it does, however, certainly depict a movement away from policy-focused policy based on the Global Fund's priorities.

Curiously, unlike the other countries that are similar to Zimbabwe in terms of wealth, most BCC prevention policies have moves away from the Global Fund policy language. In 2006 there is one mention of injecting drug users in the NSP: "While the mainstay of prevention efforts will be aimed at unmarried young people and married couples generally, specific programmes will be developed targeting such at-risk and minority groups as [...] injecting drug users (IDU)" (Government of Zimbabwe, 2006, p. 19), whereas in 2011 there is no policy language for this population. Similarly, in 2006 the policy on BCC for men who have sex with men was that "Other groups that have been identified as particularly vulnerable to infection include [...] men who have sex with men (MSM)" (Government of Zimbabwe, 2006, p. 13) and "While the mainstay of prevention efforts will be aimed at unmarried young people and married couples generally, specific programmes will be developed targeting such at-risk and minority groups as [...] MSM" (Government of Zimbabwe, 2006, p. 19).

This is also noteworthy: "While homosexuality remains illegal in Zimbabwe, there can be no doubt that there are men who have sex with other men. They are at risk of HIV infection and passing on the virus to their partners, including female partners. Furthermore, international experience has shown that ignoring this group or adopting punitive approaches will only serve to drive MSM underground and reduce opportunities to dialogue with this group. An assessment of MSM patterns, meeting points and behaviours will therefore be carried out,

and adequate public health interventions developed based on the findings" (Government of Zimbabwe, 2006, p. 20). However, in 2011, the policy essentially says this has not been carried out: "No size estimation or bio-behavioural surveillance on MSM as proposed under the ZNASP [Zimbabwe National AIDS Strategic Plan) has been done to date severely hampering opportunities to develop appropriate evidence based SBCC interventions for this population" (Government of Zimbabwe, 2011, p. 8).

Life Skills-Based Education

In Lesotho, the policy on Life Skills Education first moved towards the Global Fund policy then moved away. The Global Fund policy (HIV-P5) language wants "Schools that provided life skills–based HIV education in the last academic year (percentage) (HIV-P5)" (Global Fund, 2009, p. 72). In 2000, Lesotho's NSP does make one minor mention of the policy, saying "life skills programmes empower children, youth and adults to realise their human rights and develop skills to avoid risky behaviours of contracting HIV/AIDS" (Government of Lesotho, 2000, p. 9). In 2006, this policy becomes much more in line with the Global Fund M&E policy, stating that Lesotho emphasizes the strategy of "Promot[ing] Life Skills education in primary, secondary and tertiary schools and target out-of-school youth"(Government of Lesotho, 2006, p. 52) and sets the goal of "100 % of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year" (Government of Lesotho, 2006, p. 52-53). This was given a score of 3 out of 4, because ideally, according to the Global Fund, this percentage data should be disaggregated for primary and secondary schools. Then, at T3 in 2009, the NSP changes its language around Life Skills to say "The Mid-term review of the NSP noted that approximately 376,318 out of school youth were trained in life skills based HIV and AIDS education in 2006. This number increased to 388,741 by June 2007" (Government of Lesotho, 2009, p. 26). Additionally, "% of in and out of school youth aged 6 -24 years have had capacity building through life skills HIV and AIDS Education" at "Baseline 408,526 (Sept 2008)" (Government of Lesotho, 2009, p. 31).

It is important to consider here how deviation from the Global Fund Toolkit can reflect increased country ownership of certain policies. The policy of life skills education is still included in Lesotho's 2009 NSP, but the country has changed and adapted the data collection system, deviating from the Global Fund's suggested M&E framework, which it followed in

2006. Perhaps collecting data on the number of students instead of the number of schools is something that Lesotho has found to work better for them as a country. If this is true, this is certainly suggestive of an improved response. It is also important to remember that when assessing policy later in this thesis, it is certainly not true that domestic policies are inherently better than global ones, or vice versa. However, for this chapter, the aim is not to suggest which policies ought to be complied with or deviated from, but rather to illustrate what deviation and compliance from Global Fund policy actually looks like in terms of the written NSPs in Africa.

A similar trend to Lesotho's deviation from Global Fund Life Skills policy is also occurring in Swaziland. In 2006, the Swazi NSP reads: "Percentage of schools with at least one teacher who has been trained in participatory life skills based HIV and AIDS education and who has taught it during the last academic year" and "Number of young people exposed to life skills-based HIV and AIDS education in the last 12 months" (Government of Swaziland, 2006, p. 22). This is a fairly well-aligned policy, though it collects data on number of teachers and number of students instead of number of schools (similar to Lesotho). Then, in the 2009 NSP, the Life Skills language is significantly downplayed, noting only the objective to "Strengthen programmes for in- and out of-school children for life skills development" (Government of Swaziland, 2009, p. 73).

The same is true of Zimbabwe. From 2006 to 2011 the alignment of the Life Skills education policy moved sharply away from Global Fund policy language. In 2006, the Government of Zimbabwe notes how "The country's 13 Teachers' and 11 Technical Training Colleges have each either a full time coordinator or a team of trained lecturers to teach the life skills based HIV/AIDS Education Programme in schools which all trainee teachers are required to take as part of their training since 1994" (Government of Zimbabwe, 2006, p. 8). And, "The life skills education and HIV prevention and care components […] for OVC [orphans and vulnerable children] will be strengthened" (Government of Zimbabwe, 2006, p. 14). Lastly, "There is need to consolidate and expand the in school life skills program. The HIV/AIDS and Life Skills Strategic Plan for the period 2006-2010 is being finalized by the Ministry of Education, Sport and Culture (MOESC). Its provisions will need to be widely operationalized to reach as many in-school young people as possible" (Government of Zimbabwe, 2006, p. 20). However, by 2011, the data collection in terms of number of schools and emphasis on the policy is much less: "The youths will be mobilised for HTC [HIV testing and counseling]

services through the In-school HIV and AIDS Life skills based education, tertiary institutions programme, youth groups, associations and organisations working with youths to improve the interest of the youth out of school" (Government of Zimbabwe, 2011, p. 30).

Conversely, South Africa, Malawi, Namibia and Zambia continue to prioritize Life Skills education, all aligning their most recent NSP with the Global Fund policy very heavily (scoring 4 out of 4). For instance, in 2000 in Malawi, the NSP notes that the country "Integrate life skills training in school curricula and youth development programmes nation-wide" (Government of Malawi, 2000. p. 11). By 2003, the policy aligns itself further with Global Fund rhetoric, suggesting that "Government shall ensure that young girls and boys, both in and out of school, have access to life skills education"(Government of Malawi, 2003. p. 20) and "Government shall incorporate reproductive and sexual health education, including life skills and peer education, into the school curriculum as subjects of continuous assessment" (Government of Malawi, 2003. p. 21) and "Government shall ensure that young women and men who are approaching adulthood and are engaged in transactional sex, are supported through multidisciplinary interventions with life skills and sexuality education" (Government of Malawi, 2003. p. 22). Then, in 2010 the policy is completely aligned, saying that "Life skills education has been scaled up to all primary and secondary schools, now potentially reaching 3 million primary and over 250 thousand secondary school students. In 2007 there were almost 7,000 Edzi Toto Clubs, one third of them out of school" (Government of Malawi, 2010. p. 21).Additionally, "% of schools that provided life skills based HIV/AIDS education within the last academic years" is at 6% baseline in 2002 (Government of Malawi, 2010. p. 47).

Condoms

Chief among the contentious prevention strategies is the promotion of condoms. Helen Epstein (2007) points out how Uganda's policies were not favourable of condoms in the early days of the country's prevention efforts in the mid -1980s. She also notes how attitudes towards them tend to ebb and flow depending on funding from the US government. Epstein (2007, p. 54) notes too, how "as condom use soared, the HIV rate soared as well." As does Edward Green, the engineer of the ABC [abstain, be faithful, use condoms] prevention program based on his research in Uganda. He similarly notes now condom use is often positively correlated with HIV infection increases (Green & Hanon, 2008).

However, the Global Fund M&E Toolkit has one overarching policy for condoms: HIV-P7 "Number of male and female condoms available for distribution nationwide during the last 12 months per person aged 15-49 years" (Global Fund, 2009, p. 93). However, the Toolkit also specifies that this policy is meant to be disaggregated into four sub-categories. As such, this project's policy framework has four policies related to condoms: (1) Male Condoms, (2) Female Condoms, (3) Private Sector Condoms and (4) Free Condoms. The degree to which countries in this study internalize Global Fund policy on condoms is wide and varied. Additionally, the disaggregation of condom policy in four sub-policies helps to further shed light on national priorities in this regard.

Table 4.3 Swaziland's Condom Policies

Policy	Code	T1	T2	T3	TREND
Male Condoms	HIV-P7	3	4	1	Towards Then Away
Female Condoms	HIV-P7	1	4	1	Towards Then Away
Private Sector Condoms	HIV-P7	2	3	1	Towards Then Away
Free Public Condoms	HIV-P7	0	3	1	Towards Then Away

In 2006 (T2) in Swaziland, the NSP is entirely in line with the Global Fund policy language. It states that "While a total of 1,275,000 male condoms were distributed in 2000, six million two hundred and eighty six thousand eight hundred (6, 286, 800) were distributed in 2004" (Government of Swaziland, 2006, p. 26) with an objective to "increase the number of available male condoms from 6,286, 800 in 2004 to 10,000,000 by 2008" (Government of Swaziland, 2006, p. 27). This received a score of 4 (out of 4) as is shown in Table 3.3, since the policy does exactly what the Global Fund policy prescribes. The same was true of the female condom policy in Swaziland in 2006: "In 2000, a total of 10,366 female condoms were distributed compared to 19,966 in 2004" (Government of Swaziland, 2006, p. 26) with an objective to "To increase the number of available female condoms from 19,966 in 2004 to 80,000 by 2008" (Government of Swaziland, 2006, p. 27).

In 2009 (T3), the subsequent NSP in Swaziland was much less aligned with Global Fund policy on both male and female condom distribution. The only mention in the policy is that the "The NSF [National Strategic Framework] interventions will continue to increase and expand the availability and distribution of condoms, and focus on promoting increased, consistent and correct use of male and female condoms" (Government of Swaziland, 2009, p. 49).

This shift in condom policy in Swaziland from 2006 to 2009 represents a movement away from the Global Fund objectives since data is no longer included to show distribution levels in the last 12 months.[15]

Table 4.4 Malawi's Condom Policies

Policy	Code	T1	T2	T3	TREND
Male Condoms	HIV-P7	3	3	4	Static Then Towards
Female Condoms	HIV-P7	0	3	4	Towards Then Towards
Private Sector Condoms	HIV-P7	0	2	4	Towards Then Towards
Free Public Condoms	HIV-P7	0	0	4	Static Then Towards

Similarly, in Malawi, private sector and free public condom policy has moved heavily in line with Global Fund policies in the most recent NSP. In 2003, at T2, one note of private sector ones: "Government shall periodically review and revise fiscal and other measures to ensure equitable access to and affordability of socially marketed condoms" (Malawi, 2003, p. 14.). There are no mentions of free public condom policy in the 2003 NSP in Malawi. Then, in 2010, the policy on private sector condoms reads: "# of socially marketed condoms distributed to outlets in the last 12 months (Retail shops, Health facilities)" at baseline 29 million in 2004, going down to 14 million according to most recent numbers (Malawi, 2010, p. 48). This represents heavy alignment with the Global Fund policy requirements. The same is true of Malawi's 2010 free public condom policy, which says "# of (1) free condoms and (2) social marketed condoms distributed to end users in the last 12 months" at 14 million in most recent data, with a target of 17 million in 2012" (Malawi, 2010, p. 48).

In Lesotho, private and public condom policy also witnessed an increased alignment with Global Fund objectives, though not as heavily as Malawi. In 2006, Lesotho's NSP made no mention at all of private or public condom distribution. By 2009, in the updated NSP, language was added to read "Additional condoms are available through commercial outlets including retail shops and pharmacies" and "Condoms are made available for free by government and through social marketing by PSI" (Government of Lesotho, 2009, p. 35).

Testing and Counseling

There are three policies for testing and counseling in this project's framework: (1) "Women and men aged 15–49 years who received an HIV test in the last 12 months and who know

[15] Interview data from Swaziland revealed that this movement away from social and behavioral programming, such as behavior change and condom use, occurred because of the country's increasing prioritization of biomedical policies, such as TB medication and male circumcision. This is connected to pressures by the new Investment Framework to be able to demonstrate tangible results from funding. For more detailed analysis of this change in policy focus, see Chapter 6.

their results (percentage) (HIV-P8a)" (2) "Most-at-risk populations who received an HIV test in the last 12 months and who know their results (percentage) (HIV-P9)" and (3) "Sexually active young women and men aged 15–24 years who received an HIV test in the last 12 months and know their results (percentage) (HIV-P10)" (Global Fund, 2009, p. 72).

In Zambia and Swaziland, the NSPs tend to just focus on policy for testing the general population (women and men aged 15-49), not most-at-risk populations. In Zambia, there has never been any written policy for testing most-at-risk populations or for youth 15-24. However, since 2006, in the last two NSPs, testing for the general population has been a highly aligned policy area with the Global Fund's policies. In the most recent NSP, the policy reads: "Percent of the general population aged 15-49 years receiving HIV test results and post-counselling" (Government of Zambia, 2011, p. 54). Baseline value in 2010 was 1,763,896 with the following targets for the next 5 years 2,887,988 (2011) 3,450,034 (2012) 4,012,081(2013) 4,574,127 (2014) and 5,136,173 (2015) (Government of Zambia, 2011, p. 54). In Swaziland, the case is the same. There have never been policy considerations for testing most-at-risk populations, and there have been minor policy focuses on youth. For instance, in the most recent Swazi NSP the youth testing policy exists just to note that "Provision of counselling and testing for children under the age of 12 years is not well articulated or supported by policy guidelines" (Government of Swaziland, 2009, p. 52).

On the other hand, policy for testing the general population in Swaziland is heavily aligned to the Global Fund policies, just as the case is in Zambia. Swaziland's NSPs have emphasized 15-49 testing at a score of 4 out of 4 for the last two NSPs, the latest one reading: "By 2007, 26.5% (37% women and 17% men) of the population age 15-49 had ever taken a HIV test and had received their results (Government of Swaziland, 2009, p. 57). By contrast - and curiously given President Mugabe's strong stance against homosexual relationships - the Zimbabwean NSP does make greater policy provision for the testing of most-at-risk populations than its neighbors. In its 2011 NSP, Zimbabwe makes note that "The criminalisation of sex among MARPS hinders provision of HIV services because they are hard to reach. These groups operate underground for fear of arrest and victimisation. There is need for a policy to be developed on provision of HIV services to these MARPs given that they contribute a significant proportion of new HIV infections" (Government of Zimbabwe, 2011, p. 91). The NSP also notes that the "% of key affected populations reached with HIV services" (Government of Zimbabwe, 2011, p. 29). There is data for this at 50% and 80% in 2013 and 2015.

Table 4.5 South Africa's Testing and Counseling Policies

Policy	Code	T1	T2	T3	TREND
Testing and Counseling for Women and Men (15-49)	**HIV-P8b**	**2**	**4**	**3**	Towards Then Away
Testing and Counseling for Most-at-risk populations	**HIV-P8b**	**0**	**3**	**2**	Towards Then Away
Testing and Counseling for Young women and men aged 15–24	**HIV-P8b**	**2**	**4**	**2**	Towards Then Away

In South Africa the policy emphasis on testing and counselling, for all three policies, in its NSPs has become less in line with Global Find policies from T2 to T3. For the first policy, on testing for the general population, this represents an expansion of the policy. At T2, in 2007, the policy reads exactly in line with the Global Fund policy: "Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results" (Government of South Africa, 2007, p. 136). And "Around 30% of those aged 15 years and older report ever having tested for HIV in 2005, with a significant proportion having tested for HIV in the past year (e.g. 49.5% of 15-24 year olds)" (Government of South Africa, 2007, p. 136).

Then, in the most recent NSP in 2012, the age bracket is shifted to start targeting children for testing starting at age 12: "A national HCT campaign was introduced in April 2010 with the intent of testing 15 million South Africans, with referrals to continued care. By June 2011 more than 13 million HIV tests had been conducted – a significant increase over previous years, when less than 3 million tests were conducted per annum" (Government of South Africa, 2012, p. 14). The age bracket is "Universal HIV testing and TB screening refers to annual testing and screening of every South African (for HIV – 12 years and older, sexually active, with previous HIV negative test, or of unknown status)" (Government of South Africa, 2012, p. 43). The language becomes less in line with Global Fund policies for most-at-risk populations, too. At T2 the policy reads: "Percentage of most at risk populations that have received an HIV test in the last 12 months and who know their results"(Government of South Africa, 2007, p. 136), which is a direct reflection of the Global Fund policy language (it got a 3 and not a 4 as a score because there was no actual data to go with the policy). Then in 2012 at T3, the policy for most-at-risk populations is less compliant, just noting that "Testing services must also take place at multiple settings to reach all at-risk populations, including homes [...] in workplaces, in schools and tertiary institutions, social grant distribution points, correctional services and through mobile services in communities [...] and for sex workers at sex work venues and locations" (Government of South Africa, 2012, p. 43).

By contrast to South Africa, Namibia's testing policies have become more in line with Global Fund rhetoric, across all three policies, from T2 to T3.

Table 4.6 Namibia's Testing and Counseling Policies

Policy	Code	T1	T2	T3	TREND
Testing and Counseling for Women and Men (15-49)	**HIV-P8b**	**3**	**3**	**4**	Static Then Towards
Testing and Counseling for Most-at-risk populations	**HIV-P8b**	**1**	**0**	**1**	Away Then Towards
Testing and Counseling for Young women and men aged 15–24	**HIV-P8b**	**0**	**0**	**4**	Static Then Static

At T2 in Namibia, in 2004, the policy for testing the general population was that "Counselling and Testing (including routine and voluntary testing)" is #1 under the Prevention strategy (Government of Namibia, 2004, p. 8) with "In 2007 the target population is estimated to be 424,444 people while for 2012 it is 455,723 people based on the 2004 prevalence rate. The coverage in 2005/06 was 25% of the target population. [...] The roll-out of public sector counselling and testing sites to 319 from the 250 in 2006" (Government of Namibia, 2004, p. 11). The only thing missing here is the age bracket, which gets added in 2010 (representing the change in score from a 3 to a 4, in Table 3.6). In 2010, the Namibian NSP says "% of women and men aged 15-49 ever tested for HIV and received their results increased from 51% in 2007 to 80% in 2012/13 and 90% in 2015/16 for women and from 32% in 2007 to 40% in 2012/13 and 75% in FY2015/16 for men" (Government of Namibia, 2010, p. 29), which represents perfect alignment with the Global Fund policy language. Similarly, for the youth testing policy, those 15-24, there is no mention in any Namibian policy until 2010, when it gets included in the NSP. "Among young people 15-24 years, only 31.3% women and 12.9% men had tested and received results 12 months prior to the survey" (Government of Namibia, 2010, p. 27). This also represents perfect Global Fund policy compliance.

The final noteworthy observation is the movement of testing policy in Botswana for most-at-risk populations. In 2003, at T2, most-at-risk populations were a fairly well-aligned policy consideration, which focused on "Targeting vulnerable groups with behaviour change interventions and promotion of voluntary counselling and testing services" (Government of Botswana, 2003, p. 55). Additionally, HIV testing is listed as a policy under MARPS such as "Mobile populations (Commercial Sex Workers (CSWs), Truck drivers)" (Government of Botswana, 2003, p. 33). Then, in 2010, this language is removed from the NSP. The focus instead seems to be on the general population, with this policy moving closer in line with the

Global Fund policy language. In 2010 the general population language received a score of 4 out of 4: "Proportion of persons aged 15-49 years who have tested within the last 12 months and know their HIV status" Baseline 41.2% in 2008 (Government of Botswana, 2010, p. 37).

Prevention of Mother-to-Child Transmission (PMTCT)

The Global Fund 2009 M&E Toolkit policies for Prevention of Mother-to-Child Transmission (PMTCT) are fourfold: (1) "Pregnant women who were tested for HIV and who know their results (percentage) (HIV-P11)", (2) "HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (percentage) (HIV-P12)", (3) "Infants born to HIV-infected women who receive an HIV test within 12 months of birth (percentage) [disaggregated into virological testing at <2 months or 2–12 months or antibody testing at 9–12 months] (HIV-P13)" and (4) "Infants born to HIV-infected women starting on co-trimoxazole prophylaxis within 2 months of birth (percentage) (HIV-P14)" (Global Fund, 2009, p. 73). For policies on PMTCT, most agree that when the science is clear on the benefits of the intervention then action should be taken to implement it. However, different countries still take different approaches in terms of how they incorporate Global Fund policies on PMTCT into domestic National Strategic Plans.

Table 4.7 Lesotho's PMTCT Policies

Policy	Code	T1	T2	T3	TREND
Pregnant women who were tested for HIV and who know their results	**HIV-P11**	**2**	**3**	**4**	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	**HIV-P12**	**0**	**3**	**4**	Towards Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	**HIV-P13**	**0**	**0**	**3**	Static Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	**HIV-P14**	**0**	**0**	**4**	Static Then Towards

In Lesotho, both testing for pregnant women and antiretroviral treatment for positive mothers have steadily become well-aligned policies with Global Fund policies. In the most recent NSP, in 2009, the language for both these policies scored 4 out of 4, reflection perfect policy compliance. The policy includes language on the "Proportion of women attending ANC offered quality testing and counselling for HIV is increased from 91% in 2007 to 100% in 2011" (Government of Lesotho, 2009, p. 34). Additionally, "Among the key services being offered is counselling and testing for PMTCT" (Government of Lesotho, 2009, p. 37). Similarly, for ARV treatment for HIV-positive pregnant women, the policy is equally comprehensive: "In 2007, the number of pregnant HIV positive women who received anti-

retroviral treatment to prevent mother to child transmission (PMTCT) was estimated to be 3966. Available data indicate that PMTCT coverage increased from an estimated 5% in 2005 to 56% in 2009. Antenatal care, post natal care (PNC) and PMTCT were being offered in 19 hospitals and 116 health centres out of 167 public health facilities" (Government of Lesotho, 2009, p. 25). The goal is to get to "80% by 2011" (Government of Lesotho, 2009, p. 11). The policy for infant ARV treatment is also very heavily aligned with Global Fund language at T3: "The % of HIV positive pregnant women and infants who receive a complete course of ART [antiretroviral therapy] prophylaxis to reduce the risk of MTCT is increased from 56% (2008) to 80% by 2011" (Government of Lesotho, 2009, p. 11). Additionally, "The ART prophylaxis is given to [...] infants during the first weeks of life" (Government of Lesotho, 2009, p. 34). Malawi has also increased in its policy compliance with Global Fund PMTCT Policies, though not quite as heavily as Lesotho has.

Table 4.8 Namibia's PMTCT Policies

Policy	Code	T1	T2	T3	TREND
Pregnant women who were tested for HIV and who know their results	HIV-P11	1	3	4	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	1	4	4	Towards Then Static
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	2	0	4	Away Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	1	3	4	Towards Then Towards

In Namibia, the 2010 NSP received scores of 4 out of 4, across all of the PMTCT policies, representing movement towards Global Fund policy compliance in all areas. In Namibia, the 2010-2015 (T3) NSP notes that "Approximately 67% of pregnant women had also been counselled and tested during antenatal clinics," (Government of Namibia, 2010, p. 27), "During January to December 2008, 7,474 (63%) of HIV positive mothers received ARVs for prevention of infections of the child" (Government of Namibia, 2010, p. 44) and "% of babies of HIV positive pregnant mothers receiving Cotimoxazole increased to 75% by 2012/13 and to 90% by 2015/16" (Government of Namibia, 2010, p. 46). The NSP also makes reference to infant testing: "As part of strengthening the PMTCT programme, Namibia introduced HIV DNA [deoxyribonucleic acid] PCR [polymerase chain reaction] in 2005 for early infant diagnosis of HIV from as early as 6 weeks. By March 2009, 202 health facilities were collecting and submitting Dried Blood Spot specimens for HIV PCR DNA test to the Namibia Institute of Pathology (NIP). A total of 13,067 babies were tested using PCR from January 2006 to March 2008" (Government of Namibia, 2010, p. 44).

In Zambia, the PMTCT policies at T3 are almost as compliant as Namibia's, except for the policy on testing pregnant women, which while heavily aligned at T2, received no mention at T3. However, Zambia's 2011 NSP does have heavily aligned policy on treatment for HIV-positive pregnant women: "Percent of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT" (Government of Zambia, 2011, p. 63) at baseline 61% with 85% and 95% targets for midterm and 2015 respectively. There is also data on total numbers: "53,588" at baseline 2010 (Government of Zambia, 2011, p. 62). It is also very compliant in terms of testing infants: "Annual no. of exposed infants (0-1 year) new infection [at] 11,782 baseline 2010" (Government of Zambia, 2011, p. 67). The same is true for treatment of infected infants: "Increased proportion of exposed infants who receive efficacious and complete ARV prophylaxis from 36% to 90%" (Government of Zambia, 2011, p. 40).

Post-Exposure Prophylaxis (PEP)

The Global Fund policy for PEP reads "Health facilities with post-exposure prophylaxis available (percentage) (HIV-P15)" (Global Fund, 2009, p. 73). The Global Fund rational for PEP, is also made explicit:

> [P]ost-exposure prophylaxis (PEP) reduces the probability of HIV infection after exposure to potentially HIV-infected blood or body fluids. For maximum effectiveness, PEP should be provided within hours after exposure. PEP may be provided following occupational exposure (for example, in health care facilities) or non-occupational exposure (such as after sexual assault). Within the health sector, PEP should be provided as part of a comprehensive standard precautions package that reduces staff and patient exposure to infectious hazards in health care settings (Global Fund, 2009, p. 73).

Most countries in this study have moved their policy language in line with the Global Fund policies over time. Lesotho, Swaziland, Zambia and Zimbabwe went from scoring a 0 at T1, to a 4 at T3.

Table 4.9 Zambia's PEP Policy

Policy	Code	T1	T2	T3	TREND
Health facilities with post-exposure prophylaxis available	HIV-P15	0	3	4	Towards Then Towards

In Zambia, the policy on PEP was non-existent at T1, in 2001, then at T3 in 2011, the policy reads: "Increased uptake of PEP services by survivors of sexual and gender-based violence" (Government of Zambia, 2011, p. 39) and "Provide PEP for health care workers and victims

of sexual abuse" (Government of Zambia, 2011, p. 40), with "Percentage of health facilities providing PEP services" at 15% in baseline 2008 (Government of Zambia, 2011, p. 69). Similarly, in Swaziland there was no mention of PEP at T1 in 2009 the NSP reads: "% of people reporting to be in need of PEP and have received PEP services as per national guidelines is increased to 50% in 2011 and 80% by 2014." Additionally, "PEP registers from the 22 health facilities which provide PEP services showed that 432 clients accessed PEP in 2007" (Government of Zambia, 2011, p. 69). Lesotho's most recent NSP in 2009 also makes note that its baseline PEP service provision is at 10% with a goal to have "All health facilities providing ART and PMTCT are providing PEP and Universal Precautions services by 2011" (Government of Lesotho, 2009, p. 43). The leap from T2 to T3 in Zimbabwe is also a interesting observation. In 2006, there is just one minor mention or PEP: "Post Exposure prophylaxis (PEP) will be made available for victims of sexual and gender-based violence" (Government of Zimbabwe, 2006, p. 17). Then, in 2011 the language moves very directly in line with the Global Fund policy language to say: "The percentage of health facilities providing post exposure prophylaxis (PEP) increased from 7.8% (122) to 100% (1560) by 2015" (Government of Zimbabwe, 2011, p. 45).

PEP remains a very absent policy in Botswana's NSPs, with the only mention in any of its national policies being this one line at T3 in 2010: "Scale-up the provision of PEP services" (Government of Botswana, 2010, p. 21).

