

# Who Governs Public Health? Donor Retreat and the Shifting Spheres of Influence in Southern African HIV/AIDS Policy Making

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## Abstract

For the last decade, discussions about who governs policy on prevention and treatment of HIV/AIDS have revolved around the controversial relationship between Western donors and the power they have over their recipient governments. While these debates were once politically germane, recent trends show a decline of donor funding, as well as an increase of financial ownership of the epidemic within Southern Africa. Commensurate with this shifting financial influence, some well-governed, wealthy African states are beginning to deviate from global M&E (monitoring and evaluation) indicators. These policy movements, away from global M&E indicators, also correlate with increases in HIV prevalence, which signals the need for further investigation into policy efficacy.

## Keywords

HIV/AIDS, policy, governance, donor, national strategic plans (NSPs)

In 2007, UNAIDS (the United Nations Joint Programme on HIV/AIDS) issued a statement that global HIV/AIDS incidence had likely reached a peak in the late 1990s, and was now on the decline (UNAIDS and WHO 2007). In other words, the worst had come and gone, in terms of the number of new infections. After a decade of surging external finance, international assistance for AIDS decreased. It was difficult to pinpoint when this shift began to take place, but financial data suggested that donor priorities began to shift in the following year, around 2008. While a multitude of factors were likely at play, including the global financial crisis and a change of leadership in the US, it was clear that around this time, things began to change. International funding for HIV fell by approximately 10 percent in 2010, when

compared with 2009 funding levels (Kates et al. 2011). The drop of available HIV funding from US\$7.6 billion in 2009 to US\$6.9 billion in 2010 represents that for the first time funding has decreased in more than a decade. To put this shift in perspective, HIV/AIDS funding was six times higher in 2008 than in 2002, before it flat-lined in 2009. UNAIDS and the Kaiser Family Foundation attribute this decline in HIV funding to reductions in development assistance, which they say is primarily as a result of a slower

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disbursement rate from the donor governments. With the exception of Uganda, the US President's Emergency Plan for AIDS Relief (PEPFAR) has reduced its funding for antiretrovirals (ARVs) in 2009 and 2010 and frozen its overall HIV/AIDS budget for 2009-2014. Additionally, the International Drug Purchase Facility (UNITAID) is ending funding for second-line ARVs in Zimbabwe, Mozambique, the Democratic Republic of Congo, and Malawi by 2012. The most alarming evidence of this recent shift in financial commitment to the fight against HIV comes from the Global Fund to fight AIDS, Tuberculosis, and Malaria. In November 2011, the Fund announced the cancellation of its 11th round of grants, due to cutbacks in donations from contributing countries. This is a substantial culmination of many precipitating aid curtailments, which effectively turns off the tap from the largest on-budget donor for the majority of high-burden countries. It is the prerogative of this paper that these funding cuts, predominantly from the Global Fund, are related to changing HIV/AIDS policy agendas in affected countries. These shifts may also be relevant in evaluating the efficacy of those policies.

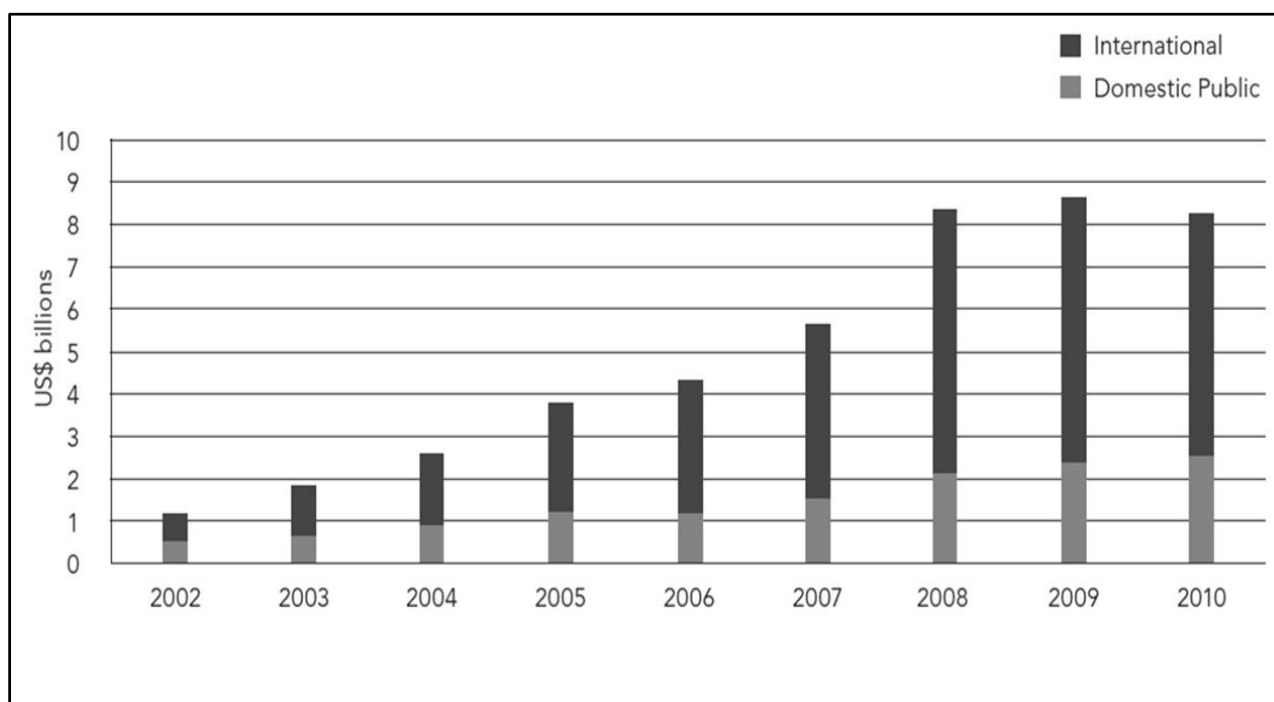
### **BACKGROUND: THE NEW GLOBAL POLITICS OF HIV/AIDS**