South Africa is the only country to mention PEP in its T1 NSP, in 2000. Here, the policy language received 2 out of 4, as it was moderately aligned with the Global Fund policies. The 2000 policy says it aims to "Develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault" with a strategy to "a) Develop criminal law mechanisms which protect the rights of victims of sexual violence b) Investigate the provision of PEP to the victims of sexual violence" (Government of South Africa, 2000, p. 25). However, earlier in the document it says "Developing other national policies including, the Syndromic Management of STDs [sexually transmitted diseases] and post exposure prophylaxis (PEP) following occupational exposure to HIV" (Government of South Africa, 2000, p. 11), indicating this policy may be more directed at health care workers. This becomes even more compliant at T2 in South Africa, where the 2007 policy receives a score of 4, for very heavy Global Fund compliance (data included): "Increase the accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support"

(Government of South Africa, 2000, p. 11). And, "The availability of post exposure prophylaxis (PEP) services has also improved during the NSP 2000-2005. Policies are available; and the number of sites and drug availability has improved since 2000" (Government of South Africa, 2007, p. 47). Also, "Increase the proportion of facilities providing post sexual assault care that offer PEP to all survivors testing HIV negative" at 30% 50% 60% 70% 90% over the next 5 years (Government of South Africa, 2007, p. 73). Then, curiously, in the 2012 NSP there is just one line on PEP: "Number of survivors of sexual assault/abuse receiving PEP within 72 hours" (Government of South Africa, 2012, p. 45), where the data is no longer expressed as a percentage of total facilities as it was at T2, and as the Global Fund policy prescribes.

Sexually Transmitted Infections

The policy for Sexually Transmitted Infections in the Global Fund's 2009 M&E Toolkit is: "Cases of sexually transmitted infections treated (number) (HIV-P16)" (Global Fund, 2009, p. 73). The Global Fund's policy toolkit notes how:

> [S]imilar types of behavior put people at risk for both sexually transmitted infections and HIV. People with sexually transmitted infections may be at higher risk of acquiring or transmitting HIV infection due to the co-factor effect of an existing sexually transmitted infection. Services for sexually transmitted infections provide opportunities for comprehensive care that includes early treatment; counseling and communication about behavior change and information for sexual partners; access to testing for HIV infection; and an entry point into care programs for people living with HIV. Treating sexually transmitted infections quickly and effectively reduces the possibility of further transmission of infection (Global Fund, 2009, p. 106).

For most of the countries in this study, treatment of sexually transmitted infections has been a heavily aligned policy from T1. In Swaziland and Namibia, NSP policies on treatment of sexually transmitted infections received a score of 3 out or 4 for Global Fund policy compliance for T1, T2 and T3. Lesotho, South Africa, Malawi and Zimbabwe have all increased the compliance of their policies on sexually transmitted infections with the Global Fund policy language, though their initial scores were not very discordant to begin with. The only difference, for most of them, is the inclusion of data at T3. In Malawi, at T1, the 2000-2004 NSP language aims to "Procure and equitably distribute adequate STI drugs and condoms to all health institutions, […] train health workers in counseling and syndromic management of STI's at all levels of health institutions,[…] adopt and strengthen syndromic management of STI in all health institutions [and] Institute routine STI screening and

treatment in antenatal women in central and district hospitals" (Government of Malawi, 2000, p. 47). The difference from this, to the 2010-2012 policy is really just the inclusion of numbers, where STI management is in the resource needs budget, and there is some money (up to US$ 0.8 million) specified for them (Page 50) and "% of patients with STI [sexually transmitted infections], who are diagnosed, treated and counselled at health care facilities according to national guidelines" at 36% in 2004, 90% according to most recent data, and 90% goal for 2012 (Government of Malawi, 2010, p. 7).

The compliance for STI policy in two countries – Zambia and Botswana – did, however, diverge from Global Fund policy language from T2 to T3. Unlike the other six countries were data inclusions occurred at T3, in Zambia, there was data at T2 and then do data at T3. In 2006, the Zambian NSP makes note of the "% of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines at 10% (2005), 30% (2007) 50% (2009/2010)" (Government of Zambia, 2006, p. 58). Then, in 2011, the policy is strictly narrative, without data. There is language that aims to calculate the "Percent of clients with STIs who report having been diagnosed, treated and counselled according to national guidelines" (Government of Zambia, 2011, p. 34), but no data reported to go with it. There is also mention in the policy that "Various interventions have been put into place to reduce sexually transmitted infections" (Government of Zambia, 2011, p. 37).

Perhaps most intriguing is Botswana, where sexually transmitted infections have decreased in emphasis in the NSPs from T1 to T2 to T3. At T1, Botswana's 1993 policy makes strong mention of "The control of STDs [and] STD prevention and care" (Government of Botswana, 1993, p. 7). At T2, this is less focused, just speaking about sex workers, truck drivers and data collection (Government of Botswana, 2003, p. 33 & p. 60). Lastly, at T3 in Botswana's 2010 NSP there is no mention of sexually transmitted infections as a policy focus area.

Blood Safety

The Global Fund M&E Toolkit prioritizes the policy of"Donated blood units screened for HIV in a quality assured manner (percentage) (HIV-P17)" (Global Fund, 2009, p. 73).

South Africa and Botswana hardly make mention of this policy at T3, while they were heavily compliant before. In Botswana, in 2010, the policy just makes one reference to blood safely, calling it a "standardized formula" that needs redressing (Government of Botswana, 2010, p. 20). In South Africa, there is no mention of this policy in its 2012 NSP. Perhaps this is because blood safety protocol has become such common practice in these countries, so they no longer feel the need to include it in their national policy documents.

Malawi, Lesotho, Swaziland, Namibia, Zambia and Zimbabwe all scored 4 out of 4 at T3 for this policy, with little discrepancy in the way this policy lines up with the Global Fund policy. As far as AIDS policies go, blood screening carries little political or bio-medical disagreement, so it would make sense for countries to all be similarly aligned with this policy.

Treatment

This project's framework has adopted three treatment policies from the Global Fund's 2009 M&E Toolkit: (1) "Adults and children with advanced HIV infection (currently) receiving antiretroviral therapy (percentage) (HIV-T1)", (2) "Health facilities that offer antiretroviral therapy (prescribe and/or provide clinical follow-up) (percentage) (HIV-T2)" and (3) "Facilities providing antiretroviral therapy using CD4 monitoring in accordance with national guidelines or policies, on site or through referral (percentage) (HIV-T4)" (Global Fund, 2009, p. 73). The Global Fund 2009 M&E Toolkit has two other treatment policies, one on stock outs and the other on picking up medicines in time. These were less policy-related, so were omitted from this project's framework.

In similar fashion to the sexually transmitted infection and blood safety policies, Botswana also diverges from treatment policies post-2008. In fact, it is the only country to do so, out of the countries examined in this study. At T2, Botswana's policy says it will endeavour to "Increase the productivity of People Living with HIV/AIDS receiving Anti-Retroviral Therapy" (Government of Botswana, 2003, p. 101) and it measured and "Number of people with advanced HIV infection eligible for therapy and receiving HAART [highly active antiretroviral therapy] in last 12 months" at 8000 in baseline 2002 (Government of Botswana, 2003, p. 25). Then, in 2010 at T3, Botswana's subsequent NSP says "ARV Therapy is one of the significant programmes" (Government of Botswana, 2010, p. 10). Additionally, the policy says it will "Increase demand and provision of quality HIV Testing and Counselling services"

(Government of Botswana, 2010, p. 21). It also notes the "Proportion of HIV+ children and adolescents accessing a package of HIV/AIDS treatment, care and support" at baseline 22% in 2009 (Government of Botswana, 2010, p. 40). This represents a departure from the Global Fund M&E policy, since the T3 policy language lumps treatment in with care and support, while at T2 the data is strictly treatment-related. Additionally, it only seems to speak about treatment for children and teens, not the total number of people (adults and children) and the policy prescribes.

For the second treatment policy – health facilities providing antiretroviral therapy – Malawi, Swaziland and Zambia have moved their NSPs very strongly in line with this policy. In Malawi's 2000 and 2003 NSPs, there was no mention of the number of health facilities that provided these services, then, in the 2010-2012 NSP, the policy is clearly aligned with the Global Fund's M&E priorities, with a clear policy around the "% of health facilities with drugs in stock and no stock outs of more than 1 week" at 100% for ARVs (Government of Malawi, 2010, p. 48). Similarly, in Swaziland, the policy of health facilities with treatment available was not very heavily emphasized at T1, with the NSP just mentioning "Under the Care, Support, Treatment and Counselling Strategy, they mention an aim to "Strengthen the management of drugs and medical supplies" and to "Subsidise drugs" (Government of Swaziland, 2000, p. 28). Then, this policy language moves very much towards the Global Fund requirements by T3, in 2009, the policy states that "The number of facilities providing ART increased from 17 in 2005 to 29 public and private facilities in 2008. In addition, 40 outreach sites were established and serviced by personnel from the 29 sites" (Government of Swaziland, 2009, p. 59).

Lastly, in Zambia, the alignment of this policy with the Global Fund policy went from scoring a 1 at T2, to a 3 at T2 to a 4 at T3. At T1, in Zambia, in 2001, the policy does not mention the idea of health facilities carrying treatment, (hardly at all outside of PMTCT), but there are budget considerations for highly active antiretroviral therapy (Government of Zambia, 2001, p. 52). Then, at T2 in 2006, there is a Strategic Objective to "Provide Universal Access to ART including access to CCT [confidential counseling and testing] at all treatment centres" (Government of Zambia, 2006, p. 27) with a policy of "# of public and private health facilities providing ART services" (Government of Zambia, 2006, p. 61). However, there is no data reported. Finally, at T3 in 2011, Zambia's policy on health facility antiretroviral provision is fully in line with the Global Fund policy (Scoring 4 out or 4),

reading "The number of ART service centres for both private and public sectors increased from 107 in 2005 to 355 by March 2008. All the 72 districts continue to provide ART services" (Government of Zambia, 2006, p. 61) and "Percentage of health facilities providing ART" at 29% in baseline 2009, with 31% midterm goal and 35% for 2015 (Government of Zambia, 2006, p. 61).

The third treatment policy – facilities providing CD4 monitoring - South African and Zimbabwe are the only two countries which are heavily compliant with this M&E objective at T3. South Africa's 2012 NSP says that "Currently, all public health care facilities in South Africa provide antenatal care and CD4 testing services out of which 65% offer ARV prophylaxis for PMTCT on site" (Government of South Africa, 2012, p. 24). It also says that "Point of care tests for TB, HIV and CD4 should be available in every health facility by 2016 (dependent on available appropriate technology)" (Government of South Africa, 2012, p. 42). Likewise, in Zimbabwe, while no mention of CD4 was present at T1 or T2, at T3 the policy states that the "Number of labs with capacity to run CD4 cell counts" at 74 baseline, with 85, 95, 105, 115 and 126 targets for 2011 to 2015" (Government of Zimbabwe 2011, p. 49).

Care and Support

This project's framework has adopted three treatment policies from the Global Fund's 2009 M&E Toolkit: (1) "Adults and children enrolled in HIV care and eligible for co-trimoxazole prophylaxis (according to national guidelines) currently receiving co-trimoxazole prophylaxis (number and percentage) (HIV-CS1)*"* (2) "Adults and children living with HIV who receive care and support services outside facilities (number) (HIVCS2)" and (3) "Orphaned and vulnerable children aged 0–17 years whose households received free basic external support in caring for the child (percentage) (HIV-CS3)" (Global Fund, 2009, p. 74).

Zambia, South Africa, Botswana and Zimbabwe have all moved their most recent NSP policy language away from the Global Fund's M&E policy on treatment for opportunistic infections (co-trimoxazole prophylaxis). At T2 in South Africa the 2007 policy notes an aim to "Increase percentage of TB/HIV co-infected adults receiving cotrimoxazole" at 20%, 25%, 40%, 65% and 80% across the next 5 years (Government of South Africa, 2007, p. 87). There are two other mentions of this policy as well (Government of South Africa, 2007, p. 99 & 100). Then, at T3, the policy language is less in line with the policy, mentioning a goal for "Expanded access to opportunistic infection medication, such as gancyclovir and macrolides,

needs to be made available at primary care" (Government of South Africa, 2012, p. 50). Even more so, in Botswana at T2 the 2003 policy was very heavily in line with the Global Fund's M&E objective for opportunistic infections: "Objective 2.3: Increase the number of skills of health workers (doctors and nurses) providing accurate diagnosis and treatment of opportunistic infections by 40% by 2009" (Government of Botswana, 2003, p. 101). Additionally, the "Number of Health personnel trained in the proper diagnosis and treatment of opportunistic infections is 590 in 2002 baseline" (Government of Botswana, 2003, p. 25). In 2010, at T3 in Botswana, there is no mention of policy for opportunistic infections at all. This is a significant shift in policy compliance with Global Fund policies.

While Botswana has moved many of its policies away from an policy-based format since 2008, its alignment with home-based care policies has always been heavily congruent with the Global Fund's M&E Toolkit. At T2, Botswana's 2003 NSP says Goal 2 is the "Provision of Treatment, Care and Support, and "Percent of households receiving home based care and support for PLWA" is 57% in baseline 2002 (Government of Botswana, 2003, p. 25). In 2010, at T3, the alignment with the Global Fund policy has not wavered: "Proportion of HIV+ children and adolescents accessing a package of HIV/AIDS treatment, care and support" at baseline 22% in 2009 (Government of Botswana, 2010, p. 40).

Table 4.10 Swaziland's Home-Based Care Policy

Policy	Code	T1	T2	T3	TREND
Adults and children living with HIV who receive care and support services outside facilities	HIV-C52	1	2	4	Towards Then Towards

In Swaziland, the NSP policy on home-based care increases in its compliance with the Global Fund policy from T1 to T2 to T3 (Table 3.11). At T1 there is a slight mention in the 2000 policy to "Promote and engage communities and families in the caring and support of those infected and affected by HIV/AIDS" (Government of Swaziland, 2000, p. 71) but most of the care and support language it within ministries of companies: "Ensure the existence of care and support services within the respective works, transport and communication companies" (Government of Swaziland, 2000, p. 75). However, when compared to T3, the move to align with Global Fund M&E framework is clear: "There were 5,443 home based care clients of whom 40% were men and 60% women by the end of first quarter 2008" (Government of Swaziland, 2009, p. 63).

For the policy on orphans and vulnerable children policy, Zambia, Lesotho and Botswana have aligned their most recent NSPs at a score of 4 out of 4 with the Global Fund M&E language. Lesotho's T3 NSP says "This has been achieved by making primary education free, providing bursaries and supporting OVC with education needs such as books and uniforms. By 2008, 32% of OVC were receiving free basic support" (Government of Lesotho, 2009, p. 26).Similarly, Zambia's NSP at T3 states that "Approximately 19.1% of the estimated 1.3 million orphans and vulnerable children (OVC) in Zambia receive external basic assistance" (Government of Zambia, 2011, p. 22) and "Percentage of OVC whose households received free basic external support in caring for the child (disaggregated by wealth quintile)" at 53.2% in baseline 2007 with 10 and 15% more respectively for the 2 lowest quintiles at midterm and again by 2015 (Government of Zambia, 2011, p. 67).

In South Africa, however, the alignment for this policy has decreased from T2 to T3. In 2007, at T2 in South Africa, the policy was that the "Percentage of Orphaned and Vulnerable Children (boy/girl) aged 0-17 whose household have received a basic external support in caring for the child"(Government of South Africa, 2007, p. 138) and "The second most expensive programme (7% of the total) relates to the support of orphans and vulnerable children thus emphasizing the importance of safeguarding families through delaying maternal and paternal mortality" (Government of South Africa, 2007, p. 140). In 2012, at T3, this language is much less rigid in terms of the policy, noting only that "The rising numbers of orphans and vulnerable children and youth need a comprehensive package of services to enable smooth transition to adulthood" (Government of South Africa, 2012, p. 75).

Collaborative Activities

While the Global Fund's 2009 M&E Toolkit has four TB/HIV collaboration policies, this project only uses one. The other three are heavily outcome based, and less policy-related. The policy that this project uses is **"**Adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting period (number and percentage) (TB/HIV-1)" (Global Fund, 2009, p. 74).The most interesting result of the collaborative activities policy comes out of the South African policies. At T2, the 2007 had a quite an aligned objective with the Global Fund's HIV/TB policy above, suggesting that it would "Integrate sexual & reproductive health services and HIV prevention guidelines and programmes into family planning, ANC [anti-

natal care], STI, TB, ARV treatment services and vise versa in the public and private sector" at 30%, 40%, 60%, 70% and 80% of services over the next 5 years (Government of South Africa, 2007, p. 70). However, at T3 in 2012, the NSP switched the 'integration' language, saying that "Critical is the integration of services, ensuring all HIV positive people know their TB status and vice versa" (Government of South Africa 2012, p. 29). Also, there is also a priority to "the development of innovative new approaches for the prevention, diagnosis, treatment and care, and mitigation of the impact of HIV, STIs and TB either singly or in combination" (Government of South Africa 2012, p. 86). The notion that these policy areas can be carried out separately (singly) is certainly a departure from the previous policy language, and from the Global Fund policy language. This is especially intriguing since the 2012 NSP in South Africa is the first HIV/TB combined NSP.

Supportive Environment

The Global Fund's 2009 M&E Toolkit has three policies which focus on Supportive Environments, all three of which are also adopted into this project's framework: (1) "National Composite Policy Index (HIV-SE1)", (2) "Enterprises implementing an HIV workplace program (number and percentage) (HIV-SE2)" and (3) "Municipalities with at least one human rights network functioning (number and percentage) (HIV-SE3)".

Table 4.11 Botswana's Supportive Environment Policies

Policy	Code	T1	T2	T3	TREND
NCPI	HIV-SE1	0	4	0	Towards Then Away
Enterprises implementing an HIV workplace program	HIV-SE2	4	4	2	Static Then Away
Reducing Stigma	HIV-SE3	2	3	2	Towards Then Away

For these three policies, Botswana has decreased its alignment across all of them. At T2, Botswana's 2003 NSP says it endeavors to "Develop and implement internal workplace programmes in all public and Private Sector institutions, including human resource management components (recruitment, retraining and re-engagement) and monitoring and reporting mechanisms for measuring absenteeism, sickness and death from HIV/AIDS" (Government of Botswana, 2003, p. 27). Additionally, it is mentioned heavily throughout the whole policy. Then, in 2010, the only line that speaks to workplace programs is to "Developing and implement HIV and AIDS specific workplace interventions" (Government of Botswana, 2010, p. 32).

At T2 and T3 in Zambia, the 2006 scored 4 out of 4 for its workplace policy compliance with Global Fund policy language. The NSP says notes the "Percent of workplaces with HIV/AIDS policies and programmes [based on the WORKPLACE BASED SURVEY] is at 80%" (Government of Zambia 2006, p. 7). There is also mention in the policy of the "# of workplaces, including line ministries, with developed workplace policies and programmes for HIV/AID" and "# of employees reached through workplace programmes" (Government of Zambia 2006, p. 58). The 2011 policy at T3 is similarly compliant, documenting the "% of public and private enterprise with workplace policies and programmes" with goals of Public - 95% Private – 50% at midterm, and Public – 95% Private – 60% by 2015 (Government of Zambia 2011, p. 73). Also, "Data from the Companies' Directories (NAC, 2008) indicate that the number of companies with written HIV and AIDS workplace policies increased to 101 in 2008 from 560 in 2007" (Government of Zambia 2011, p. 25). These two policies are in sharp contrast with Zambia's T1 NSP, which in 2001 just notes that "A number of companies have developed prevention and support programmes in the workplace. One example is the prevention and counseling programme set up by Barclays Bank for its staff members. Several other companied have initiative at varying stages of development. In the government sector, point persons were identified in each ministry with a view to coordinate HIV/AIDS programmes in their respective ministries" (Government of Zambia 2001, p. 17). There are no data reported to go with this policy and no disaggregation between the public and private sector.

Outcome Policies

The Outcome Policies section in the Global Fund 2009 M&E Toolkit is very 'outcome' heavy, as one might imagine. However, there are four outcome policies that this project deemed policy-relevant: (1) "Young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years (percentage) (HIV-O1)", (2) "Women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months (percentage) (HIV-O3)", (3) "Injecting drug users reporting the use of sterile injecting equipment the last time they injected (percentage) (HIV-O8)" and (4) "Current school attendance among orphans and among non-orphans (percentage) (HIV-O9)" (Global Fund, 2009, p. 75).

The T3 NSPs from Namibia, Malawi and Swaziland have all become more aligned, for all of these Outcome Policies, except injecting equipment which remains at a score of 0 in all three

countries. At T2 in Malawi the abstinence policy (young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years) reads "Government and partners shall ensure that all counsellors, including career, traditional and faith based counsellors, are trained to offer counselling to youth on ways of protecting themselves from early sex" (Government of Malawi, 2003, p. 21). At T3, this policy moves much more closely in line with the Global Fund M&E policy. In 2010, the T3 policy has age brackets and data to go with the NSP objective: "Several strategies and plans have been developed, including the National HIV Prevention Strategy, and technical strategies for Abstinence" (Government of Malawi, 2010, p. 24) and "Median age at first sex among 15-24 year olds is 15 yr males, 15 yr females in 2004, 18.1 yr males and 17.4 year for females at the most recent baseline, 19.0 yrs and 18.0 yrs goal in 2010 and 19.5 yrs, 18.5 yrs goal in 2012" (Government of Malawi, 2010, p. 47). This policy at T3 scores a 3 out of 4 for compliance, since it is measuring the average age at first sex, and no the percentage of youth who have sex before the age of 15. An example of a perfectly compliant policy with the Global Fund abstinence policy can be seen at T3 in Swaziland. In this 2009 NSP, the policy language is exactly in line with the policy prescription: "Young men and women wait longer before having sex (delay sexual debut): % of young women and men aged 15-24 years who had sexual intercourse before age 15 years is reduced from 6.9% in 2007 to 6% in 2011 and 3.5% for women by 2014 and from 4.8% in 2007 to 4% in 2011 and 2.5% for men by 2014" (Government of Swaziland, 2009, p. 43).

Unlike these three countries, Lesotho has become more aligned across all four, *including* injecting equipment. This is a rare case for Southern Africa, with most countries electing not to comply with that specific Global Fund policy. However, in Lesotho, at T3 (not before that), the NSP says "Further the universal precautionary measures which include the use of gloves [...] and use of properly sterilised and injecting and other skin-piercing instruments as well as their none-reuse, safe disposal should be provided to minimise the risk of acquiring HIV from work" (Government of Lesotho, 2009, p. 42). Now, this may be in a medical context and not for drug users, per se, but it is still a policy consideration that stands out from its neighbours in terms of compliance.

Botswana's most recent NSP is also very compliant with the Global Fund's M&E policies on abstinence and faithfulness. While faithfulness has always been a heavily aligned policy in the country (scoring 4 out of 4 at T1, T2 and T3), the abstinence policy has become

increasingly congruent, moving from a 0 at T1, to a 3 at T2 to a 4 at T3. At T3, in Botswana 2010 NSP "Adolescent and intergenerational sex" (Government of Botswana, 2010, p. 8) is identified as one of the drivers of the epidemic. Also, ""Scale up comprehensive gender-sensitive HIV and AIDS knowledge [...] abstinence programmes" (Government of Botswana, 2010, p. 21). Additionally, "55% of the total population was initiated to sexual intercourse by 19 years of age and around 8% had have sex by age 15" (Government of Botswana, 2010, p. 11). Similarly, for the Global Fund's Multiple Concurrent Partnerships (faithfulness) policy, Botswana's 2010 NSP identifies "Multiple and concurrent sexual partnerships" (Government of Botswana, 2010, p. 8) as one of the drivers of the epidemic. It is also detailed on Page 11. "Scale up interventions for reduction of multiple and concurrent sexual partnerships" is under 3.1.4 of implementation strategies (Government of Botswana, 2010, p. 21). They do track "Proportion of males and females who engage in MCP" at baseline 11.2% in 2008 (Government of Botswana, 2010, p. 37).

Both Swaziland and Botswana are very strongly aligned with these outcome policies, which are linked to behavioral policies. This may partly explain their large drops in incidence in the last few years, an inference that will be discussed in more detail in Part II of this dissertation.

Concluding Remarks

It is clear that the specific written policies, across all six Global Fund policy categories, vary greatly from country to country, as well as from policy to policy over time in one country. These shifts are minor in some cases, and quite significant in others. But how can they be explained and what are their consequences? While the individual background and orientation of the policy writer is certainly relevant, the broader structural and contextual factors in a country are also closely related to the way policies get written.

The next chapter analyzes these structural and institutional variables and investigates the degree to which these contextual factors can act as predictors or explanations for the ways in which HIV/AIDS policies are written in Southern Africa.

Chapter Five

Exploring the Causes of HIV/AIDS Policy

"Contextual variables and AIDS-related polices must be seriously addressed if we are to bring about effective HIV-risk reduction, and work on these broad structural factors should therefore be understood as centrally important in order to contextualize and design relevant interventions" (Parker et al., 2000, p. S29).

Introduction

Is it clear from previous two chapters that high-prevalence Southern African countries can sometimes take different policy approaches to HIV/AIDS, despite being confronted with very similar epidemics. How can this be explained? In many ways, HIV/AIDS might be better observed as a political challenge, rather than a public health issue. There is a wide literature that suggests structural and institutional factors affect the way an HIV epidemic looks and how policy is developed to combat it (Altman & Buse, 2012; Butler, 2005; Dinkelman, Lam & Leibbrandt, 2007; Epstein, 2007; Halperin et al., 2011, Lieberman, 2011; Menon-Johansson, 2005; Nattrass, 2012; Parkhurst, 2011; Patterson, 2006). These popular explanations for HIV policy-making include a host of variables to do with government, civil society, economic strength, financial priorities, and more.

The objective in this chapter is to use my data on HIV policy and policy change to perform a tentative initial investigation to see if the available evidence corroborates or challenges current thinking on the structural and institutional factors of HIV/AIDS policy-making. In putting arguments to the initial test, I explore two key sets of explanatory variables: (1) economic structural variables, such as a country's overall wealth and spending; and (2) political institutional variables, such as the level of democracy and corruption.

Causes of HIV/AIDS Policy

The table below presents the correlations of all the variables I examined. Here, it is clear that some variables explain policy compliance very well, whereas others do not. These relationships will be unpacked further in the following sections.

Table 5.1 Correlation between HIV/AIDS Policy Compliance (post-2008) and Structural and Institutional Variables

Variable	Correlation[16]
Structural Economic Variables	
GNI per capita	*r* = -0.55
GDP (Billions)	*r* = -0.28
GDP per capita	*r* = -0.52
Net ODA	*r* = 0.30
Net ODA per capita	*r* = -0.13
Domestic Public Spending on HIV	*r* = -0.41
Health Expenditure (Total)	*r* = -0.64
Health Expenditure per Capita	*r* = -0.73*
% of Funding Made up by the Global Fund/UN	*r* = 0.54
Institutional Political Variables	
Age of National AIDS Council	*r* = -0.30
Government Effectiveness	*r* = -0.29
Voice and Accountability	*r* = -0.17
Political Stability	*r* = -0.11
Regulatory Quality	*r* = -0.28
Rule of Law	*r* = -0.18
Control of Corruption	*r* = -0.28
Freedom	*r* = -0.05
Corruption Perceptions Index	*r* = -0.52
Year of Colonial Independence	*r* = -0.47
% of Country Coordinating Mechanism Made up of made up of NGOs and Bi-Laterals /Multi-laterals	*r* = 0.67

* Correlation is significant at the 0.1 level (2-tailed).

[16] Pearson's *r* correlations revealed significant results ($p < 0.1$) for just one of the indicators measured in Table 5.1: Health Expenditure per capita ($p = 0.062$). This is likely due to the small n number in this study, as well as missing data for some indicators. However, some relationships have p values that are approaching significance. These moderately significant relationships include GNI per capita ($p = 0.162$), GDP per capita ($p = 0.189$), Health Expenditure (Total) ($p = 0.122$), % of Funding Made up by the Global Fund/UN ($p = -.164$) and Corruption Perceptions Index ($p = 0.182$).

Economic Variables

The first set of variables that I examine have to do with a country's economic situation. These include indicators of overall wealth (such as gross national product per capita, gross domestic product per capita, government revenue, etc.) and spending or budgetary patterns (such as resource allocations for health and donor funding).

My hypothesis turned out to be largely true with indicators such as Gross National Income (GNI) per capita, where richer countries are more likely to diverge from Global Fund policy preferences in favour of locally-informed HIV/AIDS strategies. The correlation coefficient for this relationship is r = -0.55. This relationship is also approaching significance, with a p value of p = 0.162. Further, it is not just the trends that we see that are significant, but sometimes the trends that we do not (Figure 5.1). In this instance, there are many poorer countries that comply relatively strongly with Global Fund policies, a couple richer countries that do (although South Africa has moved away from this adherence since 2008), and one rich country that does not. However, the shaded area in Figure 5.1 shows, among this collection of countries, there are *no* poor countries that fail to align their NSPs with Global Fund policy preferences. Perhaps there is a threshold of wealth (>$4000/GNI capita) that a country must reach before it has the freedom to choose the design of its HIV policies, without fear of detrimental retribution from overseas donors.

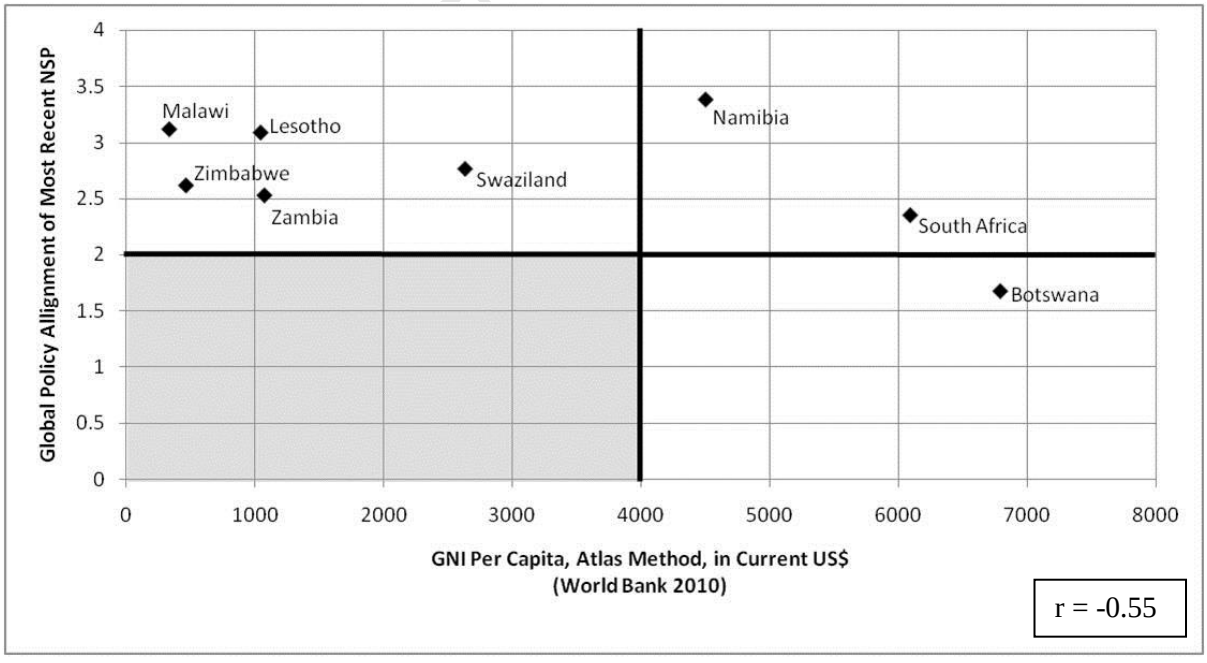


Figure 5.1: The Compliance of NSPs with Global Fund M&E Indicators and GNI per Capita (World Bank, 2010).

If the wealth of a country is related to how it directs its HIV policy, it stands to reason that the amount of development aid it receives also matters. However, compared with GNI per capita, Official Development Assistance (ODA) is not as strongly correlated with the degree to which a country's policy internalizes Global Fund policies. Net ODA correlates with policy compliance at a relatively weaker $r = 0.30$. These findings provide support for previous work done by Bor (2007), Nattrass (2006), Putzel (2004) and Strand (2007) which has already indicated that donor aid and wealth are related to government HIV policy-making. The results of this study also support Bor's (2007) finding that wealth per capita is a stronger predictor of HIV policy decisions than donor aid.

But what about HIV-specific aid? Domestic spending on HIV/AIDS programs (measured as a percentage of the total AIDS financing in the country) might explain trends in National Strategic Plans even stronger. As one might expect, the more money a country contributes to the total amount of AIDS funding in the country, the more it is able to steer its HIV policy away from donor-driven preferences ($r = -0.41$). Thus, if a country is contributing large sums of its own money towards HIV/AIDS, as is the case with South Africa, it is logically very invested in the policy-making and programmatic design of how that money will be spent. It will also have more control, since donor money comes with regulations and restrictions about how it may be spent. On the other hand, the percentage of HIV funding that a country generates domestically may also indicate that a country is not regarded favourably by bi-lateral or multi-lateral donors. This can be said to be true of Botswana, where they have not received funding from the Global Fund since Round 2. As such, their domestic funding percentage looks large, only because they have not been receiving much in the way of international support.

Apart from domestic funding, it is also relevant look at the explanatory power of the amount of external donor money received. As one might expect, the amount of money for HIV/AIDS that is provided by donor institutions is a highly relevant factor for how well a country adheres to global HIV policy recommendations; the more money for HIV that comes from the Global Fund and UN, the more likely that country is to internalize Global Fund policies within their national strategic plans ($r = 0.54$) (Figure 5.2). This relationship is approaching significance, with a p value of $p = 0.164$. Until now, all we had was a literature review from Biesma et al. (2009), analyzing articles and reports on the effects of Global Fund, PEPFAR and World Bank AIDS funding. Here, they find that these programs alter domestic policy by "distracting governments from coordinated efforts to strengthen health systems and re-

verticalization of planning, management and monitoring and evaluation systems" (Biesma et al., 2009, p. 239). Thus, my data provides support for the argument that policy can be warped by donor money. While my data is certainly not conclusive, it contributes evidence to the previously existing debate on foreign aid and HIV policy, which previously rested only on anecdotal evidence from civil society and government stakeholders.

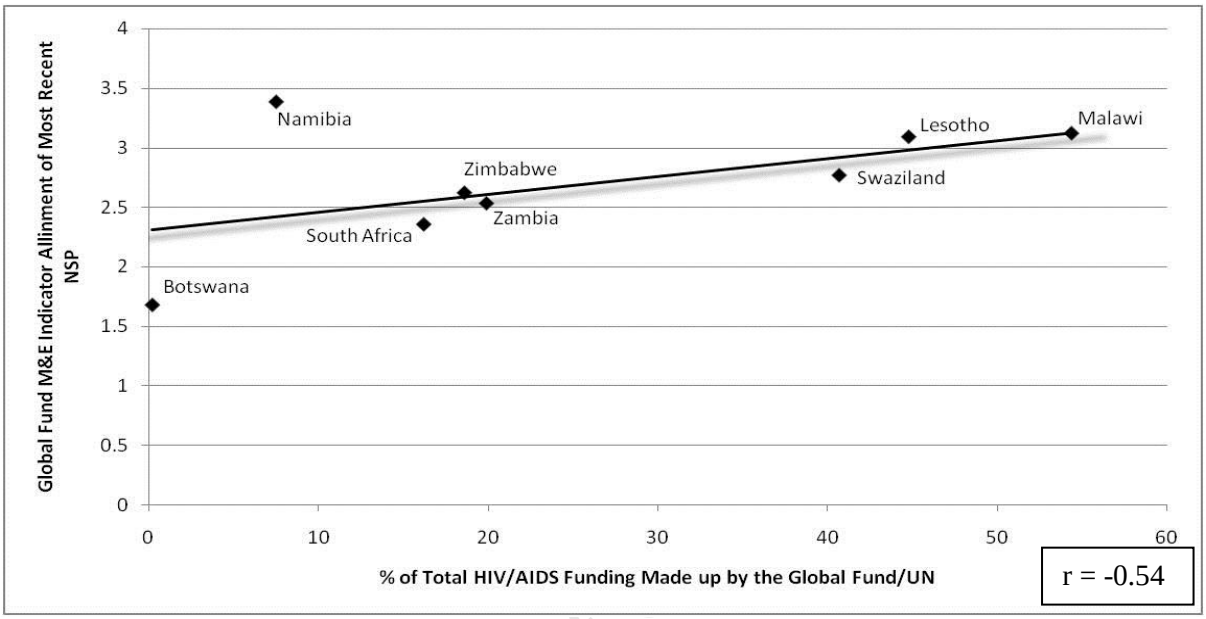


Figure 5.2: The Relationship between the Compliance of NSPs with Global Fund M&E Indicators and the Percentage of Funding Made Up by the Global Fund/UN (UNAIDS, 2010; National AIDS Spending Assessment, 2010).

While GNI per capita, domestic spending on HIV and donor funding all help to explain how strongly countries align their national HIV/AIDS strategic plans with Global Fund policies, the economic variable which shows the strongest correlation with NSP compliance is domestic health expenditure per capita (r = -0.73) (Figure 5.3). This correlation is also the only one that is significant, with a p value of p = 0.062. Curiously, general health spending correlates much stronger with HIV policy-making trends than does HIV-specific spending. Amongst these countries examined in this study, those that countries that more heavily prioritize health in general are more inclined to devise more locally informed and less Global Fund-based HIV/AIDS policies. There may be a spill-over effect, as health expenditure contributes more broadly to health systems strengthening. For instance, it has been shown that higher levels of health expenditure are associated with higher quality health infrastructure (Lambo, 1993). Additionally, increased health expenditure leads to higher staffing levels, which affords patients more time to get involved in making-decision around the care they receive (Valentine, de Silva & Murray, 2000).

Lastly, there is also a connection between health expenditure and overall wealth, which this chapter has previously shown to be a strong predictor of AIDS policy compliance on its own. Narayan (2007) demonstrates how a 1 per cent increase in health expenditure (per capita) can lead to a 0.6 per cent increase in per capita income. This external effect of health expenditure may help to explain why it is such a strong predictor of how compliant a country's NSP is with Global Fund policies. Perhaps it is the strength of a health system in general that inspires or affords a country the leeway to design more locally informed and domestically tailored AIDS policies.

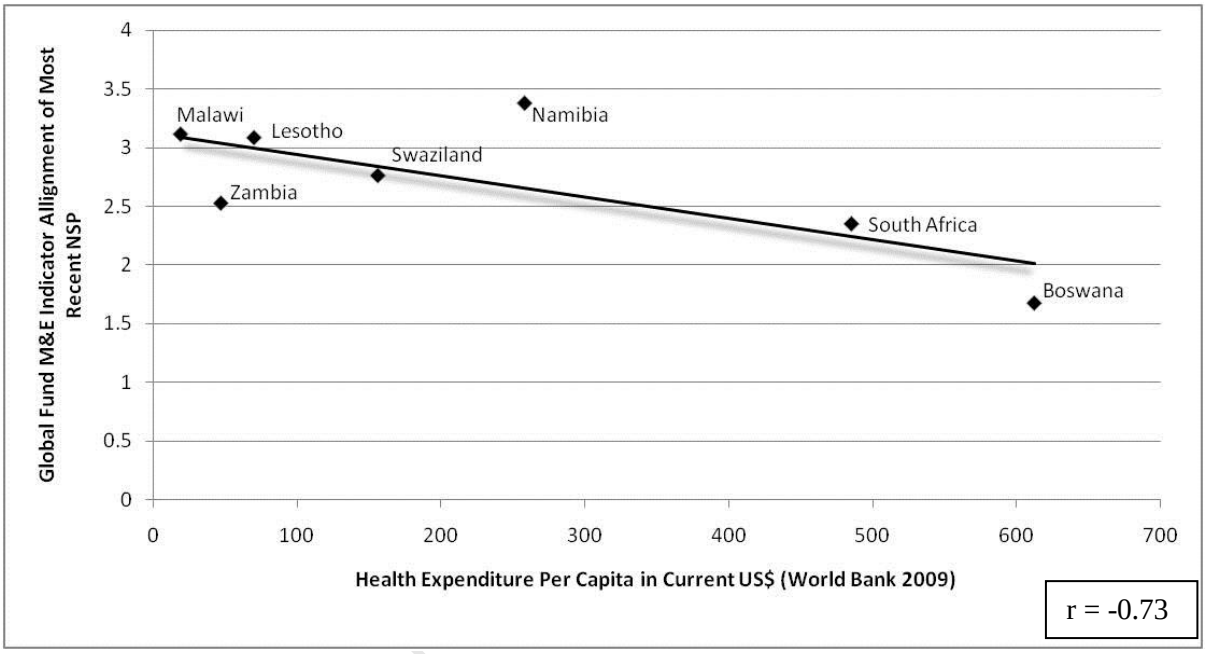


Figure 5.3: The Relationship between the Compliance of NSPs with Global Fund M&E Indicators and Health Expenditure Per Capita (World Bank, 2009).

Political Variables

In addition to economic variables, there are also a number of political variables which help to account for whether a country's NSP complies with Global Fund policies. The World Bank governance indicators (Government Effectiveness, Voice and Accountability, Political Stability, Regulatory Quality, Rule of Law, and Control of Corruption) have previously been shown to be connected to HIV prevalence (Menon-Johansson, 2005). Similarly, certain governance indicators also help to explain trends in HIV policy-making (Table 5.2).

The explanatory variables from the World Bank's governance indicators are weak, with the strongest being Government Effectiveness (r = -0.29) and Regulatory Quality (r = -0.28). According to the World Bank, the Government Effectiveness indicator "captures perceptions

of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies" (Kaufmann, Kraay & Mastruzzi, 2009, p. 6). The indicator on Regulatory Quality captures "perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development" (Kaufmann, Kraay & Mastruzzi, 2009, p. 6).

At best, the negative correlations between policy compliance and the World Bank indicators suggest that more effective states with better regulatory quality are less likely to write NSPs that comply with Global Fund policies. These results provide support for previous research by Bor (2007) and Nattrass (2006) who both found government effectiveness to be related to HIV policy-making. My finding that political stability correlates very weakly with policy compliance (r = -0.11) also corroborate Bor's (2007) finding that political stability is not a strong predictor of HIV policy decisions. Third, these results also provide support for the work of Suzette Heald (2006), who has also postulated that while we might imagine Western aid to work in the hands of an effective government such as Botswana's, in fact the opposite is the case for HIV/AIDS funding; strong states are more likely to reject these programs and devise their own instead.

Table 5.2: The Relationship between the Compliance of NSPs with Global Fund Policies and Government Effectiveness (Kaufmann, Kraay, & Mastruzzi, 2010).

Country	Global Fund M&E Indicator Alignment of most recent NSP	Government Effectiveness
Botswana	1.676	0.64
South Africa	2.353	0.51
Zambia	2.529	-0.67
Zimbabwe	2.618	-1.70
Swaziland	2.765	-0.70
Lesotho	3.088	-0.26
Malawi	3.118	-0.52
Namibia	3.382	0.19
		***r* = -0.29**

In addition to government effectiveness, there is also a noteworthy link between how well a country complies with Global HIV policy and their Perceived Corruption Index (Figure 5.4). As defined by Transparency International, this index is designed on a scale of 1-10, with

higher numbers representing more favourable corruption perceptions. The correlation between global HIV policy compliance and corruption perceptions is r = -0.52, suggesting that countries that are perceived to be more corrupt, adhere more compliantly with Global Fund HIV policies in their NSPs. This is also the only governance indicator that is approaching significance, with a p value of p = 0.182.

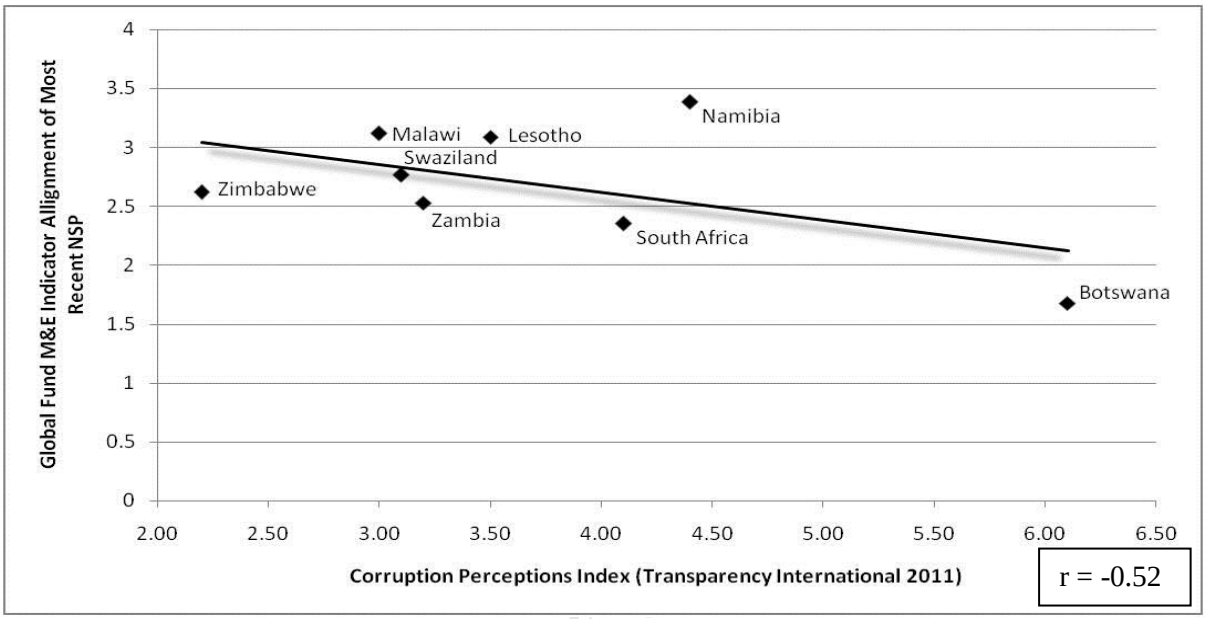


Figure 5.4: The Compliance of NSPs with Global Fund M&E Indicators and the Corruption Perceptions Index (Transparency International, 2011).

The reasons for this relationship would appear to be as follows: The largest direct-government donor for each of the countries in this study is the Global Fund, which means that appeasing these organizations is important for sustained funding. The Global Fund, in particular, has been known to have a 'zero tolerance' towards corruption, cancelling grant rounds after corruption scandals in Zimbabwe, Zambia, Uganda Mali and Mauritania. While this indicator measures overall corruption perceptions – not strictly Global Fund grant corruption – it is still reasonable to infer that countries with higher general levels of corruption might want to compensate for this by tailoring their HIV national strategic plans to comply more strongly with Global Fund policy objectives.

Another theory that has been advanced in connection with HIV/AIDS infection rates and policy-making trends is that of the colonial past of a country. Velayati et al. (2007) show that by the end of 2003, former British colonies had far higher HIV prevalence rates than all other African states. This mode of thinking might partially help to explain Namibia's HIV/AIDS policy as the extreme outlier in all of the correlations, since it is the only former German

colony of the project. Another variable that is related to colonial past is independence. There is an interesting relationship here, where the number of years of independence from colonial rule explains its HIV/AIDS policy compliance at r = -0.48 (Table 5.3). This means that the longer a country has been independent, the more likely it is to deviate from Global Fund HIV/AIDS policies. The small number of cases examined and the small variation in the years of independence mean that this relationship should be interpreted with caution; however, the correlation between compliance and independence might be related to the state effectiveness argument, as countries which have been independent longer are arguably led by more experienced and established state institutions.

Table 5.3: The Relationship between the Compliance of NSPs with Global Fund M&E Indicators and Year of Independence (Birmingham, 1995)

Country	Global Fund Policy Alignment of most recent NSP	End of Colonial Rule	Number of Years of Independence
Botswana	1.676	1966	46
South Africa	2.353	1931	102[17]
Zambia	2.529	1964	48
Zimbabwe	2.618	1980	32
Swaziland	2.765	1968	44
Lesotho	3.088	1966	46
Malawi	3.118	1964	48
Namibia	3.382	1990	12
			***r* = -0.48**

In addition to measuring the effects of political regimes and state institutions on NSP compliance with the Global Fund, it is equally important in this field to observe the effects of governance variables that reside outside of the state. For instance, one should easily imagine that the strength and capacity of civil society has a large impact on the way HIV/AIDS is managed by government. A strong example of this is the strength of civil society in South Africa. A history of active NGOs and social movements bolstered the efforts from groups such as the Treatment Action Campaign (TAC) in their successes towards a change in national policy on HIV/AIDS treatment (Friedman & Mottair, 2006; Ballard, Habib & Valodia, 2006). A similar situation is emerging in Brazil, where NGOs experienced a revival in the late 1980s and early 1990s and are now able to affect HIV/AIDS policy by working alongside their with their government (Berkman et al., 2005).

[17] This Chapter recognizes that South Africa did not become a non-racial democracy until 1994, but technically it achieved independence from the colonial rule of Britain in 1910 with the end of the Anglo-Boer War.

There are, however, significant challenges to measuring civil society strength. There is an index of civil society strength, developed by CIVICUS (2012), but there are not measurements available for all of the countries in this study. Instead, this project uses the percentage of NGOs sitting on the Country Coordinating Mechanisms (CCMs) as a proxy for civil society strength. The CCMs are elected boards of individuals who sit in-country and help to write Global Fund proposals and direct subsequent Global Fund financing and program objectives. They are made up of several different constituencies, including government, donors, academics, key affected populations, people living with HIV, the private sector and NGOs. Each CCM is different, with some that are very government heavy, some that are donor heavy, and others still that are largely dominated by civil society. The ability to garner a high number of seats on the CCM could reflect the relative strength (or will) of civil society in that country. It turns out that NGO presence on the CCM does have some effect on HIV/AIDS policy compliance with Global Fund indicators at r = 0.45. This means that the stronger a country's NGO presence on its CCM, the more compliant the country is with Global Fund policies. What's more, if we combine the presence of NGOs and donors on the CCM, you get a much stronger predictor of Global Fund HIV/AIDS policy compliance (r = 0.67) (Figure 5.5). This suggests that political institutions that exist outside of the state may exert greater influence over the HIV/AIDS policy-making process than national governments.

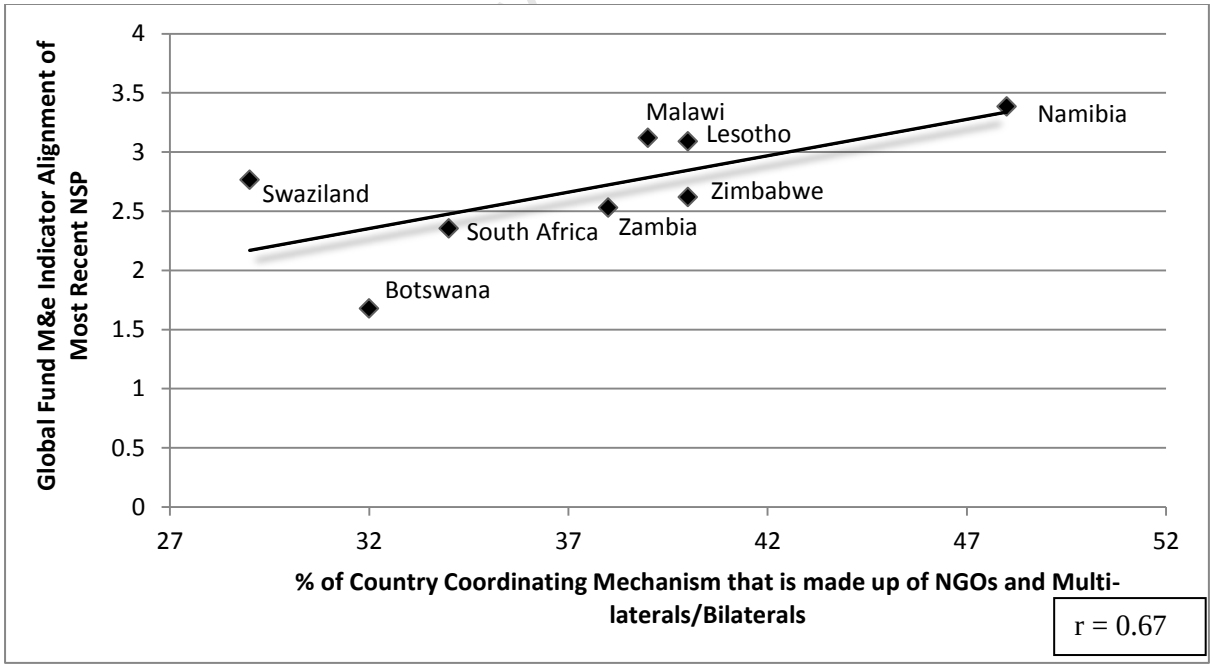


Figure 5.5: The Compliance of NSPs with Global Fund Policies and % of Country Coordinating Mechanism that is made up of NGOs and Bi-Laterals /Multi-laterals (Global Fund, 2011).

These various governance indicators also help to explain the outliers in this project. Namibia is an anomaly in this study, as it is has the most compliant HIV/AIDS policy, yet does not fit the rest of the trends of heavy donor influence in a weak state. However, there are a number of ways that these indicators explain Namibia's position. For instance, among the countries I examined in this project, Namibia has the highest percentage of NGO representation on its CCM. Furthermore, both Namibia and Malawi have the highest percentage of donors (multi-laterals/bi-laterals) on their CCMs, which also helps to explain why those two countries are also the two most compliant in terms of matching their NSPs with Global Fund policy preferences. It seems that the combination of civil society strength, along with donor presence, helps to explain Namibia's extremely compliant policy, despite its relative strong political and economic standing in the region.

Despite all of these governance indicators that *do* help to explain trends in HIV/AIDS policy-making, there are many others, somewhat counter intuitively, which do not function as strong predictors of policy making behaviour. One of those indicators is democracy. Based on Amartya Sen's premise that famines do not occur in democracies, the level of political freedom was tested to explain HIV/AIDS policy-making decisions. However, freedom levels, as listed by Freedom House International, only explain HIV/AIDS policy at a correlation coefficient of $r = 0.05$ (Table 5.4).

Table 5.4: The Relationship between the Compliance of NSPs with Global Fund Policies and Level of Freedom (Freedom House International, 2010).

Country	Global Fund Policy Alignment of most recent NSP	Level of Freedom
Botswana	1.676	2.5
South Africa	2.353	2.0
Zambia	2.529	3.5
Zimbabwe	2.618	6.0
Swaziland	2.765	6.0
Lesotho	3.088	3.0
Malawi	3.118	3.5
Namibia	3.382	2.0
		***r* = 0.05**

Recall that there is scholarly disagreement around whether levels of democracy affects AIDS and/or AIDS policies. One camp says democracies respond better (Bor, 2007; Dionne, 2007; Parker, Easton & Klein, 2000), another suggests that authoritarian regimes are more effective (Chirambo, 2008), and a third argues that there is no clear connection between governance and HIV/AIDS policy and outcomes (Patterson, 2006). The data presented here provide support for this third stance, since a correlation of $r = 0.05$ shows no significant relationship in either direction. There is no clear pattern or relationship between levels of democracy/freedom and AIDS policy-making.