The dramatic donor retreat since 2007/2008 for HIV/AIDS programs has been heavily documented by NGOs, international organizations, academics and the media (Denny and Emanuel 2008; Wenner 2009; Médecins Sans Frontières 2010; Dickinson 2010; Kates et al. 2011; PlusNews 2011a; Usher 2011; UNAIDS 2012; Zumla 2012). However, these funding cuts are just one component of the new global politics of HIV/AIDS. There are myriad adjunct circumstances, perhaps brought about by changes in Western HIV/AIDS funding, which also play an integral role in the shifting terrain of HIV/AIDS policy and programs in Southern Africa.

Commensurate with the global donor retreat in HIV/AIDS is an upswing in domestic funding in African countries (see Figure 1). When the international community has been quick to sound the alarm with respect to declining Western funding, there has been very little public attention paid to the considerable financial ownership of HIV/AIDS in the Global South. In total, African domestic spending (defined as public spending independent of Global Fund aid, bilateral aid, or multilateral aid) on HIV/AIDS efforts in affected countries rose from US\$500 million in 2000 to US\$2.5 billion in 2004 and US\$4.3 billion in 2008 (Bonnell 2009). Lesotho was a prime example, where domestic funding for HIV/AIDS programs (as a percentage of total AIDS funding in the country) increased from 18.7 percent in 2006-2007, to 37.2 percent in 2007-2008 and 56.9 percent in 2008-2009 (National AIDS Commission of Lesotho 2008). Similar upward trends were evident in Zimbabwe, where domestic funding leapt from 16.4 percent in 2005 to 49.0 percent in 2006. More recently, Kenya's 2010/2011 national budget has—for the first time ever—allocated money for local ARV programs (PlusNews 2010a). While the dollar amount coming out of these countries by no means completely mitigates the global funding shortfall, these changes may significantly restructure the politics of the disease management.

It is not just increasing financial ownership from Southern Africa that is on the rise. Research efforts toward HIV/AIDS are also increasing, demonstrating a larger scientific emphasis than before. In the US, research on HIV/AIDS has begun to level off, while South African research output on the subject is going up. By comparison, the US (the largest producer of HIV/AIDS study) is dedicating about 2 percent of its total research efforts to HIV/AIDS, whereas 5.5 percent of South Africa's research output is on HIV/AIDS (Campbell 2010).

The onus on African governments to step in and fill the gap left by the shrinking international support



**Figure 1.** Domestic Versus International Resources for AIDS in Africa. Source: UNAIDS (2012).

base is clear. Writing on South Africa, Bodibe (2010) noted how donor-assisted countries were essentially forced to finance HIV/AIDS programs from their own public coffers. His notions of a domestically-funded imperative seem to be confirmed. In 2010, South Africa approved an increase of ZAR 8.4 billion (about US\$1 billion) in the national budget for ARVs (Odendal 2010), which should add an extra 100,000 people to treatment regimes (Langa 2010). Along with this, there was an additional ZAR 100 million (about US\$12 million) in the Medium Term Expenditure Framework for HIV prevention in 2010, which formed part of a larger commitment from the South African government, of ZAR 1.5 billion (about 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 2011b). This loan represented substantial financial ownership of the HIV epidemic coming from Southern Africa, especially when compared to PEPFAR's US\$7 million emergency funding for Swaziland, which was only to go toward first-line ARVs.