From still another angle, there is an interesting relationship between public opinion data on AIDS and the policy responses of the government in this project. Afrobarometer data show that Batswana and South Africans consistently ranked HIV/AIDS as a more important problem than their neighbors do during the period covered in this study. In Afrobarometer survey Round 4, in 2008, 4 per cent of Batswana and 7 per cent of South Africans felt that AIDS was one of the most important problems facing the country that the government should address (Little & Logan, 2008). Compared to surrounding countries with similarly high prevalence levels, this is a noticeable difference. For instance, 3 per cent of Namibians surveyed felt the same way, 2 percent of Zambians and only 1 per cent of Basotho. It may be that Governments who deviate from Global Fund policies in their national strategic plans are responding democratically to public pressure to be more creative on HIV/AIDS policy reform. Despite these trends, other governance indicators that one might expect to explain trends in policy-making do not yield logical or intuitive results. For instance, voice and accountability is not strongly correlated with HIV/AIDS policy making. One might logically expect this indicator to be associated with a greater ability for citizens to direct their own culturally relevant policy making, but it has a very small correlation ($r = -0.17$).

Similarly, scores on political stability do not help to explicate HIV/AIDS policy compliance either. It would be reasonable to expect this indicator to be related to state effectiveness and therefore explain policy-making control, yet it only correlates at $r = -0.11$. Perhaps the fact that most of these indicators do not explain HIV/AIDS policy very strongly is indicative of larger influencing factors in the policy-making process. It might be that AIDS policy is driven more by non-state actors/factors, such as civil society and donor presence, than it is by government structures.

Additionally, it is also important to recognize here that there are many potentially significant factors which have not yet been systematically quantified. For instance, many have suggested that HIV/AIDS policy decisions are most heavily influenced by the personalities of leaders. In Uganda, Yoweri Museveni has been credited with developing Uganda's initial 'zero grazing' prevention policy, the successes of which have largely been associated with Museveni's open and early response (Parkhurst, 2005). Similarly important political leadership has been noted of former President Festus Mogae in Botswana (Renwich, 2007). On the other hand, personalities of decision makers have also been shown to affect HIV/AID policy making very negatively. Former South African President Thabo Mbeki and his Health Minister Manto Tshabalala-Msimang have been widely criticized for their dissident perspectives on HIV/AIDS, which ultimately shaped South Africa's policy response in the early new millennium (Sheckels, 2004; Nattrass, 2007).

Another factor that has been show to affect HIV/AIDS policy making is previous policy-making decisions (Baldwin, 2005). Trajectory of policy-making can, in some cases, strongly affect future policies in the public health arena, yet this is not something that can be measured. So while, Baldwin (2005, p. 3) suggests that "each nation tailored its AIDS strategy largely to its long domestic traditions of public health", there is no existing index of these kinds of path dependencies. Many of these kinds of qualitative factors will be explore in the following chapter, where key informant interviews supplement these statistical relationships

Concluding Remarks

This chapter on explanatory structural and institutional variables provides data that suggest that economic and political contexts are likely related to how a country designs its HIV/AIDS national strategic plans and policies. While these initial tests cannot show causation, since the number of cases is very small and I have not controlled for third variables, the results do provide tentative support or corroboration for some widely held hypotheses on HIV/AIDS policy-making. Conversely, my data also reveal evidence that does not support, and thus challenges, other popular explanations.

My initial tentative tests show that GNI per capita, official development assistance and domestic public spending on HIV may be associated with decreased policy compliance. In

other words, there is correlational evidence that richer, less aid-dependent countries who contribute more of their own public funds to HIV/AIDS programs are more likely to deviate from Global Fund policies in their NSPs. However, health expenditure per capita is the best economic predictor of HIV/AIDS policy-making tested in this chapter. This shows the strongest relationship suggesting that the more a country spends on health care per person, the more it deviates from Global Fund policy preferences.

In addition to economic indicators, governance indicators of state effectiveness and corruption correlate with policy making scores as well. Better governed states with lower levels of perceived corruption are more likely to write their NSPs in a way that deviates from Global Fund policies. The best political predictor of HIV/AIDS policy-making decisions, however, is the composition of the Country Coordinating Mechanisms, especially with respect to the presence of NGOs and donors. This indicates that non-state elements of governance, such as civil society and bi-laterals/multi-laterals, may be the most important factors in influencing the HIV/AIDS policy-making process.

In addition to these popular explanations which my data do corroborate, there are also a number of arguments about HIV policy making that my findings fail to provide support for. For the economic variables, net ODA per capita showed a very weak relationship, which does not provide support for arguments that levels of general development assistance affect HIV/AIDS policy-making decisions. For the political indicators, political stability and rule of law both have very weak correlations with the levels of policy compliance for the countries in this study, challenging ideas that these elements of state governance affect HIV/AIDS policy-making. The weakest relationship found in this investigation was the correlation between levels of democratic freedom and policy, but this actually works to support the work of Amy Patterson (2006), which previously argued that the two are not related.

Building on the findings from this chapter, the next chapter provides interview data from seven of the eight countries in this project, in an effort to supplement and further explain the relationships presented in this chapter. Chapter 6 presents 'insider' perspectives on why the relationships from this chapter might be true, and what other factors might also exist to help explain trends in HIV/AIDS policy compliance with the Global Fund.

Chapter Six

Explaining HIV/AIDS Policy Further: Interview Case Studies

"Data accuracy is important, but politics is rarely about hard and fast numbers. Politics is about perceptions" (Patterson, 2006, p. 6).

Introduction

As Patterson (2006) aptly notes, data and regression analysis can tell you a lot about relationships and trends in political science, but they cannot tell you everything. While economic and political variables presented in Chapter 5 do help to explain trends in HIV/AIDS policy-making in Southern Africa, there are also influences which lie outside of measurable indicators. These include factors such as relationships, personalities, leadership, attitudes, histories and perceptions.

In order to tap into some of these more qualitative explanatory elements, 82 key informant interviews were conducted between April 2012 and June 2013 in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia, Zimbabwe and at the Global Fund Secretariat in Geneva, Switzerland. Key informants were selected based on their experiences with the Country Coordinating Mechanisms (CCMs), the Global Fund mandated national-level boards which manage the relationship between the Global Fund and the country program. Members of CCMs and fund recipient organizations were targeted since these people have intimate understanding of the politics between the Global Fund's policies and how countries internalize these guidelines into their own proposal development, programmatic responses and domestic policy. In addition, as Key Informant N pointed out, "The CCM is really sort of a microcosm of the broader response. All the same stakeholders are there" (personal communication, September 18, 2012).

An effort was made to interview as many of the different constituencies as possible, including multi-lateral and bi-lateral partners, government, international and local civil society, PLHIV and the private sector. A complete list of all 82 key informants can be found in Appendix E. While some respondents requested that their identity be kept confidential, this list includes names and organizational affiliations where consent was given to do so.

This chapter will be organized according to the explanatory themes presented in Chapter 5. First, I will outline perspectives on the effects of structural economic variables on HIV/AIDS policy compliance with the Global Fund. Here, interviews shed further light on the explanatory power of a country's development rate, Global Fund spending and corruption levels. Second, I will discuss institutional political variables. For this category, respondents illuminated the impacts on policy from dominant institutions, political culture, National AIDS Commissions, the Global Fund country relationship and political decentralization.

Economic Variables

Development Rate

A country's development rate - often reflected in levels of wealth such as GDP or GNI per capita as discussed in Chapter 5 - was cited in Botswana as a contributing factor to its HIV/AIDS policy and the way in which Batswana engage with them. Key Informant B said that performance indicators, especially around things like maternal mortality, do not necessarily correlate with development. He noted how maternal mortality is worse in Botswana than in Malawi, for instance. While this is perhaps intuitively true due to the differences in HIV prevalence rates, his point was rather that there is a certain complacency that comes with development whereby people in Botswana do not think that these are problems that they should concern themselves with (personal communication, June 5, 2012). He suggested that this is a product of 'developing too quickly' or having an 'overly developed perspective'. This prerogative could contribute to a deviation from Global Fund policy if the government of Botswana regards itself as having moved past issues like the ones emphasized in the Global Fund's M&E Toolkit.

Key Informant B's analysis corroborates the work of Helen Epstein (2007), who suggests that one of the reasons why home based care is not a popular policy in Botswana is because it comes with an association of poverty. For Batswana, if you are sick then you go to the hospital, not stay at home. So, instead of focusing on the policies in the Global Fund Toolkit, Key Informant C highlighted how other policies are now being focused on in Botswana. She told me how "There was always an intervention to the cross-border issues of mobile clinics at border posts, so that people can access services," an objective which the Global Fund does not incorporate into its M&E toolkit (personal communication, June 6, 2012).

Development and wealth is also related to how donors may perceive a country as a desirable investment cite. Recalling from Chapter 5 that GNI per capita was negatively associated with policy compliance (the richer the country, the less compliant its policy is with Global Fund objectives). Interviews revealed that in addition to richer countries having more financial power to direct their own programs, wealth was also potentially a push factor for donors. Vulindlela Msibi with the CCM Secretariat in Swaziland suggested that "Most donors are not even in Swaziland because of that, they look at our GDP. And Global Fund is the same. They look at where you stand in terms of your income" (personal communication, June 10, 2013). In the same vein, Richard Cunliffe with the Global Fund in Geneva (Fund Portfolio Manager for Swaziland and Botswana) intimated that Botswana was unlikely to see any Global Fund money ever again, on the basis of the country's own wealth (personal communication, April 16, 2013). Once again, these interviews provide support for the previous findings of Bor (2007), Nattrass (2006) and Putzel (2004) which suggest wealth and donor aid help to explain why countries exhibit such variation in their government response to HIV/AIDS.

Global Fund Spending

Another explanatory variable explored in Chapter 5 was the amount of money that countries receive from the Global Fund. This factor also emerged as a trend in my interviews, but in more intricate ways than the raw spending data could convey.

In Malawi, respondents were in consensus about the fact that the Global Fund is certainly the largest donor, both in terms of dollar amount and in terms of its influence over policy and programs. For instance, Key Informant G noted how the "Global Fund is almost the sole funder of our HIV/AIDS programme, and therefore has a lot of influence on our local programming" (personal communication, May 23, 2012). In agreement, Newton Kumwenda, with the University of Malawi, College of Medicine, suggested that "The Global Fund policies do have a lot of influence on Malawi's local HIV/AIDS programming" (personal communication, May 23, 2012). As a result, those guiding the policy and programming response in Malawi feel a great deal of pressure to please the Global Fund. This has created a feeling of extreme domination over the country's governance of its HIV/AIDS epidemic, helping to further explain Malawi's policy compliance as the second highest in the region. Edith Mkawa, with the Malawi Global Fund Coordinating Committee Secretariat, emphasized this pressure, expressing the frustration that:

> No matter how much you try to work on, say, they give you feedback, you work on something and they bring more feedback. So it's like an ongoing battle between the country - the CCM or the implementers - and the Global Fund (personal communication, May 23, 2012).

Similarly, Key Informant H was very adamant that "It's not a partnership with the Global Fund, you just have to do what they expect you to do, and then you qualify for funding, or you pass the test" (personal communication, May 23, 2012). Key Informant J said the same thing, in terms of making sure the Global Fund is happy. She said how "All we're doing is ticking the boxes and saying we've done this. We've introduced life skills education courses in schools. Where's the impact? How are you measuring behavior change and everything else?" (personal communication, May 24, 2012). There was also a sense that a lot of this disconnect between what the Global Fund wants and what Malawi feels it needs, stems from Geneva's distance from the country. This is especially related to financial matters, referring to the OIG (Office of the Inspector General), an independent body which reports directly to the Global Fund Board on audits and investigations of county portfolios. According to Key Informant M*:*

> Much of what I am seeing is, top down. When I met the OIG group, I say, you know what, it's easier when you are looking at something from a theoretical point of view, when in Geneva you can get a receipt for everything. But, transport yourself. Be in Malawi. If I have to tell my elder that I want a receipt for everything, you are actually questioning their integrity. You have people in Geneva all the time - they have never experienced the reality – that are busy making decisions and policies and everything, and they don't have time to look at what is the practice and what is the reality on the ground, to make sure that they at least put in some flexibilities. They don't. They don't (personal communication, May 25, 2012).

Key informant K also shared this perspective in Malawi, noting that "You have that disconnect between the theory and the actual practice (personal communication, May 24, 2012).

In Swaziland, too, there was a strong sense that the Global Fund's expectations for documenting expenses were not realistic in the African context. Like Key Informant M in Malawi, Emmanuel Ndlangamandla with the Coordinating Assembly of Non-governmental Organizations (CANGO) said "If you go to a rural area, where do I get an invoice for buying food there?" (personal communication, June 11, 2013). He also voiced that the way the Global Fund sees financial accountability is nonsensical from his perspective:

> Nothing wrong has happened here, no one has eaten this money, you cannot trace it to people's bank accounts. All these things are there, but perhaps the paper trail, or we ordered more than we were supposed to, because we said we were going to get 10 and we got 20 because we got is cheaper, it became wrong because we did that so they say 'bring our money back' (personal communication, June 11, 2013).

This notion that requirements are out of touch with practicality in Africa has led people to become frustrated with how policy and programming must be designed, even if it does not fit the reality on the ground or in their country. Key Informant F in Botswana said "Basically Global Fund processes and procedures are cast in stone. That's what we have learnt, and we do it to the letter. If 45% percent goes to this, you do it exactly. And I think it got frustrating (personal communication, June 7, 2012). Similarly, Rudolph Maziya with The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) in Swaziland aired how Global Fund preferences on spending leave no room for domestic knowledge or expertise:

> So it really doesn't matter how you see your epidemic in your country. The people with money will come in and you will just be following the money. So my suggestion has been, let us not spend time on developing strategic plans. Let us just wait for people who are coming with money and follow the money. What else do you do? So it's just a waste of time having these things that can never be funded by anyone. They will only be funded if you construct them in the fashion that the people who have money want them. Right now the Global Fund is telling us where they will put their money. So why do we need a strategic plan? Why don't we just look at what they are saying and put proposals to do those things (personal communication, June 12, 2013).

Hlobsile Dlamini with the Swaziland Rural Women's Association felt the same:

> Donors come with so many requirements, you end up forgetting your sole agenda, you know, why you are actually here, because, you know, 80% of the time you are merely trying to respond to donor requirements. And you lose focus on what you initially dreamt of as an institution (personal communication, June 13, 2013).

When I asked Key Informant L if he felt like there was a partnership between Malawi and the Global Fund he confessed "It wasn't and it isn't and I doubt it ever will be. Primarily because even when they talk about country ownership and everything else, there is still a donor-grantee relationship that is going on there" (personal communication, May 25, 2012).

In Namibia, too, there was a strong sense that 'country ownership' was not really happening. Zack Makari, with the Namibia Network of AIDS Service Organizations (NANASO), noted how his civil society organization feels a strong amount of pressure from the Global Fund to follow their agenda. When asked about Global Fund control over NANASO's operations, he said the degree of influence was:

> Very much. There are very many limitations. As much as someone will say 'country ownership, country ownership', you are really being dictated to do many things. Change this, this should read this way, at times it is challenging (personal communication, September 17, 2012).

As a civil society Principal Recipient (PR), Zack proceeded to give examples of how the Global Fund influences civil society possibly to a greater degree than government PRs. He said that when NANASO became a PR, the Global Fund forced the organization to change their constitution, in line with Global Fund objectives (personal communication, September 17, 2012).

Following this discussion about country ownership, Key Informant L from Malawi said that sometimes Global Fund influence and control is not necessarily a bad thing because the inclusion of SOGI (sexual orientation and gender identities) groups is an important thing and that would not get consideration unless the Global Fund had significant control over this policy area. Key Informant L continues, "For me, that was a good outcome out of that interaction, even though if we just kind of said in the country that this were a full-owned proposal, then the country would go for generalized, then ignore these other sub-populations. So that to me was a good outcome" (personal communication, May 25, 2012).

This is an important insight since it reveals that Global Fund spending in a country, and its subsequent control over policy and programming, can have some very positive effects in terms of inclusion of certain populations. This is especially relevant since homosexuality is criminalized in all the countries in my study (except South Africa), yet inclusion of SOGI populations in policy and programming is extremely important since they are often placed a higher risk of infection than the general population. This adds depth to the findings from Chapter 5 that show that Global Fund spending is correlated with policy compliance. It is important to see policy influence from the Global Fund as a power that sometimes creates space and opportunity for improved responses. By contrast, Key Informant I voiced resistance to Global Fund policy influence around the inclusion of certain groups. He linked this disconnect especially to policies and programming mandates that had to do with key populations such as MSM, women who have sex with women (WSW) and transgender communities. He said that "Geneva's policies, such as the SOGI strategy, may be uninformed. They may have 25 gay people meet to discuss, but what they really need are local informants" (personal communication, May 23, 2012).

Others, while acknowledging this, were not so clear on why the disconnect was so large. Robert Ngaiyaye, with the Malawi Interfaith Aids Association, noted confusion about why the Global Fund had previously rejected the countries proposals which were based on Malawian AIDS policy. He asked "it was a home grown agenda, so why do they fail?"

(personal communication, May 24, 2012). It may be that Malawi has learned from this, and has really begun to align its proposals and national policies with the Global Fund's agenda. Key Informant L, who was involved in the Global Fund proposal writing for Rounds 9, 10 and 11, noted how Malawi is always trying to keep in tune with the Global Fund's objectives. He said that "Then in round 10 there was always this kind of idea that you have to generalize the proposal" (personal communication, May 25, 2012).

By contrast, while Malawi receives the highest proportion of Global Fund money in the region (making up 55% of the country's total HIV/AIDS budget in 2009), Botswana receives the least. In fact, recall Table 2.2 which shows that in 2008 the Global Fund did not contribute anything to the country's HIV/AIDS budget. In fact, Botswana has not been funded by the Global Fund since Round 2. While this certainly means little to no financial influence over the country's policies, interview respondents indicated that this has also led to a wide disillusionment with the Global Fund in general. Dundu Macha, Executive Director of BONEPWA+ (Botswana Network of People Living with HIV & AIDS) explained how the relationship between the country and the Global Fund has unraveled over the years. She spoke about how CCM meetings are often called and postponed and members rarely show up:

> I think maybe they lost heart, in terms of the Global Fund, and say, we spend a lot of money talking and talking and talking. We are not getting the results of the talking. You know, people have other work to do (personal communication, June 8, 2012).

She says most organizations they have begun to prioritize the aims and objectives of other donors, since the other ones are following through and Global Fund is not. She suspects this is the sentiment among government as well, to prioritize other financing avenues.

The same frustration was brought up by Key Informant F with the European Delegation to Botswana and SADC (Southern African Development Community) who reminded me that "the truth is, if you remember very well the last time we were funded was for Round 2" (personal communication, June 7, 2012). When I asked her if they had applied for grants since then, she said "Enough times to last a lifetime. […] I think it got frustrating for the CCM, because you keep on applying for funding and you are always category 2. Where are you going wrong? Nobody says" (personal communication, June 7, 2012). Lefetogile Bogosing, with the National AIDS Coordinating Agency, expressed the same confusion about why Botswana has not received funding in almost 10 years. She said "That is

something that is beyond our control. CCM has been putting in proposals every Round, it's only that we were not successful" (personal communication, June 8, 2012).

So, while spending data shows that Botswana is not being funded by the Global Fund, interview data reveals insight into why this might be the case and what its effects might be o domestic policy changes; the country has largely given up on pleasing this donor, choosing instead to either source funds domestically or appeal to other funding partners.

This same disillusionment with the Global Fund and a preference to move to other donors was raised in Swaziland by a number of people. Rudolph Maziya (AMICAALL) said "If I had funding elsewhere, I would not really bother myself with the Global Fund. There are some organizations on the country that have decided that they will not deal with the Global Fund" (personal communication, June 12, 2013). Likewise, Emmanuel Ndlangamandla (CANGO) echoed a preference for the style of other donors over the Global Fund:

> It's just not easy working with Global Fund. Those who are working with Pact under USAID funding, they will not experience such glitches, because the system is supportive. The system tries to identify problems with you, you solve the problems, you go forward. It's easy. They help you to build your capacity (personal communication, June 11, 2013).

It was not just civil society in Swaziland that voiced wanting to remove themselves from involvement with the Global Fund. Vulindlela Msibi (CCM Secretariat) told me that NERCHA (The National Emergency Response Council on HIV and AIDS) is threatening to retire as Principal Recipient (personal communication, June 10, 2013). When I spoke with Khanya Mabuza, NERCHA's Director, he said that the backlash at NERCHA as the sole PR after the recent negative OIG report has been immense. He said dual tracking would be optimal, but no one else has the capacity. He said "if you phase out NERCHA, this is how it is going to be phased out" (personal communication, June 11, 2013). He then suggested Ministry of Finance or Ministry of Planning should step in.

Another element of Global Fund spending that became clear in my interviews was the nature of how Global Fund money is pooled and dispersed within a county. In Malawi, several respondents cited the relevant factor of the Global Fund's recent move to become a discrete donor in the country. Until recently, the Global Fund used to add its funds into a larger HIV funding pool in the country, along with DFID, the Norwegian Agency for Development Cooperation (NORAD), the World Bank, etc. Any funds that were dispersed were then non-earmarked in terms of where they came from and where the funders felt they ought to go. This used to be the case, uniquely, in Malawi and Mozambique. Now, the Global Fund has

decided to pull out of this funding pool and become a discrete donor, where it is now a separate donor from this larger funding pot. Key Informant J and Key Informant K noted how pooled funding meant that implementers were now responsible for writing 40 different M&E reports. Speaking to this change from pooled to discrete funder, Key Informant K discussed how the new reporting processes for the Global Fund are a significant change in the country:

> Talk about conditionalities? [laughs] Compare their conditionalities to the World Bank and the IMF – I'd be willing to bet that things are a lot more onerous with the Global Fund than either of the others (personal communication, May 24, 2012).

The Global Fund's move from pooled to discrete donor in Malawi began three years ago, exactly as the new national strategic plan for 2010-2012 was being written (personal communication, May 24, 2012). With this massive change in how reporting to the Global Fund needed to occur in the country, this is a potential explanation for the way in which the national strategic plan adapted to line up with the Global Fund's policies. However, they did not pull out of the funding pool entirely, at first. Key Informant J detailed how this change is not happening all at once. They highlighted how:

> But at the same time, they've got a very different funding cycle, so they demand very particular deliverables before they can disperse their money. So it means that they are still discrete in that sense, they are still earmarking for money. With one foot in the pool and one foot out, they're pooled when it suits them and then they're not when they want to be dictatorial (personal communication, May 24, 2012).

Then, in September 2011, Key Informant K noted how the Global Fund became an *entirely* discrete donor, making things a whole lot stricter in terms of following rules and regulations**.**

Others did not feel that the Global Fund's switch from pooled to discrete donor was as large a factor in Malawi's policy alignment. Key Informant L said that this alignment has been a much more long-term institutionalized process born out of an 'incestuous' relationship:

> Nearly 70% of money in HIV in Global Fund money. So essentially, if you have such an incestuous relationship eventually you kind of know each other's minds, so to speak, and that kind of aligns it in that way. Probably that progression is longer term rather than more drastic ones that you might see. But that's why I say it wasn't anything that wasn't already in the works or under discussion (personal communication, May 25, 2012).

Changes in Global Fund spending preferences were also highlighted in Swaziland. There, people voiced that there was a marked change from the early years to now, where the Global Fund became much stricter in terms of how money was spent and how it must be accounted for. Khanya Mabuza (NERCHA) said:

> In the early days it was much, much easier to be on the CCM. Global Fund was more flexible. Then in 2004/2005 things became more structured. 10 years ago, we were told 'go and spend'. Go and spend, our job is to save lives. Now, things are so nitty gritty. If you buy four cars for the money of one, you will be in trouble (personal communication, June 12, 2013).

Emmanuel Ndlangamandla (CANGO) also voiced the feeling that the Global Fund has now prioritized fiscal management over programming and saving lives (personal communication, June 12, 2013). In agreement, Rudolph Maziya (AMICAALL) felt that "When we started with the first round, the idea was to get money out for things to happen. But all of a sudden it's become rigorous like a bank" (personal communication, June 12, 2013). Commenting on this, Key Informant T, who represents the donor constituency on the Swaziland CCM, said that the backlash around the Global Fund's demand for accountability was largely cultivated by the Global Fund in the early days, when organizations were given funding and were not responsible for demonstrating impact or for having up to date and accurate books (personal communication, June 12, 2013).

Lastly, another way in which Global Fund spending patterns may have an influence on policy-making has to do with changes in classifications of countries in terms of their priority level. Key Informant J voiced the impact that this has had in Malawi, as the Global Fund no longer classifies the country as a high burden area. Key Informant J felt that "this is crazy" suggesting that this has had an impact on the rigid policy compliance of the country with Global Fund objectives, as it struggles to remain on the receiving end of large levels of financial support (personal communication, May 24, 2012).

These perspectives highlight how institutional or strategic changes within the Global Fund's spending and reporting framework can have a heavy impact on the way in which a country perceives the donor and the way in which its national policy may change as a result. This finding has especially timely relevance for 2014 and beyond, as the Global Fund implements its New Funding Mechanism (NFM), which will be discussed at greater length in Chapter 7.

Corruption

The third economic variable which my interview data illuminates is the relationship between corruption perceptions and HIV/AIDS policy making. In Chapter 5, this was shown to be a fairly strong predictor of HIV/AIDS policy compliance ($r = -0.52$), meaning that countries with higher levels of perceived corruption were more likely to comply with Global Fund policies. Many interview respondents spoke to this trend, indicating that corruption in their countries plays a huge role in the government's ability to direct its own HIV/AIDS policy and programming.

Corruption may have been a factor in Zambia, where in late 2010 it was discovered that the Zambian National AIDS Network (ZNAN) and the Ministry of Health, two Principal Recipients of Global Fund money, had misused approximately US$ 10.7 million of Global Fund money (PlusNews, 2011, March 14). As a result of the scandal, ZNAN is no longer a PR and the United Nations Development Programme (UNDP) is handing the Ministry of Health's grants. The Churches Health Association of Zambia (CHAZ) is the second PR, which is now handling much larger grants than before since ZNAN is no longer sharing that responsibility. Chilambe Katuta with Youth Vision Zambia pointed out how even with the remaining two PRs, CHAZ is incredibly dominant with how the funds are managed. He said:

> [T]hey have allocated for Faith Based Organizations, for the next three years, they will receive about $42 million. Then, for the civil society organizations, they receive about $5 million. So, when you look at the balance, it's skewed more to the Faith Based Organizations (personal communication, April 19, 2012).

In agreement is Key Informant Y, who voiced concern in CHAZ's dominance, suggesting that "for them to say they can handle it all is even more worrisome when you look at the portfolio" (personal communication, April 20, 2012). As corruption leads PRs to be suspended from the Global Fund governing process, perhaps the connection between corruption and policy compliance has to do with less compromise in the policy and grant writing process. If one organization is chiefly responsible for all of the money, this may allow it to influence the policy making process more strongly, with a clear incentive for increased resources from the Global Fund.

In this similar fashion, the Zimbabwean Global Fund recipient system is also coming off the back of a negative OIG report, where the UNDP is now the sole PR in the country. As is the case in Zambia, this circumstance is certainly relevant with respect to the way in which the current CCM can negotiate autonomous advocacy and decision-making within the larger Global Fund apparatus.

Britone Chitakunye, with TelOne (representing the private sector on the CCM), suggests that the sole PR status of the UNDP, following misappropriation of funds, has significant effects on how decisions are made. He voiced how country ownership of those decisions is significant compromised without having Zimbabwe as PR:

> A number of decisions are outside of our control. Where to procure, for example. Where things might be available in Zimbabwe and where local public sector, or even private sector, could provide, the procurement system is done such that it is done elsewhere (personal communication, May 3, 2012).

In agreement was David Zinyengere with HEDEC (Health Environment & Development Consulting). Confirming findings on Global Fund spending and corruption perceptions from Chapter 5, he also focused on how financial ownership and loss of PR status due to OIG mismanagement reports are intricately related to how much flexibility a country has to exert policy autonomy within a Global Fund partnership:

> There are times when we would feel certain things should happen in one way, and Global Fund wants them to happen in another way, but because we are recipients, and the fact that we are also not – Zimbabwe for instance – does not have PR status, it makes life very difficult. So we just aim to achieve that level where we say 'at one stage we will be able to make the decision' and that period will only come when our own contribution towards those particular programs is significant. (personal communication, May 4, 2012).

In a final example, Maria Padkina, Fund Portfolio Manager for Mali at the Global Fund Secretariat in Geneva, spoke about how corruption in her portfolio in West Africa has led to similar suspensions and altered landscapes for Global Fund governance in the country:

> I work in Mali, and our CCM is pretty non-functional at the moment. There are no regular CCM meetings; it happens on an ad hoc basis. Because of the Malian context, as you know there was OIG investigation and there was an amount of money that was misused, we have most of our grants suspended. We are now signing new grants, but the CCM involvement is pretty much limited (personal communication, October 12, 2012).

Perhaps the greatest testimony to how corruption perceptions affect country relationships with the Global Fund came out of interviews conducted in Swaziland. Key Informant R emphasized that the main context of the CCM right now is the fallout of the OIG investigation, which happened over the last couple years. This caused backlogs of money and distribution slowed significantly. If this hadn't happened, social and political factors might be more important, but right now dynamics in the CCM are predominantly dictated by financial tensions as a result of misappropriated funds (personal communication, June 10, 2013).

After the investigation, which had only just concluded during the time of my interviews in June 2013, Vulindlela Msibi (CCM Secretariat) noted that there were 30 sub-recipients which were there during phase 1 of the Global Fund Round 8 grant. Now, in phase 2, there are only 8 left. Because of all the funding stoppages during the OIG investigation they dropped out or closed down (personal communication, June 10, 2013). As sole principal recipient, Khanya Mabuza (NERCHA) also commented on SRs falling out with government over the OIG situation, saying:

> We started to have problems with Global Fund, as NERCHA, as of 2009/2010. 2008. That's when OIG came in. Things changed because OIG said they will not reimburse us advances and relationships in country and with the Global Fund stretched. So it took us about 7 or 8 months, not even a penny coming from Global Fund, with the pressure from this side that money's not coming. Some of these things we could not correct – they were beyond our capacity. So, we know that we then lost favor (personal communication, June 12, 2013).

He continued, "It's not worth the insults. Whatever you do, either you are on the wrong side of the fund, the Global Fund, or you're on the wrong side of the SRs" (personal communication, June 12, 2013). This disillusionment as a result of corruption/mismanagement issues may be connected to why Swaziland's most recent HIV/AIDS policy did not move as sharply in line with Global Fund objectives as other countries in the region. Since NERCHA is the National AIDS Council in the country, and they are feeling quite discouraged with Global Fund processes now, this could be an influencing factor that helps bring nuance and depth to the relationship between corruption and policy compliance which was presented in Chapter 5.

Further, Dr. Kwame Amphomah with UNAIDS in Swaziland emphasized how the *perception* of corruption is an important factor, which also corroborates findings from Chapter 5. Speaking about the OIG report, he said corruption perception has impacted the way in which the Global Fund views Swaziland and views the repayment scheme (the initial US$ 5 million to repay has now been negotiated down to US$ 1.1 million). He said, "This is also a cite where you may not associate that level of corruption – the Nigerian levels of corruption – and that also helps" (personal communication, June 11, 2013).

These perspectives from Zambia, Zimbabwe, Swaziland and Geneva all illuminate how corruption – and the perception of corruption – can be a significant explanatory variable in the degree to which countries comply with Global Fund policies in their NSPs and HIV/AIDS programs. By limiting the number of country PRs, often revoking the government's recipient status in favour of the UNDP, OIG reports on corruption remove any leadership ability of the state with respect to Global Fund proposals and programming. This alters governance landscape which logically then has an effect on policy writing, with non-state actors having a increased power in the policy-making process.

Political Variables

Dominant Institutions

In terms of political variables, an enormously relevant factor that emerged during my interviews was the nature of dominant institutions in the country's HIV governance apparatus. Richard Cunliffe (Fund Portfolio Manager for Swaziland and Botswana at the Global Fund Secretariat in Geneva) called the political context within which the CCMs "a power struggle" (personal communication, October 22, 2012). This power struggle was readily apparent during my in-country visits, with the dominant institution on each CCM varying depending on the political context.

In Botswana, I got an overall sense from respondents in Gaborone – government and NGOs alike – that civil society in Botswana is generally weak. This political circumstance is reflected on the CCM, where Botswana has 11 per cent NGO representation, much lower than the regional average of 17 per cent (Global Fund, 2011). In addition, perspectives from CCM members were in agreement that the board is largely government-steered. Key Informant B with the Ministry of Health spoke about a lack of accountability in this regard. He especially mentioned how it is very hard to be fired from within government, unless you really embezzle large amounts of money. Otherwise, performance-based accountability does not really happen (personal communication, June 5, 2012). The notion of government dominating the policy and programing arena in the country was echoed by Thatayotlhe Molefe, with LEGABIBO (Lesbians, Gays and Bisexuals of Botswana) who said that "not too many people are reached, at the end of the day, 'cause the government keeps the money to themselves" (personal communication, June 7, 2012). This notion of government control over AIDS financing was also heavily emphasized by Dundu Macha, with BONEPWA+ (Botswana Network of People Living with HIV & AIDS) as she said:

> I think in Botswana, the organizations are government heavy. All of them. It's government. I mean people who are coming from outside can feel that they are really from outside, 'cause there's a lot of government presence, 'cause the Government does all of things there, unlike in other countries where there is a strong civil society. There's no strong civil society here and the government is too strong. This is why, maybe, BONEPWA doesn't talk too much, because who gives us the money to talk? It's government (personal communication, June 8, 2012).

Despite this general notion that government in Botswana feels very little pressure from civil society in terms of how it should write and implement its HIV/AIDS policies, it was also expressed that there has been a motion recently to improve the balance of power, with the

inclusion of a Principal Recipient from civil society. This means that a portion of Global Fund money (should Botswana's future proposals be successful) would go directly into the hands of an NGO. Right now, the only Principal Recipients in the country are government bodies - the National AIDS Coordinating Agency (NACA) and the Ministry of Health.

So, with the Global Fund seemingly to have all but pulled out of Botswana, government has assumed control of the AIDS response in the country. Interestingly, many civil society respondents voiced that this makes for a rather difficult relationship, where all the money for programming comes from government, so civil society does not feel like it can readily challenge government on policy decisions.

Similarly, in Swaziland the issue of government having almost sole control over funding (Global Fund or otherwise) was raised as a factor that constrained civil society's ability to challenge the status quo. Key Informant R raised the problem that since government (NERCHA) is the sole Principal Recipient in Swaziland, civil society feels they do not get enough of the Global Fund money and often feel that government is letting them down. She said how this constrains civil society's ability to challenge and debate with government, asking "How do you criticize government when they are your main funder as sole PR?" (personal communication, June 10, 2013). Khanya Mabuza with NERCHA was in agreement, noting that as civil society, "If 100% or 90% of your income is from government, surely speaking, are you not a government organization? You are" (personal communication, June 12, 2013). This dynamic of government control over Global Fund money was certainly voiced by members of civil society. Rudolph Maziya (AMICAALL) spoke very strongly about this issue and how it leaves civil society feeling completely shut out of the process:

> You are talking to someone who is very disillusioned at this moment. I have been sitting on the CCM ever since the first proposal in Swaziland. I'm disillusioned because, having sat for so many years on the CCM, I have seen that is has really not worked for civil society in Swaziland, and let alone for groups below. We have moved back and forth between staying on the CCM or coming out, because it's of no value. If you look at the amount of money that's gone to civil society, at one point I don't think it's been more than 14%. You sit down and write proposals and at the end of the day most of the money goes to Government (personal communication, June 12, 2013).

Zelda Nhlabatsi with the Family Life Association of Swaziland (FLAS) echoed this frustration, noting that "There's a tendency to always put forward government initiatives to be THE ones that need to be done. When we [civil society] bring the activities, they are generally dismissed like they are nothing" (personal communication, June 12, 2013). While this is likely true, as Vulindlela Msibi (CCM Secretariat) pointed out that "The budget

allocation in any proposal is in favor of government" (personal communication, June 10, 2013), respondents suggested that the reason for this is that civil society does not really have the capacity – or the strategic direction – to manage grants effectively. Khanya Mabuza (NERCHA) said that the CCM was set up and lead predominantly by government, and that "Civil society were coming in as people who want just to get the money, but were not fully involved in setting up the CCM" (personal communication, June 12, 2013). This sense that civil society just wanted money without having a clear understanding of what their role is and how that money would be spent on effective programming was also echoed by Key Informants, S, T and U, who represent the donor constituency on the CCM. According to Vulindlela Msibi (CCM Secretariat), it all comes down to a lack of capacity:

> I think our civil society's weak. That's my opinion. What normally makes civil society weak is issues of capacity. When they have to attend meetings, they are not there, when they have to get to meetings there's a challenge with the means of getting there. Looking at their governance structures [laughs] it's either you don't have a board, or permanent board. You find their books of account are not up to date; they are not audited (personal communication, June 10, 2013).

He continued to highlight how "In terms of advocating for some things, I would say they would be swallowed. Some of them are just too quiet and they take whatever it is that's being put on the table because they didn't read and they're not prepared for the meeting" (personal communication, June 10, 2013). Alison End with the Clinton Health Access Initiative also noted how there is pressure to include civil society in discussions, but often civil society does not really have the capacity or the voice to really participate or to be involved early enough. From the side of civil society, there was agreement on this perspective, with Emmanuel Ndlangamandla (CANGO) confessing that "We even don't know what should be our role at CCM. What is our role? What is our value of being at CCM? Because at the end of the day, we don't see the value addition in terms of our voice, our issues, and stuff like that" (personal communication, June 11, 2013). This power dynamic between government and civil society within the context of the Global Fund in Swaziland may help to explain the country's policy decisions. There is a relationship between state effectiveness and policy compliance which was presented in Chapter 5. This more in-depth understanding of how the Swazi state dominates the Global Fund grants and programming may provide a better understanding of how and why that relationship exists.

Where government is clearly the dominant institution in the Global Fund governance in Botswana and Swaziland, this is not the case in Malawi. Here, CCM members described the terrain of HIV/AIDS governance in the country as incredibly donor-led. This is immediately

clear if you look at the membership composition of the CCM, which is 30 per cent multi-lateral and bi-lateral seats (Global Fund, 2011). This is the highest donor presence in Southern Africa, and is almost twice the regional average, which is 17 per cent of CCM seats made up by multi-laterals and bi-laterals. Interestingly, here, if one looks at the actual membership breakdown, according to Global Fund (2011) data, it looks like there is 35% government representation, which is higher than Botswana's. The composition of the CCM is a good proxy measure for influence in AIDS governance generally. It also tells us about who is making decisions for the Global Fund country program.

However, while looking at composition alone does reveal certain power dynamics, interviews reveal 'insider' information on who actually shows up for meetings and who has a loud voice in terms of directing and steering policy and programming.

Key Informant M revealed that in practice, "Government composition in the CCM is not much. It's actually very limited in Malawi" (personal communication, May 25, 2012). Perspectives like these made it clear that the political deference that people spoke of was much more often geared towards powerful donors than it was to other constituencies, such as government or the faith-based community. He pointed out how "in countries like Malawi, it is almost entirely run by DFID, UNAIDS, etc." (personal communication, May 23, 2012). He also articulated that he thinks this is a good thing, as he heralded the CCM for allowing donors to enjoy even greater leadership in the country, saying that the "CCM also provides a good opportunity for WHO and UNIADS to provide greater stewardship in the response" (personal communication, May 23, 2012). Key Informant M also suggested how President Joyce Banda's recent call to repeal gay marriage bans was "a political step to make the donors happy"; it is not to change behaviour (personal communication, May 23, 2012). In the same vein, Key Informant L spoke about Banda's stance on gay marriage, joking about a political cartoon that came out shortly after the decriminalization announcement:

> There are two guys standing next to each other one. The headline says 'Joyce Banda allows homosexuality'. This guy says 'I thought we were a god fearing nation?' and the other says 'no, we are a donor fearing nation' (personal communication, May 25, 2012).

With respect to this, Key Informant I stressed how "The CCM does the best it can to follow policy. Global Fund says it doesn't make policy, but it does" (personal communication, May 23, 2012). This indicates that Malawi's policy-making is very much guided by donor agendas, even if these are not regarded as priority interventions in the country. This is especially true when it comes to making policy provisions for most-at-risk populations

(MARPS) which are illegal in the country, such as lesbian, gay, bisexual and transgender communities. Key Informant L spoke about how and why Malawi chose to include men who have sex with men (MSM) for the first time in its Round 10 Global Fund proposal as well as its 2010-2012 National Strategic Plan. He illustrated how "Within the country, people were really realizing that to be able to access recourses then we really had to take into account the comments that we received from the Global Fund previously. We are responsible to a donor, right?" (personal communication, May 25, 2012). Key Informant H with the Malawi Global Fund Coordinating Committee Secretariat confirmed this, telling me about how the laws and cultural beliefs of the country are secondary to global policies, especially when it comes to including MSM in the national strategic plans:

> It is a big challenge to be seen to be advocating for something that is illegal in a proposal that is supposed to provide for national needs. For instance, if you talk about gay people, and the law says that is illegal, and then you produce a document that explicitly calls for interventions targeting an illegal group. I don't think that would go down well. But, then there is a way that these are taken care of, for instance, through the frameworks, the national strategies, there provisions for these minorities. Even though they may not be very conspicuous there are interventions that are included (personal communication, May 23, 2012).

Key Informant K also touched on this, noting how donor pressure has had a huge impact on what gets included in national policy: "And MSM is also explicitly in government's national prevention policy, which was launched by the President. I don't think he read it though [laughs]" (personal communication, May 24, 2012). He continued to put forward that this type of external control over policy may be a really detrimental thing:

> Realistically, what portion of the epidemic do they represent? Because, one of the things that we do very well in HIV is that we create lots of set-aside little fiefdoms – you have your seat and you have your seat and you have your seat – and those kind of cast or class reservation policies may or may not contribute to good decision making at country level, because they may or may not actually reflect the reality of the epidemic (personal communication, May 24, 2012).

Lastly, while Malawi's dominant institution is certainly donor constituencies, like Botswana it is also faced with a rather weak civil society. In Malawi, there are two PRs - the National AIDS Commission (NAC) and the Ministry of Health. The CCM Secretariat would like to have more PRs, especially some from civil society. Ideally, most respondents felt that having some local civil society PRs would be advantageous, but so far the organizational or knowledge capacity to financially manage large grants has not been demonstrated by these organizations.

The same is true in Swaziland, where many voiced the need for dual tracking (having both government and civil society as Principal Recipients) but that civil society was simply not

strong enough. Key Informant R said that there has been progress in the last couple of months for CANGO to potentially be a sub-recipient, however, the Global Fund team fears there may not be time, since the Round 8 grant ends in December 2013 (before transitional funding begins in January 2014). However, her worry was less about time and more about capability. She said comparing CANGO to NERCHA is like comparing apples and oranges; CANGO is very small scope while NERCHA is huge. She said "You could easily crush CANGO with giving them too much, too soon" (personal communication, June 10, 2013). They have to start out small and grow incrementally. Emmanuel Ndlangamandla, Director of CANGO, was in complete agreement, voicing how previous experiences with Global Fund grants have been detrimental for his organization:

> It has created a loss of confidence in the whole set up and questioning amongst ourselves as civil society 'is it worth it?' because if you happen to get Global Fund money then it literally destroys your institution instead of building it up. Your staff loses morale, they are not paid on time, and you are just stuck with something that doesn't work (personal communication, June 10).

Organizations like Pact are helping to grow and support civil society in Swaziland, especially with an objective to help them become recipients of Global Fund money. Until they have that capacity it is likely that government will continue relatively unchallenged in Swaziland's Global Fund program.

Like Botswana and Malawi, civil society respondents from the Zambian CCM also voiced the political context of weak civil society. When I spoke with civil society key informants about the sources of HIV/AIDS funding and how different constituency influence factored in, there were mixes views. Carol Nawina Nyirenda, who was previously the civil society representative on the Global Fund Board in Geneva, noted that civil society in the country is really no match for the government or international NGOs. When I asked her if she felt local groups could raise their voices and speak in CCM meetings, she said:

> Frankly? No. You have the big NGOs and then you then have the government – they are very intimidating. People sometimes tread with care, even when they know what is happening is not good. They would know what they are doing is a disservice to their constituencies, but they don't really have […] the information. Sometimes the people who come to represent people don't even know who it is they really represent, or why they are there (personal communication, April 18, 2012).

It seems that government in Zambia is one of the more dominant institutions in the HIV/AIDS governing process, as Nyirenda pointed out:

> The CCM is a different jungle altogether. You could be a good speaker among your fellow youth, or you could be a good speaker among your fellow women, then you come to this group, and if you are not used to working with governments, it is easy to get intimidated (personal communication, April 18, 2012).

She also said that civil society has greater power dealing with donors than they do with the Zambian government. When we spoke about governmental control on the CCM, and their control over resources, she said:

> For me, my personal view, if the money is coming from here is might even be worse, especially if the money's from the government. They might say 'this money is for this! Take it or leave it!' Sometimes I feel, at international level, we even have more space as civil society than at country level (personal communication, April 18, 2012).

The Zambian government also showed a level of willingness to stand up to Global Fund prescriptions, which is not as evident in other contexts. Edwidge Mutale, who is the Permanent Secretary in the Cabinet Office of the Gender and Child Development Division, said that:

> What I would want to believe is, for me, I don't think I see any contradictions. The Global Fund, who have a generic kind of strategy, because it's looking at a broader perspective worldwide, but then when it comes to the specifics, this is where now we should say, as Zambians, *this* is where we've got issues. This is where we need help. Because I think some of the issues that might be issue with us, might not be issues somewhere else (personal communication, April 19, 2012).

Mutale continued to indicate that the Zambian government is willing to assert its dominance in policy priorities to the Global Fund, telling me that the country will not budge on its position on certain policy issues. When I asked her about HIV/AIDS policy for lesbian, gay, bisexual and transgender (LGBT) populations, she revealed that global policy *would not* affect local decision making in this regard:

> [T]hat issue…let's talk about what is the position on that. In Zambia, legally, it's illegal. Traditionally, it's taboo, so we don't even want to talk about it. From a religious point of view, this is a country that has got Zambia being a Christian nation embedded in its constitution, so again that is a no-go area. So for us that position is very clear. If they [the Global Fund] are going to use it as conditionality, then it's unfortunate for us, because that's our position. We cannot move from there" (personal communication, April 19, 2012).

The relative strength of the Zambian state on the CCM and in relation to the Global Fund may help to explain how state strength is related to less HIV/AIDS policy compliance than other countries in the region. Next to Botswana and South Africa, Zambia HIV/AIDS policy is the least compliant of the eight countries in this study. Its other governance indicators do

not explain its position in the region very well, the results of my interviews suggest that the state really is the dominant institution in Global Fund processes in Zambia.

Similar to Botswana and Zambia, it appears that the government is also the dominant institution on the Zimbabwean CCM. Key Informant Z2 spoke to this notion quite directly, noting how:

> It's always been led by the ministry, and their agenda. And not always the wrong agenda.The ministry wants activities that they can manage, and they want the funds coming to them. But most of what they have advocated for hasn't been terribly wrong. It's fairly well aligned. It's not off the wall (personal communication, May 2, 2012).

Sebastian Chinhaire, Zimbabwe Network for People Living with HIV, also said that Global Fund influence in the country is not really that strong, mainly due to government power. He said that "Global Fund policies have *some* influence over Zimbabwe's local HIV/AIDS programs, because of the guidelines on what they consider high impact interventions" (personal communication, May 3, 2012), but that this control is limited due to state dominance.

Contrary to Botswana, Malawi, Swaziland, Zambia and Zimbabwe, interview data from Namibia highlights it as an example of a country with a *strong* civil society. Unlike Botswana, Swaziland and Zambia where government is a very dominant force, and unlike Malawi where donors influence policy and programming the most, Namibia's civil society sector is a very strong component of their HIV/AIDS response. As briefly highlighted in the previous chapter, Namibia has the highly proportion of NGO representation on its CCM of all the countries in Southern African region. Where the regional average is 17 per cent NGO representation, this constituency on Namibia makes up 26 per cent of the CCM (Global Fund, 2011). Along with having the highest proportion of NGO representation on its CCM in the region, Namibia also has the lowest proportion of government seats, at 26 per cent, 11 per cent below the regional average.

Diane Cooper, with the University of Cape Town, School of Public Health, Women's Health Research Unit immediately began to draw stark contrasts between her experiences with Namibian and South African policy-making. Having recently taken part in an Open Society of Southern Africa HIV Advocacy Agenda Setting Project she had some insight on these comparative processes. She noted how "For Namibia, there was an incredibly strong women living with HIV organization, and they've been doing fantastic advocacy work in Namibia" (personal communication, August 6, 2012). She continued to recall the very active and

effective civil society advocacy from the Namibian constituencies, which bolter the ideas in the previous section. Diane Cooper mentioned how:

> The guy who was from the LGBT constituency, from the gay men's association in Namibia was unbelievably involved in lots of advocacy and getting their government to sort of account for what they were doing. Given the difficult legal situation, I was really impressed with how they've managed to get quite a few interviews with government, getting them to commit themselves to various things (personal communication, August 6, 2012).

Recalling from Chapter 5 that the size of donor and civil society constituencies on the CCM were good predictors of how compliant a country's HIV/AIDS policy would be with the Global Fund Toolkit, there are other ways in which CCM membership helps to explain policy trends. Interview data revealed that there are often alliances formed on the CCM, where certain constituencies will band together. In different countries, alliances are formed between different groups. These alliances may actually matter even more in terms of explaining why some countries are more compliant with Global Fund policies than others.

Viviane Hughes-Lanier, Fund Portfolio Manager for Niger, told me in Geneva that "looking at the composition and actually being in a meeting is so different. Power dynamics don't come through in numbers" (personal communication, April 16, 2013). She said representation and participation are two completely different things, and you have to get at who is participating and the quality of that participation in order to really understand who is influencing decision making in Global Fund processes. Similarly, Susan Amoaten, independent consultant on systems strengthening in Swaziland also emphasized that "The first and most obvious things that always ignored in CCMs is the power relations" (personal communication, June 12, 2013). While CCM alliances were clear in all countries I conducted interviews in, Swaziland was perhaps the most striking example.

In Swaziland civil society groups such as CANGO, FLAS and AMICAALL all voiced that government and donors form a strong team on the CCM and this often leaves civil society on their own in terms of support from other constituencies. Emmanuel Ndlangamandla (CANGO) said "civil society is on their own and they don't attract the voice from the others as allies, as government does" (personal communication, June 11, 2013). Zelda Nhlabatsi (FLAS) said the same thing, pointing out how the donors always seem to be supporting government or international groups rather than local civil society on the CCM:

> Eh, UN. We recently did some courtesy visits to just strengthen them. Sometimes you just feel like they are just on government side. You want to hear them support civil society,

> but…..that's what happened. The UN and PEPFAR. PEPFAR for example, or USAID, are supporting these international organizations who hardly interact with the locals (personal communication, June 12, 2013).

Similarly, Rudolph Maziya (AMICAALL) noted that the donor constituency has quite a lot of power on the CCM:

> The interest of donors on the CCM arises from the fact that they want to control the agenda because they want to direct not only their funds, but also the funds that we get though the global fund process, on interventions that they're convinced on, not interventions as we see them as a country. So their power comes from money (personal communication, June 12, 2013).

Continuing, Maziya noted how donors on the CCM often use this power in support of government, rather than civil society. In reference to supporting the government's proposed activities for the Transitional Funding Mechanism starting in January 2014, he said "The donors like PEPFAR, I'm sure, came on board" (personal communication, June 12, 2013). Interestingly, this perspective was shared by government as well. Khanya Mabuza (NERCHA) agreed with Nhlabatsi (FLAS) and Maziya (AMICAALL) that there are 'camps' on the CCM – donors vs. government vs. civil society. He said when these camps form, they are often able to influence decision-making:

> We know that some partners have very strong connections within the Global Fund. They can easily influence CCMs. When you disagree, the next day the Global Fund will be aware and they will take sides.

When I spoke to the donor constituencies about this perception that funding partners and government band together on the CCM, Key Informant S said "it would seem that way", but this is mostly because civil society's capacity is so weak. She gave the example of the proposal for transitional funding. The Global Fund made it clear that you cannot propose new activities. What does civil society do? Come to the table with three new activities (personal communication, June 12, 2013). She continued to explain that donor and government cooperation stems from a frustration with civil society's capacity: "Does civil society understand what's required of them? No. They just want funding. Period (personal communication, June 12, 2013).

So, when looking at CCM composition and participation of difference constituencies, it was clear that different countries were experiencing different power dynamics with respect to the dominant institutions (state, donor or civil society) and how those groups interact with each other, often forming political alliances on the CCM. These insights shed light on some of the trends from Chapter 5, which show relationships between government effectiveness, the age of the National AIDS Council and CCM composition and policy compliance. Understanding

the power dynamics that underlie these relationships helps to further elucidate why some countries are influenced by Global Fund policy more than others.

Political Culture

In addition to the role of dominant institutions, the political culture of a country was raised by nearly all respondents, across all eight countries, as a contributing factor to the way HIV/AIDS policy is developed and who leads the process. Richard Cunliffe, who is the Global Fund Portfolio Manager for Botswana and Swaziland highlighted two elements of political culture that are relevant in Swaziland in particular. He began by saying that culture shapes who speaks and which what authority on the CCM. According to him, "although you might have people sitting, on the CCM, the cultural power dynamic is that the voice that women perhaps isn't as strong. There's definitely a very sort-of hierarchal system" (personal communication, October 22, 2012).

However, Cunliffe noted that the more important political cultural context is that of the King and the monarchy. He said that "The context within which the CCM sits is that it is a very political CCM to the point where the chair of the CCM is also the advisor to the King, who is an absolute monarch. That's always going to be a real challenge" (personal communication, October 22, 2012). He also said that the King picks and chooses CCM members, when they are really supposed to be elected by their constituencies. Commenting on this, Susan Amoaten (Independent Consultant – Systems Strengthening) said it is a strange dynamic to be sit in on CCM meetings in Swaziland, since the CCM is a system of democracy in a country that does not believe in that (personal communication, June 12, 2013). Key Informant R said the same thing, noting that "People do their best to be respectful of the King" (personal communication, June 10, 2013). Emmanuel Ndlangamandla (CANGO) felt very strongly that the Political Culture around the monarchy definitely influenced decision making around policy ad programming in the country:

> Some of the strategies that government may push might not be strategies that will bring results, as such, but it's because they are politically correct. Because the King will be pleased to see you are using this structure or that structure, whether they work or not. There's a lot of investment that's been done in constructing infrastructure at the chiefdom level, but it's not working. But politically it was correct to mobilize the chiefs to be part of the greater movement in fighting HIV/AIDS. Practically, not much has been done to use the facilities (personal communication, June 11, 2013).

Further, Zelda Nhlabatsi (FLAS) said influence from the monarchy extends, so it is "Not just the king, even the other influential people. So people they're always making decisions, statements, based on 'so and so would like to hear this' so people are just not objective" (personal communication, June 12, 2013).

In addition, interviews in Swaziland revealed more depth as to why the political culture of the King and the monarchy might affect HIV/AIDS policy-making. Susan Amoaten (Independent Consultant – Systems Strengthening) noted how the system of government limits civil society's ability to act freely: "Here is particular the antagonism between civil society and government is extreme because civil society is seen as the root into political activism, which is obviously illegal in Swaziland. It's illegal to criticize government. You're put into jail for it" (personal communication, June 12, 2013).

Hlobsile Dlamini (Swaziland Rural Women's Association) said the same thing: "The moment you say 'human rights' you are deemed to be talking politics, and obviously when we're speaking human rights there are a lot of issues we are going to touch on, that ordinarily we shouldn't be interfering with according to politics" (personal communication, June 13, 2013). She says she gets challenged for being a political party the moment she speaks about human rights, and this gets her into trouble with the government.

These results were very useful in terms of interpreting results from Chapter 5. The correlations from that chapter revealed that there was no association between levels of democracy and HIV/AIDS policy-making. These findings confirmed previous research from Amy Patterson (2006). However, it seems that in Swaziland, the system of government *does* matter. Perhaps this means that elements of political culture with respect to type of government are more nuanced than indicator data on levels of freedom or voice and accountability show, and are an important factor to consider when explaining HIV/AIDS policy-making trends.

Other ways in which political culture affects HIV/AIDS policy-making were discussed by interviewees in Botswana. First, Key Informant B pointed out how the small nature of the country plays a large role in its politics; tenders from certain names carry more weight than others because everyone knows the big rich names in the country (personal communication, June 5, 2012). Lame Charmaine Olebile with LEGABIBO said the same thing. She said the small population colors the way civil society engages with government. She felt that:

> It's about time that we take a softer approach. As you know, in Botswana, it's like, I would now the attorney general, the next person knows the attorney general, the case is not the same in South Africa where there are a lot of people. There are only 2 million of us here. So, a lot of the times, the work that is done is just talking to people in parliament, because sometimes some of them are your Uncles! So we're just doing a lot of negotiations in offices with government officials, and we try to avoid the whole 'toyi-toyi' and what not because it's not our approach and it's not working for us. The softer approach has helped a lot" (personal communication, June 7, 2012).

Similarly, in Swaziland it was raised that the small and inter-connected nature of the country plays a significant role in the way in which people are able to enter into debate with each other. Susan Amoaten (Independent Consultant – Systems Strengthening) said:

> Here, in terms of the inclusion of different voices, Swaziland a huge total disadvantage which has nothing to do with the mechanism [CCM], which is that everyone is related to everybody else in one way or another. It's a tiny country. Same problem in Lesotho. I gather it's the same problem in Namibia where there's very low population density, probably in Botswana. It's a really fundamental problem here. You will be members of the same village community, you'll be members of the same church, you will have gone to university together, you will be blood related or related through marriage. This makes it *extremely* difficult, therefor, to have a robust debate. And within that, of course, is the Swazi sense of pride in maintaining the status quo. This is a country that's very proud of the fact it's seen as traditionalist. And the hierarchy – I find it completely impossible to break through (personal communication, June 12, 2013).

These perspectives confirm ideas in academic circles that Botswana's political culture in this regard is fundamental in the way in which civil society engages and the way policy-making and policy-changing processes occur. Zibani Maundeni (2004) argues that the main reason why Botswana's civil society is considered weak by some is because it stages very few violent clashes with government that lead to the reversal of policies. However, for Maundeni, this is a Eurocentric measure of strength that is inappropriate for the political culture of Batswana, one that emphasizes open discussions and dissuades violent behaviour. In agreement is Deborah Durham (1999) who says that when men fight in *kgotla* (chief's court) it becomes the subject of general ridicule for days, even years. In support of this, Connie Scanlon (2002) quotes a member of the Working Group for Indigenous People in Southern Africa, a local non-governmental organization (NGO) in Botswana, as saying "you know you are not fighting, you don't go and say bad things about your government."

Lame's sentiments endorse these ideas, as she insisted that it was very important to consider the politics of Botswana in all of the advocacy civil society does with government. When she organizes marches with her friends, she says to them "remember, we are not South Africa. Our history is not the same. Some things, we really don't need to do because people will not respond to it the same way that people in South Africa respond to it" (personal

communication, June 7, 2012). However, while this may be the political culture, informants from within government noted how this is not really the way things work. While it may be culturally and politically taboo to object or voice opinions in an emphatic manner, Key Informant B with the Ministry of Health reminded me that policy-making is very much a system driven by personalities, where the one with the loudest voice gets his agenda pushed. He said he did not think this was the way things ought to be, but it was the case (personal communication, June 5, 2012).

The same sense of political culture was voiced in Malawi, where the culture of civil society is not to challenge those in power. Key Informant I noted how "Because of the culture, people are not going to piss off their peers to push an agenda" (personal communication, May 23, 2012). Key Informant K agreed with this point, as did Key Informant J, who said "I think you go against the grain when you are a local organization and you're raising it with parliament" (personal communication, May 23, 2012). In another sense, Key informant K brought up the political culture of 'equality' in Malawi. He said that the reason why Malawi's policy is so generalized is because of the cultural environment:

> In this recourse constrained environment, one of the things that a lot of us are pushing on is the fact that now you have to start making choices. What are you going to stop doing, so that you can take that money and put it somewhere else that will do more and be more useful. That kind of a discussion in Malawi doesn't happen. If we can't all have ten, then we all have three. But you don't get six, and he gets two and I get nothing. No. We all get three. Equality in that sense, of making sure that everybody's got the same, no one's different, no one's standing out. If you do a prioritization workshop, everything's a priority. Nothing is a priority because everything is a priority. We don't make choices (personal communication, May 24, 2012).

This might help explain why the most recent Malawian national strategic plan is so tailored to the Global Fund's objectives. Perhaps it is not culturally viable to produce policy that is geared or aimed towards specific people or specific interventions at the cost of others. So, you end up getting quite a broad, generalizable document, just like the Global Fund's M&E Toolkit.

As in Malawi, in Zambia, too, a political culture of passivity is a factor among civil society. Key Informant Y (a representative from the NGO constituency on the CCM) suggested how Zambian culture affects the control from Geneva. He told me how "This instruction about removing the Ministry [of Health], it came as a recommendation from Geneva, but he basically phrased it as saying 'well, it has to be done like this'" (personal communication, April 20, 2012). He continued in explaining this, noting how Zambian culture often takes

recommendations as directives. He said that "it sometimes happens here. People will not necessarily challenge you on it" (personal communication, April 20, 2012).

The same idea came out in Zimbabwe. Key Informant Z6 felt that while people might say they are in a partnership with the Global Fund, they do not have the inclination to challenge or engage. She says "The thing that is lacking is the skills of, how does a CCM member initiate with the Global Fund. The relationship currently is very much of donor/recipient" (personal communication, May 3, 2012). She continued to draw attention to the fact that:

> It's not really a partnership, but, the CCM is responsible for defining where they want to funding to go at a country level. When the Global Fund gets to dictate, it says 'cut money', how much power does the CCM have to say 'this is what we really want'?" (personal communication, May 3, 2012).

Lastly, an interesting opinion on culture was voiced by Philisiwe Khumalo with the Elizabeth Glaser Pediatric AIDS Foundation in Swaziland. Aside from political culture, she felt it might even be more basic than that. She says:

> There must be something about Swazi people. Dig deep into our culture, is it poverty or what? I think there is something about Swazis that we are failing to understand. HTC is being provided. Condoms have been provided, all over the country. Everyone in one way or another can access them, but usage is still low. So what is it? (personal communication, June 12, 2013).

So, perhaps along with the context of the kind and of civil society's weaknesses, there are other elements of culture that affect how decisions are made more generally. In Khumalo's opinion, these more basic elements of culture are also important to consider at the policy-making level. All of these key informants also provide support for Lieberman's (2009) argument that culture is a simple yet powerful explanatory variable that is useful in understanding why country responses to HIV/AIDS differ.

National AIDS Councils

A fourth political variable that was exposed during my interviews is the importance of the National AIDS Commission (NAC) in shaping the country's policy response. In two countries – South African and Namibia – the nature of their NACs is a very important explanatory factor in their HIV/AIDS policy-making.

In South Africa, Maureen van Wyk and Marieta de Vos, with the Network AIDS Community of South Africa (NACOSA) pointed to the fact that the South African CCM disbanded, when

the South African National AIDS Council did. On 1 April 2012, the entire SANAC staff was fired, and South Africa's governing structures with the Global Fund effectively dissolved. Maureen van Wyk noted this connection, indicating that the lack of a functioning CCM stems from the fact that "the whole SANAC structure was under-resourced"(personal communication, September 6, 2012).This all happened at exactly the same time as the country's new National Strategic Plan on HIV/AIDS (2012 – 2016) was being launched. She said that this resulted in an especially distant relationship with the Global Fund, both in terms of policy and implementation thereof (personal communication, September 6, 2012).

She spoke about the ways in which the new NSP reflects this 'clean slate' feeling after the disbanding SANAC and the South African CCM:

> [T]he NSP's got the same focus areas but with more emphasis on focus and specific areas and TB is also brought it. There was a need for the secretariat and the whole SANAC structure to change. There was strong lobbying for that from all side, from government from civil society, because it was just not working. The feeling was, we're starting now, on a clean page with a new SANAC secretariat, SANAC structures, making sure we can implement the new NSP" (personal communication, September 6, 2012).

This move for the South African NSP to focus on 'specific areas' is quite the opposite of what respondents in Malawi and Namibia spoke about, where they were aiming for a much more broad and inclusive approach. The broader the policy, the close its alignment with Global Fund objectives, since many of them are based on international indicators. After the CCM disbanded, Maureen van Wyk was a member of the ad hoc Resource Mobilization Committee (RMC). She said that even this governing body did not have very close engagement with Global Fund priorities, often meeting only twice a year. The RMC was chaired by the Ministry of Health, which she felt was also not a good thing, since this person was often too busy to manage the RMC. It functioned, but not very effectively (personal communication, September 6, 2012). Especially in terms of its understanding of Global Fund priorities and objectives, Maureen noted how "In the past, most of the RMC members were not really very informed about any strategy" (personal communication, September 6, 2012).

Now, things are beginning to come together again, where Maureen van Wyk pointed out that "The whole SANAC structure has changed now with the new NSP and appointment of a CEO and a staff component. Previously SANAC was very under-resourced with ad hoc contract staff" (personal communication, September 6, 2012). Maureen van Wyk also highlighted how the CCM, too, will now come back into effect, which will happen after

September 2012, they just have to nominate the members (personal communication, September 6, 2012). So, perhaps South Africa's distance with the Global Fund will be remedies as these collaborative governing structures are mended. It will be interesting to see if this will affect policy-making in the future, or if South Africa will continue to deviate from Global Fund policy objectives.

In a completely different way, the nature of the NAC in Namibia has a large impact on the policy compliance of the country. Namibia's National AIDS Executive Committee (NAEC) is a government body, located within the Ministry of Health, which sits above the CCM. According to Key Informant N, with the President's Emergency Plan for AIDS Relief, the NAEC is key in the development of the national policy and Global Fund proposals, demonstrating quite a tight-knit alignment between government policy prerogatives and Global Fund requirements (personal communication, September 18, 2012). She says "The secretariat of the NAEC, does want to present the Phase 2 renewal proposal [of the Global Fund Round 9 grant] to the NAEC for endorsement before it goes to the CCM for endorsement. Whether that's right or wrong, I don't know" (personal communication, September 18, 2012). Also speaking to this, is Sandie Tjaronda, with NANASO. He noted how the country integration with Global Fund processes is very closely overlapping in Namibia. He pointed out how the "NAEC is not part of the GFTAM, but proposals go through that in Namibia before it passes" (personal communication, September 17, 2012).

In Chapter 5 it was found that the age of National AIDS Councils was related to policy compliance, with older NACs complying less with Global Fund policy since 2008, and newer NACs complying more (r = -0.30). But interview data show it is more complex, with elements of NAC politics in South Africa and Namibia uncovering why this relationship may exist for more intricate political reasons that just looking at the age of the structure. This helps to further explain how the politics of the National AIDS Councils may play a role in how compliant a country is with Global Fund policies. These findings provide support for Strand's (2007) thinking on how elements of AIDS governance is likely the most important factor in explaining differing policy responses.

Political Decentralization

Lastly, the fifth political variable that was uncovered during my field interviews was the element of political decentralization. In South Africa, Maureen Van Wyk and Marieta de Vos emphasized how provincial processes often override national ones, especially in terms of

health. This decentralized governance makes it very difficult for a national level process – like the CCM and NSP policy making – to coordinate effectively. Maureen Van Wyk cited how:

> Often when we discuss the set up, we really feel that where the work is done is in the provinces and that the sectors also need to focus on their provinces. Okay so you might have a women's sector, but the women's sector organizations are completely different in the Western Cape to what they are in Limpopo. The needs are different, everything is different (personal communication, September 6, 2012).

She continued to focus on how "South Africa's almost like nine small countries. They actually cannot coordinate because the country's too big" (personal communication, September 6, 2012). Marieta de Vos agreed, suggesting that "We feel that the representation has to be province based" (personal communication, September 6, 2012). This is, in some ways reflected in the Principal Recipients of Global Fund money in South Africa. There are five PRs in the country, one of which is the Western Cape Department of Health. NACOSA is also PR, which has its headquarters in Cape Town, Western Cape as well. This reflects the heavy emphasis on Western Cape politics in the policy and programming of Global Fund grants in South Africa. This might also be a factor which contributes to the nation's deviation away from Global Fund objectives, if one province has a heavier influence over the AIDS response than others. It is also quite relevant that the Western Cape is the only province not governed by the African National Congress, which SANAC is part of. This is also likely why both the Western Cape Department of Health is its own PR, and not a sub-recipient of the National Department of Health. This political circumstance may certainly help explain recent HIV/AIDS policy choices in South Africa.

Political decentralization in the South African context has been widely studied as a factor affecting its HIV response (Blaauw et al., 2003; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Lieberman, 2011; McIntyre & Klugman, 2003; Schneider, Blaauw, Gilson, Chabikuli, & Goudge, 2006; Schneider, Coetzee, Dingie, and Gilson, 2010). These studies suggest that issues of coordination, as well as the rise of non-state service providers both affect how HIV policy is designed and implemented. The interview data from Van Wyk and De Vos provides support for this, intimating that the issues of decentralized politics in South Africa negatively affect the coordination of the Global Fund country program.

Quite contrary to South Africa's intense decentralization and the effect it seems to be having on HIV/AIDS policy-making, the highly centralized nature of Zambia was cited by a number

of respondents there. When I asked about rural influence on policy and programs, or other areas aside from Lusaka, Key Informant Y told me the degree to which this occurs is:

> Not at all, but I think that's a problem of Zambia to start with. Zambia is hugely centralized. The biggest problem with this country, in my opinion, is lack of decentralization. I mean, you go out to district level and people refer you back to Lusaka, cause they simply cannot make a decision, or don't want to make a decision (personal communication, April 20, 2012).

This element helps to explain why Zambia's policies are more compliant than South Africa's, but this distinction is relatively minor, since Zambia's policy after 2008 is only slightly more compliant than South Africa's (2.529 out of 4, compared with 2.353 out of 4).

In Swaziland, too the idea that political centralization affected information flow was raised. Contrary to South Africa, Dr. Kwame Amphomah with UNAIDS in Swaziland said "It's a system where information easily goes through from the top to the bottom and horizontally. It's one people, one language, one culture, so communication from the governance level, the political governance level to the community level is probably very good" (personal communication, June 11, 2013). He continued to highlight how this is not the case in all setting, citing his native Nigeria as an example:

> In Nigeria, doing a national federal investment case for me is not very meaningful. Because you have the states, each state has its own governance system, it has its own budget, and each states HIV program is supported by grant from the world bank, so that's a very good entry point. You must do a state-by-state investment case, for each state. Then it is meaningful (personal communication, June 11, 2013).

Centralized or decentralized governments are an explanatory variable for understanding national HIV/AIDS policy responses that are not captured in Chapter 5. The way in which information can be shared, and influence can be excerpted, is related to this political factor.

Fund Portfolio Managers

Lastly, the relationship between the Global FPMs in Geneva and the recipient countries was highlighted as a strong explanatory variable by respondents. When I asked Maria Padkina, Fund Portfolio Manager for Mail, about how often her team visit the country, she said:

> We should go there at least twice a year, if the security situation allows. And then it also depends on what we are doing within the country, if we have to sign a phase 2 or if there is a particular issue that needs to be discussed, for example, if the grant is supposed to be scaled down to essential services, this is something that is normally being done when we go in country. So, it's on a needs basis – there is no rule, basically. And it very much depends on the FPM and the team leader. So, some FPMs are being more in touch with their countries, some FPMs are not willing to go there that often, it's again, personal decisions sometimes (personal communication, October 12, 2012).

Viviane Hughes-Lanier (FPM for Niger) also said security issues prevent her from being present in Niger (personal communication, April 16, 2013). However, in corroborating what Pakina said about it being the personal decision of the Fund Portfolio Manager, Amy Clancy, Fund Portfolio Manager for Egypt has been visiting frequently and conducting a handover missions to the new FPM (personal communication, April 17, 2013).

Based on these insights coming from the Global Fund Secretariat, it is clear that the personality of a country's FPM can play a significant role in how the relationship between a country and Geneva is formed, which logically influences how policy and programming is subsequently designed and implemented. This explanatory variable sheds light on why Namibia may be such an outlier as the only rich, well governed country to comply with Global Fund policy. In Namibia, Key Informant N emphasized the element of Global Fund's relationship with the country at great length:

> The relationship between Geneva and the country – the CCM - and Geneva is getting closer. And that varies in different countries, in terms of their relationship with the Fund portfolio manager and that country team there and how they engage with the CCM to manage the grants. But the relationship between Geneva and the CCMs is getting closer even in terms of the grants and the grant proposal process, in term of them wanting to be more closely involved. I think that's a good idea, from where I sit; they could serve to be more engaged. Now, the balance though, is the issue around the country ownership that the Global Fund model has always, really, promulgated. The issue that CCMs are the local board, and they are managing the grants, and this is a new realm of this term 'country ownership', they are the model. But, having lofty goals and saying that you are going to do this type of thing doesn't always play out the way you maybe want it to, so we've seen challenges with the Global Fund grants, sort of hand off approach, that doesn't always worked with the grants. So, I think they're trying to strike this balance with being more involved and giving more guidance, and continuing to support the country ownership approach. What you see in Namibia is, even with the renewal process, they've given more guidance, more explicit guidance about what they expect to see in the proposal in terms of re-programming. Some may say it's too much guidance, it's too prescriptive, and that they're not technical experts, they're grant managers, so how do they know if Namibia should go to B+ and PMTCT or condoms for social marketing purposed are relevant here. How do they know those things so how can they prescribe them. So, there's that dialogue that happens and that sort of dynamic, but I think that they're trying to say, and what they usually say when they come is, we're not saying that your country strategy should be x, y or z, what we're saying is what we're gonna pay for, are these types of things, which is different, but tricky (personal communication, September 18, 2012).

She continued to elaborate on this facet of Global Fund involvement in Namibia's HIV/AIDS policy and programming response, noting that the Global Fund seems to have chosen Namibia as a pilot country for testing a more involved oversight process of the Fund in affected countries:

> Geneva - the country team - has been here twice in the last six months, which is unheard of, and they've come to manage ongoing grant challenges and issues with conditions precedent. They have engaged more, it is unusual. But Namibia is one of the first countries to go through a grant renewal process under this new Global Fund age, so, I think people generally see it as an opportunity (personal communication, September 18, 2012).

The same is perhaps even more apt for Swaziland. Richard Cunliffe became new FPM in October 2012 and told me his plan is to visit the country every quarter. This has turned out to be even more frequent, as he was in Swaziland in June 2013, and was planning to return in July. Cunliffe indicated that in Swaziland:

> They've been rather lacking in Global Fund attention from a dedicated FPM [fund portfolio manager] for the last few months so I'm going to correct that. My intention is to be a bit more visible in-country, certainly over the next few months, to try and get back on track, really (personal communication, October 22, 2012).

Vulindlela Msibi (CCM Secretariat) agrees, speaking about their history with other FPMs: "Where we were, we were coming from a period where we are hadn't had a stable fund portfolio manager for quite some time. From a period of about 2-4 years we had people coming in and going out the next day" (personal communication, June 10, 2013). Khanya Mabuza (NERCHA) also spoke about this, saying that in the past, the lines of communication are hazy between FPM, PR and CCM. He said, "The team here, they don't understand how they are supposed to be working with the CCM, with the secretariat, with the Global Fund. Those minefields, if not controlled, they are the ones that are normal causing problems on the CCM" (personal communication, June 12, 2013). However, in the last ten months, Cunliffe's move to correct this is the result of his personal leadership decision-making. Mabuza (NERCHA) said the difference is stark, and that now "There is a feeling that the [Global Fund] secretariat does micro-manage" (personal communication, June 12, 2013). Hlobsile Dlamini (Swaziland Rural Women's Association) speculated that this change might be related to recent fund mismanagement issues: "I think certainly things may have changed after the OIG report. They may have put new measures in place" (personal communication, June 13, 2013).

The explanatory variable of Fund Portfolio Managers' individual personalities and individual decisions on how involved they want to be in their country's response is perhaps the most interesting result that came out of interviews in Geneva. It is clear that this element plays a significant role in how countries are influenced by Global Fund policies. This is also not a factor that can be captured in quantitative indicator, so was overlooked in the analysis conducted in Chapter 5. This factor is also perhaps the area in which the results from this

thesis may be most usefully applied in terms of making recommendations. This will be further explored in Chapter 7 as I make suggestions for the Global Fund's New Funding Mechanism based on the findings of this research.

Concluding Remarks

Insights from the 82 key informants in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia, Zimbabwe and The Global Fund in Geneva help to inform some of the trends that emerged out of the quantitative policy data and correlation indicators in the previous chapters. For each country, a unique set of political and economic factors help to further explain trends in policy compliance. In Botswana, dominant government and weak civil society greatly affect the policy-making process, partly as a result of non-confrontational political culture and a small population. There is also a strong sense of disillusionment with the Global Fund since Botswana was last funded 10 years ago, despite submitting proposals at every Round. Lastly, Botswana's fast development rate was cited as a potential factor which contributes towards the country's deviation from Global Fund policies.

Similar to Botswana, the political culture in Malawi leads to a very passive civil society. However, in this country, the bi-laterals and multi-laterals assume the majority of control over the HIV/AIDS governance process, much more than government does. The emphasis on the importance of the Global Fund as the country's largest development partner also came up as a highly relevant factor, as did its recent shift from pooled to discrete donor, and its declassification of Malawi as a high burden country. All of these elements help to explain Malawi's very high compliance with Global Fund policies.

In Namibia, the most compliant country in the region, the level of oversight that the National AIDS Executive Committee has over Global Fund governance in the country was cited as relevant by several informants. The very high in-country presence of the Global Fund country team, which has visited twice in the last six months, was also cited as an unusual circumstance. Both of these contextual factors are anomalies which aid in explaining Namibia's position as an outlier in the region – a high income, well-governed country that complies the most heavily with Global Fund policy agendas.

In South Africa, the unusual circumstances of the disbanding of its National AIDS Commission and subsequent collapse of its CCM are also unusual contextual factors. Along with its intensely decentralized provincial politics, these factors help to elucidate why South Africa's most recent NSP deviates from Global Fund policies.

In Swaziland, the political culture of the King and the Monarchy as well as an extremely weak civil society were highly relevant, as well as the recent OIG report and the very close involvement of the FPM in country.

Lastly, the informants in Zambia and Zimbabwe reported very little change over time and very little clash of views between their country and the Global Fund, corroborating their policy position as relatively stable and constant in their moderate policy compliance. All of these reasons *why* countries comply or deviate with Global Fund policies are relevant in how future policy is designed at the international level. The following chapter will explore these options.

These findings help to further explain relationships between political and economic factors and HIV/AIDS policy-making that were tested in Chapter 5. They also provide evidence for other explanatory factors that help with a better understanding of why policy changes over time, and how the county-specific dynamics play a role in policy making and policy change.

The next chapter concludes this thesis with a summary of the major findings of the research. Then, Chapter 7 outlines three major implications of the work, closing with a recommendation for who should act on them.

Chapter Seven

Conclusions and Recommendations: Implications for the Global Fund's New Funding Mechanism

"This is not about politics. It's about real people"
(personal communication, April 18, 2012).

Introduction

Assertions about the extent with which developing countries chose to formulate their HIV/AIDS policies in line with the policies of international actors, or deviate from them, and the reasons behind this, have either been based on partial evidence, often supported by no more than selectively examples to illustrate whatever a particular analysis chooses to argue.

In contrast, in this dissertation, I have broken new ground by using systematic methods to measure the actual extent of policy conformity/deviation for eight high prevalence countries in Southern Africa. Describing the extent of policy compliance is novel and I am the first one to measure this. While I only look at eight cases, they are arguably the eight most important cases in the world, as they are the countries with the highest HIV prevalence.[18]

Second, I have also operationalized and measured a range of variables to test arguments often cited in the literature that purport to explain why developing countries make these choices. I have also conducted interviews with a wide number of donor, government and civil society officials involved in HIV/AIDS policy-making in each country to attempt to gather "insider evidence" with which to understand the trends revealed by the statistical correlational analysis.

This research has generated evidence to support a number of important, though tentative generalizations (future research needs to test them against a larger body of national cases, as well as in different policy domains).

[18] Except for Mozambique, which was excluded from this study since its policies are written in Portuguese.

Major Conclusions

There are five major conclusions of this thesis:

First, despite trends in decreased donor support and increased country ownership, most high burden countries in Southern Africa continue to move their strategic plans toward greater, rather than less, conformity with global fund policies. As a result, my initial hypothesis is not supported by the available evidence.

Second, two countries – Botswana and South Africa – do not fit this trend, as they have recently (2010 and 2012, respectively) written new national strategic plans that are less compliant with Global Fund policies than their previous national strategies.

Third, disaggregating HIV/AIDS policy into more specific sub-dimensions, I have found that the Global Fund's policies on care and support are adhered to most consistently in Southern Africa. There are two exceptions, however: (1) In South Africa, the Global Fund's prevention policies have been the most influential; and in Swaziland, the Global Fund's treatment policies have been adhered to the most.

Turning to hypotheses about the reasons why some countries deviate from global policies while others comply, the results demonstrate that national wealth matters.

Fourth, countries in Southern Africa are more likely to comply with Global Fund policies if they are poor. Gross national income (GNI) per capita, health spending per capita, and the percentage of total HIV/AIDS funding which comes from the Global Fund are the strongest economic predictors of policy compliance. Countries with lower GNI/per capita and lower health spending per capita are more likely to comply with Global Fund policies. Similarly, countries with receive more money from the Global Fund, as a percentage of total HIV/AIDS funding, are also more likely to align their national policies with the strategies of the Global Fund. In addition, interviews with donor, government and civil society officials intimately involved in HIV/AIDS policy making suggest that wealth matters because the extent to which the Global Fund does or does not fund proposals - and the way in which they do - affects the way the country perceives the donor and writes subsequent policy.

Fifth, the available evidence also suggests that governance matters. High burden countries are more likely to comply with Global Fund policies if they have a weak political commitment towards HIV/AIDS. In-country Global Fund governance via the composition of the Global Fund's Country Coordinating Mechanisms is the best predictor among the political variables examined. Countries with higher proportions of international non-governmental organizations and foreign development partners (multi-lateral and bi-lateral organizations) are more likely to comply with Global Fund policies. However, World Bank governance indicators do not account for HIV/AIDS policy compliance very well. A conclusion that can be drawn from this is that the weak state argument is moderately supported, but that components of "AIDS governance", like the CCM composition, matter much more. Here, too, interviews shed light on how the attentiveness of the Global Fund Country Team, power of the National AIDS Commission and political culture matter a great deal in how countries write their policies.

My insider interviews suggest that the reason that increased civil society presence on the CCMs results in greater policy conformity is because civil society in these Southern African countries is not very defiant and seems to align itself very closely with the donors. In addition, many of the NGO seats on the CCM are filled by large well-funded national and international organizations, which also certainly push towards compliance with donor identified policy norms. This confirms arguments in the literature that suggest donor funding creates a civil society that maintains the status quo, rather than challenging it (Hearn, 2001). These interviews also reveal nuances of how development rate, Global Fund spending and corruption affect policy-making, as well as how dominant institutions, political culture national AIDS commissions, political decentralization and the personalities of Fund Portfolio Managers play an important role.

Based on these major findings, this chapter sets out three main implications for this thesis. First, this research has implications for previous and future knowledge and literature on HIV/AIDS policy-making. Second, there are implications for the Global Fund's New Funding Mechanism and how it related to the UNAIDS Investment Framework. Third, and perhaps most importantly, there are potential implications for measuring policy efficacy, which is the thrust of this project's larger rationale. At the end of this chapter, I will present some interesting epidemiological trends to consider, in hopes of providing an incentive for future research into "what worked".

Knowledge and Literature Implications

What do these findings mean for current knowledge and the literature on power in the international health policy-making arena? Essentially, they corroborate the mainstream idea that international donors exert heavy influence over locally designed polices in Southern Africa (Campbell, 2003; Poku, 2005; De Waal, 2003; Attaran & Sachs, 2001; Boler & Archer, 2008; Heald, 2006; Cohen & Tate, 2005). However, while they bolster this mainstream idea, the evidence in this thesis provides an empirical basis for these ideas to rest on, when they were previously largely based on anecdotal likelihoods. In other words, many others have postulated that donor influence over local policy was strong, but I am the first to have actually demonstrated it using systematic methods of collecting policy data. However, the findings of this study also challenge this thinking as far as it applies to Botswana and South Africa, since their policies deviated from Global Fund objectives after 2008.

The findings of this research also provide support for *why* certain countries are more influenced by donors than others in the policy-making process. My findings demonstrate tentative relationships between economic and political variables and levels of HIV policy compliance, supporting many previous arguments about how structural and institutional factors affect policy decisions (Biesma, et al., 2009; Narayan, 2007; Epstein, 2007, Parkhurst, 2011, Butler 2005; Wouters et al. 2010; Patterson, 2006; Lieberman, 2011; Altman & Buse, 2012; Chirambo, 2008; Velayati et al., 2007).

Future Policy Implications

While my findings have a number of implications for knowledge and literature, they also have significance for the practical future policy developments within the Global Fund. Campbell (2003, p. 191) says that "there seem[s] to be little willingness among these powerful groups to consider the ways in which they themselves might need to change if the problem [is] to be addressed." In 2003 this may have seemed to be the case, but in 2013 the Global Fund can hardly be charged with a lack of introspection on how its funding processes are designed. In November 2011, after the lack of contributions from supporting countries for Round 11, the Global Fund implemented the Transitional Funding Mechanism, as it designed a New Funding Mechanism for future grants, which would drastically recalibrate the way in which it disperses resources. Given the findings of previous research, bolstered by the results presented in this thesis, it is commendable that the Global Fund is now in the process of reviewing and revising its funding mechanism in order to make it more effective.

This section will begin by detailing the environment of future grant-making policy under the new UNAIDS (2011) Investment Framework. Then, within this context, I will set out the processes under the Transitional Funding Mechanisms and New Funding Mechanism, and end with three major conclusions about how the New Funding Mechanism can maximize its effectiveness based on the findings of this research: First, the Global Fund should calculate its new 'country bands' to consider both economic circumstance; Second, it should also permit health systems strengthening concept notes to be submitted independently of the malaria, TB and HIV/AIDS grant applications; Third, the CCM composition recommendations should be revised to recommend fewer international NGO and multi-lateral/bi-lateral seats.

While the point of critical change examined in this thesis (~2008) can be characterized as a turning point of 'donor withdrawal', 'donor retreat' and 'funding crisis' for HIV/AIDS (Médecins Sans Frontières, 2010; Dickinson, 2010, June 25; Chipunza, 2010, 10 March), since then money for HIV/AIDS has stabilized and the funding landscape has evolved into a context of 'value for money', 'money well spent', 'optimization' and 'return on investment' (Schwartländer et al., 2011; WHO, UNICEF & UNAIDS, 2012; Hutchinson et al., 2012; Cook & Seymour, 2013). Established by UNAIDS in 2011, the New Investment Framework for the Global Response to HIV aims to improve responses by demonstrating that money is invested in cost-effective ways that yield optimized results. The Framework sets out a defined set of six evidence-based programme activities: (1) Focus on key populations (sex workers, MSM, IDUs), (2) Elimination of new infections in children, (3) Behavior Change, (4) Condom promotion and distribution, (5) Treatment care and support and (6) Voluntary medical male circumcision (UNAIDS, 2011). This Investment Framework will be important to the Global Fund's New Funding Mechanism because countries will now have to demonstrate return on investment in proposed activities through monitoring and evaluation. In fact, in 2012 the Global Fund's new strategy for 2012-2016 was released, entitled "Investing for Impact" (Global Fund, 2012). My recommendations for the Global Fund's future grant making, which follow, are shaped by the importance of this new 'investment' context.

Firstly, my findings suggest that in terms of country bands, the Global Fund should incorporate both wealth and disease burden into its calculations. Currently, as the New Funding Mechanism is still is the process of being finalized, is it proposed to be divided into "bands" which will be calculated based on a formula which accounts for a country's disease

burden, its per capita income, or some combination of the two. Currently, the Global Fund is considering four proposed methods for calculating country bands: (1) dividing countries based on economic indicators which will be calculated using gross national income per capita only, (2) disease-burden indicators, (3) a combination of economic and disease burden indicators, where the GNI per capita element makes sure that one country fits into one band only, and not in different bands for different diseases, and (4) an economic transition system, where countries can "graduate" from Global Fund support ad no longer be eligible for funding once they reach a certain level of economic development.

My findings, however, suggest that GNI per capita is a huge driver of locally driven policy development (recall Figure 5.1). My evidence also strongly suggests that there is a key wealth threshold which allows countries to develop domestically tailored policies, which increase country ownership and may prove more effective. This wealth threshold looks to be approximately US$ 4000 GNI/capita (see Figure 5.1). For this reason, I would recommend that either the third or fourth proposed country band formula be adopted. The findings of this project especially support consideration of the fourth proposed formula – 'graduation' from Global Fund support – since it appears that there is a wealth threshold that countries pass (US$ 4000 GNI/capita) which then allows them to design domestically driven policies and programs on their own.

The recommendation to the Global Fund to select country 'bands' based on both disease burden and economic indicators is also sensible in order to maximize effective performance within the UNAIDS Investment Framework. First, the Framework states that "To implement the investment framework, policy makers must make use of information on HIV incidence and prevalence" (UNAIDS, 2011, p. 7). This means that disease burden is closely related to which interventions a country should pursue under the new Framework. By the same logic, the grant-making system of the Global Fund's New Funding Mechanism should also take account of epidemiological factors during country dialogue. Similarly, the Investment Framework also says that countries need to have a "nuanced understanding of the scope and coverage of existing HIV prevention, treatment, care and support programmes as well as their costs" (UNAIDS, 2011, p. 7). The Framework continues to indicate that "In most countries this will mean changing investments in HIV and a re-programming of HIV efforts" (UNAIDS, 2011, p. 7). This means that the costs of programs as well as the ability of countries to understand what they can afford and what they need to re-prioritize is an

important element of successful implementation of the Framework. As a result, economic indicators in a country are closely linked with how this process will happen; countries with fewer resources may need to do a lot more reprogramming than those countries with greater government health budgets. For this reason, the Global Fund's New Funding Mechanism should also take into account the wealth of a country in its new grant-making process.

Secondly, the proposed design of the Global Fund's New Funding Mechanism should allow for country concept notes to be submitted based on health systems strengthening (HSS) proposals, rather than attaching this component to disease specific applications. In the past, HSS grants have paled in comparison to disease specific grants. For instance in Round 5, only 5 per cent of total Global Funding was allocated for HSS programs. Specially, US$ 38 million of the US$ 770 million total was dedicated to HSS grants (Global Fund, 2012b). Further, this US$ 38 million was only for 3 countries out of the 60 who received funding. However, Round 5, the first year when HSS funding was introduced, was unusual. Since then, all HSS funding has been integrated as cross-cutting requests within disease specific proposals. Applicants may divide this up however they chose (all HSS components may be in the HIV proposal, or they may be shared among three different disease-specific proposals) but HSS grants can never be a stand-alone application (Global Fund, 2008).

The results of my study suggest the increased emphasis on HSS grants as a stand-alone funding opportunity. Since overall health spending per capita is the strongest predictor of increased country ownership of policy in this study (r = -0.73, p = 0.062), the New Funding Mechanism should promote this more heavily through increased funding allocated for HSS grants. Country ownership is clearly an important part of the Global Fund's strategy for the New Funding Mechanism. A the Global Fund's 26th Board meeting (10-11 May 2012) it was stressed that the New Funding Mechanism must "reflect national ownership" and be based on "country-led formulation and implementation processes" (Global Fund, 2012c). To this end, factors that promote divergence from global indicators in favour of locally informed and nationally-devised policy should be promoted.

The recommendation for the Global Fund's New Funding Mechanism to permit concept note submissions for stand-alone HSS grants also makes sense within the UNAIDS Investment Framework. One of the key areas of investment outside of basic program activities is something called "critical enablers". These include things like strategic planning, program management and capacity building and community mobilization, which are all elements of

HSS activities. The HSS grants through the Global Fund aim to provide linkages between health systems and outcomes for the three diseases. Therefore, in order to benefit from the Investment Framework, funding critical enablers though HSS grants is highly important. Further, while the Framework says that biomedical interventions have a much stronger evidence base than critical enablers, the results of this project demonstrate that overall health spending is a more strongly related to divergence from global indicators than HIV-specific program spending, potential providing evidence that spending on critical enablers has an impact on country ownership of policy.

Third and lastly, the final recommendation that is supported by my evidence is that the Global Fund may be wise to revise its CCM composition so that bi-lateral/multi-lateral organizations and NGO composition is lower. If strong presence of these two groups seems to steer national responses in the direction of global indicator-based policies, balancing their presence with more seats for other groups may help to promote more domestically informed and nationally owned policy and programing. Other constituencies, such as the private sector, people living with HIV/AIDS, TB or malaria, and key affected populations seem to steer policy and programing towards a more locally tailored design. Bi-lateral/multi-lateral organizations and large international NGOs may have agendas that reside outside of state interests, since donors are pushing their own interests and NGOs have compromised autonomy since they too depend on international funding for existence.

This third recommendation for fewer donor and international NGO seats might also be increasingly sensible in the context of the new Investment Framework. More constituency representation for key affected populations, such as MSM, IDUs and sex workers will improve the ability of the CCM to design policy, proposals and programs that achieve the Framework's first basic program activity which suggests focusing programs for these populations. These groups may be represented by civil society on the CCM, but they are classified as "Key Affected Populations" in terms of their constituency, which is what was used to measure membership as an explanatory variable. Further, more representation for *local* civil society, as opposed to large international NGOs, might be the more salient need. This may help provide evidence for the Framework's critical enabler of 'local responses to change risk environment' (UNAIDS, 2011, p. 3). Further, more seats for PLHIV may improve the ability of the CCM to effectively follow the Investment Framework's recommended activity of "Treatment, care and support for people living with HIV" (UNAIDS, 2011, p. 3). Therefore, if the Global Fund's New Funding Mechanism is to work

in harmony with the Investment Framework, having more seats on the CCM for those most affected populations and those with expertise in critical enablers in the local context will catalyze the Framework's aim to "Support more rational resource allocation based on country epidemiology and context" (UNAIDS, 2011, p. 2).

Paraphrasing Peter Piot (2000), Campbell (2003, p. 194-195) says "An appropriate response to the epidemic is not just about best practice, but also about new practice." It may be that this has now been the realization of the Global Fund, whereby its New Funding Mechanism will be a much more consultative country-driven process. This could be in an effort to move away from its previous indicator-based toolkit towards a new institutional model of country dialogue and locally designed interventions.

To maximize the impact of the New Funding Mechanism, especially within the context of the new Investment Framework, Fund Portfolio Managers (FPMs) especially should act on my recommendations. They are responsible for assisting countries in developing concept notes for the NFM and work with the CCM secretariat on CCM membership and participation.

It was clear from my interview research that Fund Portfolio Managers were hesitant to shake things up too much. Richard Cunliffe (FPM for Botswana and Swaziland) said "what power has the secretariat been given to challenge the thinking of countries?" (personal communication, April 16, 2013). Similarly, Vivianne Hughes-Lanier (FPM for Niger) said "As FPMs, are we equipped to have this kind of impact?" (personal communication, April 17, 2013). She confessed she was not trained in public health. Similarly, Cunliffe is also not trained in public health; he has professional background as lawyer. Key informants in Africa also raised this issue. Susan Amoten (Independent Consultant, Swaziland) said that FPMs used to be more public health specialists, but now they are much more financially oriented. However, Mauro Guarinieri (Senior Specialist with the Global Fund) who used to be FPM for Nepal, said FPMs absolutely have the ability to change this landscape in country, it just depends on their will to do so (personal communication, 15 April, 2013). Linda Mafu (Head of the Political and Civil Society Department at the Global Fund) said more training for FPMs is needed, especially in relation to epidemiological issues and how FPMs engage with civil society outside of the CCM. If further training for FPMs could be implemented, then they would really be in a good position to lead change in country programs within the NFM.

Despite these issues, during my interviews with FPMs in Geneva I saw the beginning of a new willingness of FPMs to improve their engagement with African CCMs. Hughes-Lanier is pursuing a Master's degree in Public Health to try and improve her knowledge of epidemics and the politics of disease management. In addition, Cunliffe stated that he makes an effort to meet with civil society on every single trip to Swaziland. He is also working to make sure there will be a seat for key affected populations on the next CCM. These are encouraging trends. If more FPMs could demonstrate action towards engaging with local stakeholders and improving domestic governance of Global Fund programs then the results of my research – and the research of my colleagues in the field – can help to maximize the success of the Global Fund's New Funding Mechanism.

Policy Efficacy Implications

Recall that one of my final interests in undertaking this study is the need to measure "what worked" in terms of policy efficacy in a more robust manner. Since I cannot conclusively measure the impact of policy on the epidemic for a number of reasons (small sample size, inability to control for third variables) I have chosen to address this question in the form of some intriguing possibilities, providing an initial test of arguments and challenging future researchers to corroboration.

To inquire as to whether changes in HIV policy compliance since 2008 have had an impact on the epidemic, I employ Justin Parkhurst's (2008) five-step "working backwards" method. This method requires evidence, in the following order, for: (1) falling HIV prevalence, due to (2) falling HIV incidence, due to (3) changes in behavior, due to (4) behavior change interventions, due to (5) HIV prevention policies.

So, first, Parkhurst says you must demonstrate that HIV prevalence rates are falling. Since 2008, HIV prevalence fell by 0.1-2.7 per cent in all countries in this study, except for Lesotho where it rose by 0.1 per cent (UNAIDS 2008; UNAIDS 2012). But, declining prevalence rates can mean prevention of new infections, but it can also mean HIV-related deaths increased, hence driving overall prevalence down. Put differently:

> HIV *prevalence* declines can only be taken as a sign of 'success' if they reflect falls in HIV *incidence*, that is to say, if they follow from a decrease in new infections of HIV across the population (as opposed to stable incidence and increasing mortality rates, which may lower prevalence) (Parkhurst, 2008, p. 276).

Decreases in HIV prevalence as a result of increasing mortality rates is certainly not a desired policy outcome, so there is a need to unpack the nature of rising or falling prevalence rates further, as Parkhurst suggests.

Therefore, step two of Parkhurst's model, after examining prevalence rates, is to see whether falling prevalence is associated with falling incidence. The most recent data on new infections shows that HIV incidence rates have indeed also fallen in all countries in this study, again with the exception of Lesotho, where they are stable (UNAIDS, 2012). Therefore, it is likely that the falling HIV prevalence rates are a reflection of falling HIV incidence rates.

Unfortunately, steps three and four or Parkhurst's model – providing evidence for behavior change and behavior change interventions – are beyond the scope of this thesis. But there are a number of interesting considerations that my data do reveal, which may provide a first assessment upon which other researchers may improve and do a better job to satisfy the evidence requirements of these steps.

While acknowledging that steps three and four are missing, we can use our data to proceed to step 5. This provides some potentially interesting relationships between falling HIV incidence and my data on policy compliance. For instance, there is a fairly strong positive correlation between the size of incidence rate decline and changes in policy compliance between T2 (2003-2008) and T3 (post-2008) (r = 0.32). This might mean that those countries which complied less with Global Fund policy during this time also experienced fewer new HIV infections.

Furthermore, looking only at prevention policies as Parkhurst suggests, this relationship becomes even stronger (r = 0.51). This suggests that the less compliant a country is with Global Fund prevention policies, the more HIV incidence declines (Figure 7.1). The correlation supports the idea that declining HIV incidence rates may be related to deviation from Global Fund prevention policies.

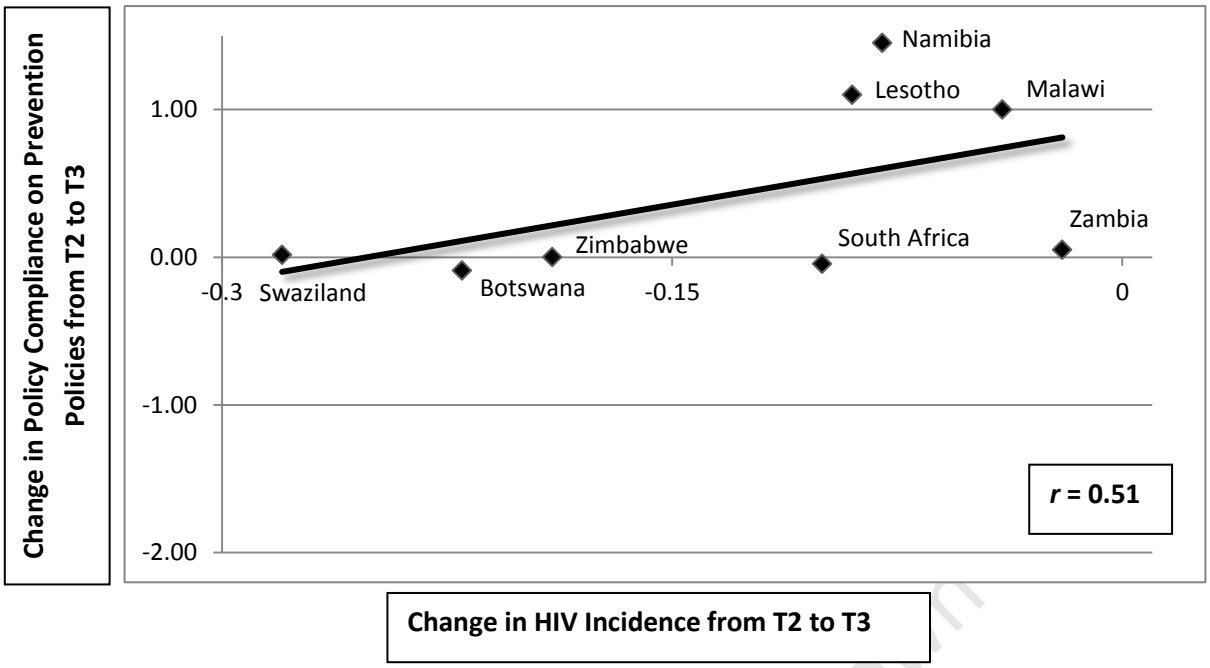


Figure 7.1: The Relationship between the Change in Policy Compliance on Prevention Policies and Change in HIV Incidence from T2 to T3 (UNAIDS, 2010).

Another hurdle that Parkhurst raises is the difficulty with measuring the time lags needed to accurately determine the point at which policies begin to impact infection rates. There is wide disagreement about how to measure the connection between policies and programs and their effects on epidemiological outcomes. Some believe that one ought to include a time-lag in the way policy and infection rates interact. Epstein (2007) says that if you want to observe a connection between policy and its effect on HIV prevalence, you need to point to behaviors that began changing long before declining prevalence is witnessed. Similarly, Campbell (2003) says it takes time for many community-level projects to bear fruit. She bases this idea on a UNAIDS (2000) review of best practices which suggest that it can take anywhere from four to five hears for HIV prevention interventions to show measurable impact.

However, other studies measure policy change and disease outcome patterns as simultaneously changing phenomena. For example Asiimwe-Okiror et al. (1997), measure changes in behavioral policies and infection rates over the same period of time. In other words, if condom promotion is on the rise from 1990 to 1995, and HIV rates fall in that same period, the deduction is that the two are related. Like, Asiimwe-Okiror et al., Glick, Younger & Sahn (2006) also suggest that policy can influence epidemiological outcomes relatively simultaneously. In their study, they find that "coverage of maternal health and immunization

services can improve significantly in a fairly short period of time as a result of policy" (Glick, Younger & Sahn, 2006, p. 10). While they find differences in mortality outcomes from 1997 to 2003 as a result of policy, they also find that the difference between 2003, 2002 and 2001 outcomes are not statistically significant, meaning that the policy had begun to impact changes long before 2003. In addition, the policy they are measuring the impact of (the Basic/Linkages project) was first implemented in 1999. This means that the impacts of the 1999 policy were already beginning to have an impact on 2001 epidemiological outcomes.

This, in addition to not being able to provide evidence for step three and four of Parkhurst's model, is another reason why my initial test of policy efficacy is in no way definitive or conclusive. However, the declines in prevalence, associated with declines in incidence are certainly worthy of further examination in so far as they might be the result of policy change in Southern Africa. In addition, I hope that the incentive provided here, with initial intriguing relationship between falling incidence and changes in policy compliance will lead to other researchers to re-examine this issue across a broader range of cases over a longer time period.

Concluding Remarks

The conclusion of this dissertation is that most countries in Southern Africa continue to align their HIV/AIDS policies with Global Fund objectives, except for South Africa and Botswana who have diverged since 2008. These compliance levels can be explained in part by structural and institutional variables, suggesting that wealth and governance are closely related to a country's ability to move away from donor policies. My initial assessment of this impact on the epidemic supports mainstream thinking that divergence from globally prescribed policy makes for more effective interventions. As a result, there are three main recommendations that this final section outlines, based on the results of this project and the future implications. The first is the way that the Global Fund will calculate its new 'country bands', the second is the emphasis on health systems stregthening and the third is the composition of the CCMs.

However, given the small number of cases in my study, I put forward this conclusion with a degree of circumspection. I call for future researchers to use the tools I have developed (as well as improve upon them) and apply them to a broader number of cases to see if the observations made here remain valid.

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APPENDICES

APPENDIX A – Global Fund Grants to Study Population

Table A1.1: Global Fund Grants to Study Population, by Round (Global Fund, 2012)

Country	**Round 1** (April 2002)	**Round 2** (Jan. 2003)	**Round 3** (Nov. 2003)	**Round 4** (June 2004)	**Round 5** (Sept .2005)	**Round 6** (Nov. 2006)	**Round 7** (Nov. 2007)	**Round 8** (Nov. 2008)	**Round 9** (Nov. 2009)	**Round 10** (Dec. 2010)
Botswana		**X**								
Lesotho		**X**			**X**		**X**	**X**	**X**	
Malawi	**X**				**X**		**X**			
Namibia		**X**							**X**	
South Africa	**X**	**X**	**X**			**X**			**X**	
Swaziland		**X**		**X**			**X**	**X**		
Zambia	**X**			**X**				**X**		**X**
Zimbabwe	**X**				**X**			**X**		

APPENDIX B – Total Global Fund Grant Amounts

Table B1.1: Total Global Fund Money Disbursed (Global Fund, 2012)

Country	Total Global Fund HIV/AID Grants[19]
Botswana	US$ 18,580,414
Lesotho	US$ 227,451,148
Malawi	US$ 563,075,534
Namibia	US$ 161,848,182
South Africa	US$ 352,798,800
Swaziland	US$ 154,925,426
Zambia	US$ 470,359,185
Zimbabwe	US$ 152,152,785

[19] These amounts do not include grants approved under the Transitional Funding Mechanism, which replaced Round 11 and were announced in August 2012.

APPENDIX C– National Policy Documents on HIV/AIDS

Table D1.1: List of National Policies on HIV/AIDS

National Policies on HIV/AIDS	
Country	**Policy**
T1 – Before 2003	
Botswana	National Policy on HIV/AIDS (1993)
Lesotho	National AIDS Strategic Plan (2000/2001-2003/2004)
Malawi	The National Strategic Framework for HIV/AIDS (2000-2004)
Namibia	The National Strategic Plan on HIV/AIDS (Medium Term Plan II)(1999-2004)
South Africa	HIV/AIDS/STD Strategic Plan for South Africa (2000-2005)
Swaziland	Swaziland National Strategic Plan for HIV/AIDS (2000-2005)
Zambia	Strategic Framework (2001-2003)
Zimbabwe	National Policy on HIV/AIDS for the Republic of Zimbabwe (1999)
T2 – Between 2003 and 2007	
Botswana	National HIV/AIDS Strategic Framework (2003-2009)
Lesotho	National HIV & AIDS Strategic Plan (2006-2011)
Malawi	Malawi National HIV/AIDS Policy (2003)
Namibia	The Namibian National Strategic Plan on HIV/AIDS (2004 – 2009)
South Africa	HIV & AIDS and STI Strategic Plan for South Africa (2007-2011)
Swaziland	The Second National Multisectoral HIV and AIDS Strategic plan (2006 – 2008)
Zambia	National HIV and AIDS Strategic Framework (2006-2010)
Zimbabwe	Zimbabwe National HIV & AIDS Strategic Plan (ZNASP) (2006-2010)
T3 – After 2007	
Botswana	The Second National Strategic Framework for HIV and AIDS (2010-2016)
Lesotho	National HIV and AIDS Strategic Plan (2006 – 2011) (Revised April 2009)
Malawi	Malawi HIV and AIDS Extended National Action Framework (2010-2012)
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia (2010/11 – 2015/16)
South Africa	National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016
Swaziland	The National Multi-sectoral Strategic Framework For HIV and AIDS (2009 – 2014)
Zambia	National AIDS Strategic Framework (2011 – 2015)
Zimbabwe	Zimbabwe National HIV & AIDS Strategic Plan [ZNASP II] (2011-2015)

APPENDIX D – Country Policy Datasets

BOTSWANA Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	3	4	3	Towards Then Away
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	2	1	Towards Then Away
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	0	1	1	Towards Then Static
BCC Community Outreach for Sex Workers	HIV-P4a	0	3	2	Towards Then Away
BCC Community Outreach for Young People (10-24)	HIV-P4a	2	3	1	Towards Then Away
Schools that provided life skills–based HIV education	HIV-P5	3	4	3	Towards Then Away
Male Condoms	HIV-P7	4	4	1	Static Then Away
Female Condoms	HIV-P7	0	4	0	Towards Then Away
Private Sector Condoms	HIV-P7	3	0	1	Away Then Away
Free Public Condoms	HIV-P7	4	2	1	Away Then Away
Testing and Counceling for Women and Men (15-49)	HIV-P8b	2	3	4	Towards Then Towards
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	3	0	Towards Then Away
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	0	2	0	Towards Then Away
Prevention Of Mother-To-Child Transmission	HIV-P11	0	0	1	Static Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	0	0	4	Static Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	0	4	2	Towards Then Away
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	0	0	Static Then Static
Post-Exposure Prophylaxis	HIV-P15	0	0	1	Static Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	2	0	Away Then Away
Blood Safety	HIV-P17	4	4	1	Static Then Away
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	0	4	2	Towards Then Away
Health facilities that offer antiretroviral therapy	HIV-T2	0	2	1	Towards Then Away
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	1	3	Towards Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	0	4	0	Towards Then Away
Care And Support For Chronically Ill People	HIV-CS2	4	4	4	Static Then Static
Support For Orphaned And Vulnerable Children	HIV-CS3	4	4	4	Static Then Static
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	1	3	4	Towards Then Towards
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	4	0	Towards Then Away
Enterprises implementing an HIV workplace program	HIV-SE2	4	4	2	Static Then Away
Reducing Stigma	HIV-SE3	2	3	2	Towards Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	0	3	4	Towards Then Towards
Multiple Partners	HIV-O3	4	4	4	Static Then Static
Sterile Injecting Equipment	HIV-O8	0	0	0	Static Then Static
School Attendence	HIV-O9	1	3	0	Towards Then Away

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
BOTSWANA HIV Policy (1993)
T2
BOTSWANA HIV Strategic Framework (2003-2009)
T3
BOTSWANA HIV Strategic Framework (2010-2016)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.400	2.250	1.350	Towards Then Away
Treatment	0.000	2.333	2.000	Towards Then Away
Care and Support	2.667	4.000	2.667	Towards Then Away
Collaborative Activities	1.000	3.000	4.000	Towards Then Towards
Supportive Environment	2.000	3.667	1.333	Towards Then Away
Outcome Indicators	1.250	2.500	2.000	Towards Then Away
Average Total NSP Score	1.412	2.588	1.676	Towards Then Away

LESOTHO Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	1	2	3	Towards Then Towards
BCC Community Outreach for Injecting Drug Users	HIV-P4a	1	0	3	Away Then Towards
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	1	0	3	Away Then Towards
BCC Community Outreach for Sex Workers	HIV-P4a	2	3	3	Towards Then Static
BCC Community Outreach for Young People (10-24)	HIV-P4a	1	3	2	Towards Then Away
Schools that provided life skills–based HIV education	HIV-P5	2	3	2	Towards Then Away
Male Condoms	HIV-P7	3	3	4	Static Then Towards
Female Condoms	HIV-P7	0	3	4	Towards Then Towards
Private Sector Condoms	HIV-P7	3	0	3	Away Then Towards
Free Public Condoms	HIV-P7	3	0	3	Away Then Towards
Testing and Counceling for Women and Men (15-49)	HIV-P8b	1	3	2	Towards Then Towards
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	3	4	Towards Then Towards
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	0	3	0	Towards Then Away
Prevention Of Mother-To-Child Transmission	HIV-P11	2	3	4	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	0	3	4	Towards Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	0	0	3	Static Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	0	4	Static Then Towards
Post-Exposure Prophylaxis	HIV-P15	0	3	4	Towards Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	2	3	4	Towards Then Towards
Blood Safety	HIV-P17	3	3	4	Static Then Towards
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	3	4	Towards Then Towards
Health facilities that offer antiretroviral therapy	HIV-T2	0	3	3	Towards Then Static
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	0	Static Then Static
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	1	1	1	Static Then Static
Care And Support For Chronically Ill People	HIV-CS2	3	3	4	Static Then Towards
Support For Orphaned And Vulnerable Children	HIV-CS3	3	3	4	Static Then Towards
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	3	3	2	Static Then Away
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	2	4	Towards Then Towards
Enterprises implementing an HIV workplace program	HIV-SE2	0	2	3	Towards Then Towards
Reducing Stigma	HIV-SE3	1	3	2	Towards Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	2	3	4	Towards Then Towards
Multiple Partners	HIV-O3	2	3	4	Towards Then Towards
Sterile Injecting Equipment	HIV-O8	0	0	3	Static Then Towards
School Attendence	HIV-O9	2	3	4	Towards Then Towards

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
LESOTHO National HIV Strategic Plan (2000-2003)
T2
LESOTHO National HIV Strategic Plan (2006-2011)
T3
LESOTHO National HIV Strategic Plan (Updated 2009)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.250	2.050	3.150	Towards Then Towards
Treatment	0.333	2.000	2.333	Towards Then Towards
Care and Support	2.333	2.333	3.000	Static Then Towards
Collaborative Activities	3.000	3.000	2.000	Towards Then Away
Supportive Environment	0.333	2.333	3.000	Towards Then Away
Outcome Indicators	1.500	2.250	3.750	Towards Then Away
Average Total NSP Score	1.265	2.147	3.088	Towards Then Towards

MALAWI Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	2	3	4	Towards Then Towards
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	0	1	Static Then Towards
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	0	1	2	Towards Then Towards
BCC Community Outreach for Sex Workers	HIV-P4a	0	4	3	Towards Then Away
BCC Community Outreach for Young People (10-24)	HIV-P4a	2	3	2	Towards Then Away
Schools that provided life skills–based HIV education	HIV-P5	1	3	4	Towards Then Towards
Male Condoms	HIV-P7	3	3	4	Static Then Towards
Female Condoms	HIV-P7	0	3	4	Towards Then Towards
Private Sector Condoms	HIV-P7	0	2	4	Towards Then Towards
Free Public Condoms	HIV-P7	0	0	4	Static Then Towards
Testing and Counceling for Women and Men (15-49)	HIV-P8b	3	2	3	Away Then Towards
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	2	2	Towards Then Static
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	3	3	2	Static Then Away
Prevention Of Mother-To-Child Transmission	HIV-P11	3	3	4	Static Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	3	3	4	Static Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	0	0	3	Static Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	0	2	Static Then Towards
Post-Exposure Prophylaxis	HIV-P15	0	3	3	Towards Then Static
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	3	4	Static Then Towards
Blood Safety	HIV-P17	2	2	4	Static Then Towards
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	2	4	Towards Then Towards
Health facilities that offer antiretroviral therapy	HIV-T2	0	0	4	Static Then Towards
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	3	Static Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	1	3	3	Towards Then Static
Care And Support For Chronically Ill People	HIV-CS2	3	3	4	Static Then Towards
Support For Orphaned And Vulnerable Children	HIV-CS3	3	3	3	Static Then Static
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	1	0	4	Away Then Towards
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	0	4	Static Then Towards
Enterprises implementing an HIV workplace program	HIV-SE2	3	3	3	Static Then Static
Reducing Stigma	HIV-SE3	1	3	2	Towards Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	2	2	3	Static Then Towards
Multiple Partners	HIV-O3	2	2	3	Static Then Towards
Sterile Injecting Equipment	HIV-O8	0	0	0	Static Then Static
School Attendence	HIV-O9	1	1	3	Static Then Towards

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
MALAWI National Strategic Framework (2000-2004)
T2
MALAWI National HIV and AIDS Policy (2003)
T3
MALAWI National Strategic Framework (2010-2012)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.250	2.150	3.150	Towards Then Towards
Treatment	0.333	0.667	3.667	Towards Then Towards
Care and Support	2.333	3.000	3.333	Towards Then Towards
Collaborative Activities	1.000	0.000	4.000	Away Then Towards
Supportive Environment	1.333	2.000	3.000	Towards Then Towards
Outcome Indicators	1.250	1.250	2.250	Static Then Towards
Average Total NSP Score	1.265	1.912	3.118	Towards Then Towards

NAMIBIA Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	3	1	4	Away Then Towards
BCC Community Outreach for Injecting Drug Users	HIV-P4a	1	0	4	Away Then Towards
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	1	0	4	Away Then Towards
BCC Community Outreach for Sex Workers	HIV-P4a	1	4	4	Towards Then Static
BCC Community Outreach for Young People (10-24)	HIV-P4a	1	2	3	Towards Then Towards
Schools that provided life skills–based HIV education	HIV-P5	0	3	4	Towards Then Towards
Male Condoms	HIV-P7	2	4	4	Towards Then Static
Female Condoms	HIV-P7	1	2	4	Towards Then Towards
Private Sector Condoms	HIV-P7	3	3	3	Static Then Static
Free Public Condoms	HIV-P7	4	3	3	Away Then Static
Testing and Counceling for Women and Men (15-49)	HIV-P8b	3	3	4	Static Then Towards
Testing and Counceling for Most-at-risk populations	HIV-P8b	1	0	1	Away Then Towards
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	0	0	4	Static Then Static
Prevention Of Mother-To-Child Transmission	HIV-P11	1	3	4	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	1	4	4	Towards Then Static
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	2	0	4	Away Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	1	3	4	Towards Then Towards
Post-Exposure Prophylaxis	HIV-P15	1	3	4	Towards Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	3	3	Static Then Static
Blood Safety	HIV-P17	3	3	4	Static Then Towards
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	4	4	Towards Then Static
Health facilities that offer antiretroviral therapy	HIV-T2	1	3	4	Towards Then Towards
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	2	Static Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	1	2	4	Towards Then Towards
Care And Support For Chronically Ill People	HIV-CS2	3	3	3	Static Then Static
Support For Orphaned And Vulnerable Children	HIV-CS3	2	3	3	Towards Then Static
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	3	3	4	Static Then Towards
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	0	0	Static Then Static
Enterprises implementing an HIV workplace program	HIV-SE2	0	4	4	Towards Then Static
Reducing Stigma	HIV-SE3	3	3	2	Static Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	0	0	4	Static Then Towards
Multiple Partners	HIV-O3	0	1	4	Towards Then Towards
Sterile Injecting Equipment	HIV-O8	0	0	0	Static Then Static
School Attendence	HIV-O9	0	3	4	Towards Then Towards

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
NAMIBIA HIV Medium Term Plan II (1999-2004)
T2
NAMIBIA HIV Medium Term Plan III (2004 - 2009)
T3
NAMIBIA National Strategic Framework for HIV (2010-2015)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.650	2.200	3.650	Towards Then Towards
Treatment	0.667	2.333	3.333	Towards Then Towards
Care and Support	2.000	2.667	3.333	Towards Then Towards
Collaborative Activities	3.000	3.000	4.000	Static Then Towards
Supportive Environment	1.000	2.333	2.000	Towards Then Away
Outcome Indicators	0.000	1.000	3.000	Towards Then Towards
Average Total NSP Score	1.382	2.147	3.382	Towards Then Towards

SOUTH AFRICA Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	2	3	2	Towards Then Away
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	3	2	Towards Then Away
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	0	4	4	Towards Then Static
BCC Community Outreach for Sex Workers	HIV-P4a	2	4	4	Towards Then Static
BCC Community Outreach for Young People (10-24)	HIV-P4a	2	2	2	Static Then Static
Schools that provided life skills–based HIV education	HIV-P5	1	4	4	Towards Then Static
Male Condoms	HIV-P7	2	4	4	Towards Then Static
Female Condoms	HIV-P7	1	3	4	Towards Then Towards
Private Sector Condoms	HIV-P7	0	1	0	Towards Then Away
Free Public Condoms	HIV-P7	0	2	4	Towards Then Towards
Testing and Counceling for Women and Men (15-49)	HIV-P8b	2	4	3	Towards Then Away
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	3	2	Towards Then Away
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	2	4	2	Towards Then Away
Prevention Of Mother-To-Child Transmission	HIV-P11	1	4	4	Towards Then Static
HIV-positive pregnant women who received antiretrovirals	HIV-P12	2	4	4	Towards Then Static
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	0	3	2	Towards Then Away
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	3	3	Towards Then Static
Post-Exposure Prophylaxis	HIV-P15	2	4	2	Towards Then Away
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	2	2	4	Static Then Towards
Blood Safety	HIV-P17	2	4	0	Towards Then Away
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	3	3	Towards Then Static
Health facilities that offer antiretroviral therapy	HIV-T2	1	0	2	Away Then Towards
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	4	4	Towards Then Static
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	1	4	1	Towards Then Away
Care And Support For Chronically Ill People	HIV-CS2	2	3	3	Towards Then Static
Support For Orphaned And Vulnerable Children	HIV-CS3	2	3	1	Towards Then Away
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	2	3	1	Towards Then Away
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	0	0	Static Then Static
Enterprises implementing an HIV workplace program	HIV-SE2	2	4	1	Towards Then Away
Reducing Stigma	HIV-SE3	1	4	1	Towards Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	0	3	3	Towards Then Static
Multiple Partners	HIV-O3	1	4	3	Towards Then Away
Sterile Injecting Equipment	HIV-O8	0	3	0	Towards Then Away
School Attendence	HIV-O9	0	3	1	Towards Then Away

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
HIV/AIDS/STD Stategic Plan for South Africa 2000-2005
T2
HIV/AIDS/STI Stategic Plan for South Africa 2007-2011
T3
National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.150	3.250	2.800	Towards Then Away
Treatment	0.667	2.333	3.000	Towards Then Towards
Care and Support	1.667	3.333	1.667	Towards Then Away
Collaborative Activities	2.000	3.000	1.000	Towards Then Away
Supportive Environment	1.000	2.667	0.667	Towards Then Away
Outcome Indicators	0.250	3.250	1.750	Towards Then Away
Average Total NSP Score	1.059	3.118	2.353	Towards Then Away

SWAZILAND Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	2	3	4	Towards Then Towards
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	1	3	Towards Then Towards
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	0	0	3	Static Then Towards
BCC Community Outreach for Sex Workers	HIV-P4a	0	1	4	Towards Then Towards
BCC Community Outreach for Young People (10-24)	HIV-P4a	2	3	4	Towards Then Towards
Schools that provided life skills–based HIV education	HIV-P5	1	2	1	Towards Then Towards
Male Condoms	HIV-P7	3	4	1	Towards Then Away
Female Condoms	HIV-P7	1	4	1	Towards Then Away
Private Sector Condoms	HIV-P7	2	3	1	Towards Then Away
Free Public Condoms	HIV-P7	0	3	1	Towards Then Away
Testing and Counceling for Women and Men (15-49)	HIV-P8b	2	4	4	Towards Then Static
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	0	0	Static Then Static
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	2	0	1	Away Then Towards
Prevention Of Mother-To-Child Transmission	HIV-P11	0	3	4	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	1	3	4	Towards Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	0	2	3	Towards Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	2	1	Towards Then Away
Post-Exposure Prophylaxis	HIV-P15	0	3	4	Towards Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	3	3	Static Then Static
Blood Safety	HIV-P17	3	4	4	Towards Then Static
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	3	4	Towards Then Towards
Health facilities that offer antiretroviral therapy	HIV-T2	1	4	4	Towards Then Static
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	2	Static Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	0	2	2	Towards Then Static
Care And Support For Chronically Ill People	HIV-CS2	1	2	4	Towards Then Towards
Support For Orphaned And Vulnerable Children	HIV-CS3	2	1	3	Away Then Towards
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	1	2	3	Towards Then Towards
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	0	4	Static Then Towards
Enterprises implementing an HIV workplace program	HIV-SE2	3	2	3	Away Then Towards
Reducing Stigma	HIV-SE3	2	3	2	Towards Then Away
OUTCOME INDICATORS					
Abstinence	HIV-O1	1	3	4	Towards Then Towards
Multiple Partners	HIV-O3	1	3	4	Towards Then Towards
Sterile Injecting Equipment	HIV-O8	0	0	0	Static Then Static
School Attendence	HIV-O9	1	3	4	Towards Then Towards

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
SWAZILAND National Strategic Plan (2000-2005)
T2
SWAZILAND National HIV Strategic Plan (2006-2008)
T3
SWAZILAND National Strategic Framework For HIV and AIDS (2009-2014)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.100	2.400	2.550	Towards Then Towards
Treatment	0.667	2.333	3.333	Towards Then Towards
Care and Support	1.000	1.667	3.000	Towards Then Towards
Collaborative Activities	1.000	2.000	3.000	Towards Then Towards
Supportive Environment	1.667	1.667	3.000	Static Then Towards
Outcome Indicators	0.750	2.250	3.000	Towards Then Towards
Average Total NSP Score	1.059	2.235	2.765	Towards Then Towards

ZAMBIA Policy Trends

Indicator	Code	T1	T2	T3	TREND
PREVENTION					
BCC Mass Media	HIV-P1	3	4	4	Towards Then Static
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	2	0	Towards Then Away
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	0	0	1	Static Then Towards
BCC Community Outreach for Sex Workers	HIV-P4a	4	1	2	Away Then Towards
BCC Community Outreach for Young People (10-24)	HIV-P4a	4	2	0	Away Then Away
Schools that provided life skills–based HIV education	HIV-P5	2	4	4	Towards Then Static
Male Condoms	HIV-P7	4	2	3	Away Then Towards
Female Condoms	HIV-P7	2	1	3	Away Then Towards
Private Sector Condoms	HIV-P7	1	0	0	Away Then Static
Free Public Condoms	HIV-P7	0	0	0	Static Then Static
Testing and Counceling for Women and Men (15-49)	HIV-P8b	1	4	4	Towards Then Static
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	0	0	Static Then Static
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	0	0	0	Static Then Static
Prevention Of Mother-To-Child Transmission	HIV-P11	1	4	0	Towards Then Away
HIV-positive pregnant women who received antiretrovirals	HIV-P12	1	4	4	Towards Then Static
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	2	3	4	Towards Then Towards
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	1	1	4	Static Then Towards
Post-Exposure Prophylaxis	HIV-P15	0	3	4	Towards Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	4	3	Towards Then Away
Blood Safety	HIV-P17	1	4	4	Towards Then Static
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	4	4	Towards Then Static
Health facilities that offer antiretroviral therapy	HIV-T2	1	3	4	Towards Then Towards
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	1	Static Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	2	3	2	Towards Then Away
Care And Support For Chronically Ill People	HIV-CS2	4	3	4	Away Then Towards
Support For Orphaned And Vulnerable Children	HIV-CS3	3	4	4	Towards Then Static
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	2	3	3	Towards Then Static
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	2	4	Towards Then Towards
Enterprises implementing an HIV workplace program	HIV-SE2	2	4	4	Towards Then Static
Reducing Stigma	HIV-SE3	2	1	2	Away Then Towards
OUTCOME INDICATORS					
Abstinence	HIV-O1	3	3	3	Static Then Static
Multiple Partners	HIV-O3	2	4	4	Towards Then Static
Sterile Injecting Equipment	HIV-O8	0	2	0	Towards Then Away
School Attendence	HIV-O9	2	4	3	Towards Then Away

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
ZAMBIA HIV Stragetic Framework (2001-2003)
T2
ZAMBIA HIV Stragetic Framework (2006-2010)
T3
ZAMBIA National HIV Stragetic Framework (2011-2015)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.500	2.150	2.200	Towards Then Towards
Treatment	0.667	2.333	3.000	Towards Then Towards
Care and Support	3.000	3.333	3.333	Towards Then Static
Collaborative Activities	2.000	3.000	3.000	Towards Then Static
Supportive Environment	1.333	2.333	3.333	Static Then Towards
Outcome Indicators	1.750	3.250	2.500	Towards Then Away
Average Total NSP Score	1.588	2.441	2.529	Towards Then Towards

Table D1.8: Zimbabwe HIV/AIDS Policy Trends

ZIMBABWE Policy Trends					
Indicator	**Code**	**T1**	**T2**	**T3**	**TREND**
PREVENTION					
BCC Mass Media	HIV-P1	2	0	2	Away Then Towards
BCC Community Outreach for Injecting Drug Users	HIV-P4a	0	1	0	Towards Then Away
BCC Community Outreach for Men Who Have Sex With Men	HIV-P4a	1	2	1	Towards Then Away
BCC Community Outreach for Sex Workers	HIV-P4a	3	3	1	Static Then Away
BCC Community Outreach for Young People (10-24)	HIV-P4a	2	2	1	Static Then Away
Schools that provided life skills–based HIV education	HIV-P5	3	3	1	Static Then Away
Male Condoms	HIV-P7	3	3	1	Static Then Away
Female Condoms	HIV-P7	3	4	4	Towards Then Static
Private Sector Condoms	HIV-P7	2	4	4	Towards Then Static
Free Public Condoms	HIV-P7	2	4	4	Towards Then Static
Testing and Counceling for Women and Men (15-49)	HIV-P8b	2	4	4	Towards Then Static
Testing and Counceling for Most-at-risk populations	HIV-P8b	0	1	3	Towards Then Towards
Testing and Counceling for Young women and men aged 15–24	HIV-P8b	0	1	0	Towards Then Away
Prevention Of Mother-To-Child Transmission	HIV-P11	1	3	4	Towards Then Towards
HIV-positive pregnant women who received antiretrovirals	HIV-P12	0	3	4	Towards Then Towards
Infants born to HIV-infected women who receive an HIV test within 12 months	HIV-P13	2	3	3	Towards Then Static
Infants born to HIV-infected women starting on co-trimoxazole prophylaxis	HIV-P14	0	3	3	Towards Then Static
Post-Exposure Prophylaxis	HIV-P15	0	1	4	Towards Then Towards
Diagnosis And Treatment Of Sexually Transmitted Infections	HIV-P16	3	3	4	Static Then Towards
Blood Safety	HIV-P17	3	4	4	Towards Then Static
TREATMENT					
Antiretroviral Therapy And Monitoring	HIV-T1	1	4	4	Towards Then Static
Health facilities that offer antiretroviral therapy	HIV-T2	0	4	4	Towards Then Static
Facilities providing antiretroviral therapy using CD4 monitoring	HIV-T4	0	0	4	Static Then Towards
CARE AND SUPPORT					
Prophylaxis For Oportunistic Infections	HIV-CS1	0	3	2	Towards Then Away
Care And Support For Chronically Ill People	HIV-CS2	3	1	4	Away Then Towards
Support For Orphaned And Vulnerable Children	HIV-CS3	2	4	3	Towards Then Away
COLLABORATIVE ACTIVITIES					
TB/HIV	TB/HIV-1	1	1	3	Static Then Towards
SUPPORTIVE ENVIRONMENT					
NCPI	HIV-SE1	0	0	4	Static Then Towards
Enterprises implementing an HIV workplace program	HIV-SE2	1	1	1	Static Then Static
Reducing Stigma	HIV-SE3	2	0	3	Away Then Towards
OUTCOME INDICATORS					
Abstinence	HIV-O1	2	2	0	Static Then Away
Multiple Partners	HIV-O3	2	2	4	Static Then Towards
Sterile Injecting Equipment	HIV-O8	0	0	0	Static Then Static
School Attendence	HIV-O9	0	1	1	Towards Then Static

Scale	
Q: To what degree does the National Strategic Plan promote this Global Policy?	
0	Not at all
1	Just a little
2	To a moderate degree
3	Quite a lot
4	Very heavily

Timeframe Key
T1
National Policy on HIV (1999)
T2
National HIV and AIDS Strategic Plan (2006-2010)
T3
National HIV and AIDS Strategic Plan (2011-2015)

AGGREGATE INDICATORS	Aggregate Policy Trends			
	T1	T2	T3	TREND
Prevention	1.600	2.600	2.600	Towards Then Static
Treatment	0.333	2.667	4.000	Towards Then Towards
Care and Support	1.667	2.667	3.000	Towards Then Towards
Collaborative Activities	1.000	1.000	3.000	Static Then Towards
Supportive Environment	1.000	0.333	2.667	Away Then Towards
Outcome Indicators	1.000	1.250	1.250	Towards Then Static
Average Total NSP Score	1.353	2.206	2.618	Towards Then Towards

APPENDIX E - Key Informant Interview Participants

Table E1.1 : Botswana Key Informant Interview Participants

BOTSWANA (n=14)

Name	Organization
Key Informant A	Private Sector
Key Informant B	Ministry of Health
Key Informant C	-
Lame Charmaine Olebile	LEGABIBO (Lesbians, gays and bisexuals of Botswana)
Thatayotlhe Molefe	LEGABIBO (Lesbians, gays and bisexuals of Botswana)
Dundu Macha	BONEPWA+ (Botswana Network of People Living with HIV & AIDS)
Key Informant D	BONEPWA+ (Botswana Network of People Living with HIV & AIDS)
Key Informant E	BONEPWA+ (Botswana Network of People Living with HIV & AIDS)
Tshepo Kgositau	Rainbow Identity Association
Max Mabaka	Rainbow Identity Association
Lefetogile Bogosing	CCM Secretariat, National AIDS Coordinating Agency
Kabelo Ebineng	Botswana Business Coalition on HIV/AIDS
Diana Meswele	National AIDS Council Ethics, Law and Human Rights Sector
Key Informant F	European Delegation to Botswana and SADC

Table E1.2 : Malawi Key Informant Interview Participants

MALAWI (n=13)

Name	Organization
Key Informant G	-
Key Informant H	Malawi Global Fund Coordinating Committee Secretariat
Edith Mkawa	Malawi Global Fund Coordinating Committee Secretariat
Key Informant I	-
Key Informant J	-
Ruth Mwandira	DFID
Key Informant K	-
Roberto Luiz Brant Campos	UNAIDS
Robert Ngaiyaye	Malawi Interfaith Aids Association (MIAA)
Key Informant L	-
Key Informant M	-
Newton Kumwenda	University of Malawi, College of Medicine
Gift Trapence	Centre for the Development of People

Table E1.3 : Namibia Key Informant Interview Participants

NAMIBIA (n=5)

Name	Organization
Zack Makari	Namibia Network of AIDS Service Organizations (NANASO)
Sandie Tjaronda	Namibia Network of AIDS Service Organizations (NANASO)
Key Informant N	President's Emergency Plan for AIDS Relief (PEPFAR)
Key Informant O	President's Emergency Plan for AIDS Relief (PEPFAR)
Key Informant P	President's Emergency Plan for AIDS Relief (PEPFAR)

Table E1.4 : South Africa Key Informant Interview Participants

SOUTH AFRICA (n=3)

Name	Organization
Diane Cooper	University of Cape Town School of Public Health, Women's Health Research Unit, South Africa
Maureen van Wyk	Network AIDS Community of South Africa (NACOSA), South Africa
Marieta de Vos	Network AIDS Community of South Africa (NACOSA), South Africa

Table E1.5 : Swaziland Key Informant Interview Participants

SWAZILAND (n=16)

Name	Organization
Vulindlela Msibi	CCM Secretariat
Key Informant Q	CCM Secretariat
Key Informant R	-
Dr Kwame Amphomah	UNAIDS
Emmanuel Ndlangamandla	Coordinating Assembly of Non-governmental Organizations (CANGO)
Khanya Mabuza	The National Emergency Response Council on HIV and AIDS *(*NERCHA*)*
Zelda Nhlabatsi	Family Life Association of Swaziland (FLAS)
Rudolph Maziya	The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL)
Key Informant S	-
Key Informant T	-
Key Informant U	-
Philisiwe Khumalo	Elizabeth Glaser Pediatric AIDS Foundation
Khanyisile Lukhele	Ministry of Health
Susan Amoaten	Independent Consultant – Systems Strengthening
Hlobsile Dlamini	Swaziland Rural Women's Association
Alison End	Clinton Health Access Initiative (CHAI)

Table E1.6 : Zambia Key Informant Interview Participants

ZAMBIA (n=11)

Name	Organization
Key Informant V	University of Zambia School of Medicine
Carol Nawina Nyirenda	-
Chilambe Katuta	Director of Programmes at Youth Vision Zambia
Chanda Katonga	Youth Vision Zambia
Edwidge Mutale	Permanent Secretary, Cabinet Office of the Gender and Child Development Division
Key Informant W	The World Bank
Key Informant X	The World Bank
Isaac Chanda	Ndola Youth Resource Centre
Key Informant Y	-
Gershom Kapalaula	Zambia Network of Religious Leaders Living or Personally affected by HIV/AIDS
Elijah Ngwale	Forum on HIV/AIDs for Persons with Disabilities

Table E1.7 : Zimbabwe Key Informant Interview Participants

ZIMBABWE (n=12)

Name	Organization
Wisdom Masunda	Traditional Medicine Practitioners' Council
Key Informant Z	-
Key Informant Z2	-
Key Informant Z3	-
Key Informant Z4	SAfAIDS
Key Informant Z5	-
Key Informant Z6	-
Britone Chitakunye	TelOne
Sebastian Chinhaire	Zimbabwe Network for People Living with HIV
Rangarirai Chiteure	Coordinator Zimbabwe CCM Secretariat for Global Fund
Solmon Zwana	CCM Vice Chair
David Zinyengere	HEDEC (Health Environment & Development Consulting)

Table E1.8: Geneva, Switzerland, Key Informant Interview Participants

GENEVA, SWITZERLAND (n=8)	
Name	**Organization**
Maria Padkona	The Global Fund, Fund Portfolio Manager (Mali)
Richard Cunliffe	The Global Fund, Fund Portfolio Manager (Botswana & Swaziland)
Viviane Hughes-Lanier	The Global Fund, Fund Portfolio Manager (Niger)
Amy Clancy	The Global Fund, Fund Portfolio Manager (Egypt)
Linda Mafu	The Global Fund, Political and Civil Society Department
Sara Davis	The Global Fund, Senior Specialist, Human Rights and Equity
Motoko Seko	The Global Fund, Gender & Human Rights Specialist
Mauro Guarinieri	The Global Fund, Senior Advisor, Community Systems Strengthening and Civil Society