Rwanda has also been increasing its financial contributions to global HIV/AIDS efforts, by pledging US\$ 1 million to the Global Fund in 2010 (The New Times 2010). The donation came from the Rwandan financial institution—Access Bank, demonstrating the mounting commitment of the African private sector in filling the financial chasm left by Western donor retreat. Youde (2010) suggested aid for HIV and domestic health spending's rise and fall together. He said that when foreign aid rose, this freed up public resources to be spent on other health care needs. By the same logic, if foreign aid falls, public money in affected countries will be re-allocated to HIV/AIDS

programs.

Along with South Africa and Rwanda, Tanzania has also been increasing 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 5 percent or higher) would be allocated more money from the federal government, though the Medium Term Expenditure Framework (MTEF), for HIV programming (Lucas 2010).

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

Another element of the new global politics of HIV/AIDS is a movement in the political and rhetorical approach to HIV/AIDS strategy. Since 2010, there has been political impetus for global donors to re-allocate their efforts away from AIDS treatment,

toward more cost-effective health interventions such as childhood immunization, malaria, tuberculosis, maternal mortality, and family planning. The World Bank has already begun to move in this direction. In its evaluation of its programs for the previous year, the Bank notes that the earlier emphasis on HIV/AIDS may have distorted the rest of the health care system. It also found that its portfolio performance for HIV/AIDS has performed much lower than that of other health, population and nutrition projects. Furthermore, the US government is also harmonizing their foreign public health policies with recommendations like these. The Obama Administration's Global Health Initiative, which has subsumed PEPFAR, now shifts the focus from HIV/AIDS to the abovementioned, as well as child health, nutrition, reproductive health, and neglected tropical diseases.

The point here is that a dramatic modification is witnessed in the political terrain of HIV/AIDS. Along with the immense impact of the global donor retreat, the politics of HIV/AIDS is being reshaped by the increased domestic financial contributions toward HIV/AIDS from the affected countries and a rhetorical movement in Western discourses on public health. The rationale behind this paper is that this global shift necessitates a re-interrogation into who governs public health. Conventional wisdom suggests that policy pressure from global institutions and donors dictate HIV/AIDS policy and programming in the Global South, and that these imported strategies are less effective than locally devised interventions (Epstein 2007; Pisani 2008; Timberg and Halperin 2012). However, given the recent financial and political donor retreat detailed above, this line of thinking might be less relevant today than it was a decade ago. More importantly, in 2010, for the first time ever, global HIV/AIDS incidence began declining. If there is a change in policy making as a result of the new global politics of HIV/AIDS, it might help explain declining incidence rates and therefore contribute new

evidence toward the debate about whether local or international HIV/AIDS policies are more effective.

### **THEORETICAL MODEL: DAHL'S PLURALISM**

This project is expected to find that the HIV/AIDS policies of global institutions exerted less influence over Southern African national strategic plans (NSPs) than the previous case, which was a postulation based on pluralist political theory. Where the question asked in this paper is borrowed from Robert Dahl (who governs?), so too is the reasoning of the hypothesis.

Traditionally, pluralism suggests that political power and decision-making processes reside within the framework of governments, but the myriad non-governmental "interest groups" may also exert influence (Dahl 1961). For Dahl, this was a way of conceptualizing political power sharing in what he called "spheres of influence" (Dahl 1961: 190). The pivotal question for classical pluralism, Dahl, and this project, is how influence is distributed between governments and these interest groups. Conflicting interests are many, as demonstrated in the background section of this paper. Additionally, these interests are fluid, as shifts in priorities of vested parties are continuous.

Dahl's distinction between actual and potential influence also colours how this project theorizes the descriptive part of its hypothesis that the HIV policy-making power of global institutions is decreasing. It is not so much that global players do not have the potential to exercise previous levels of influence, but rather that since they have now chosen to use their resources in different ways, their actual level of influence may have changed. More clearly, since global institutions are reallocation funds and political emphasis away from HIV/AIDS and toward other public health interventions (such as child immunization and mosquito nets), patterns of influence change and the power of national

governments in domestic policy making is predicted to increase.

Furthermore, Dahl's emphasis on variation of influence among different actors forms the basis for this paper's explanatory logic that there will necessarily be divergence from global policy to a varying degree, depending on other variables (resources, state effectiveness, etc.). Dahl remarked how this variation in power-sharing arrangements was of crucial importance in accounting for differences in influence.

### **METHODOLOGY: MEASURING POLICY CHANGE**

The objectives of this research are threefold: First, it measures the degree to which Southern African HIV/AIDS NSPs comply with international policy language; second, it draws out variables, such as wealth and governance, which might help explain what makes a country more likely to comply with international policy; and third, the paper investigates whether changes in policy and epidemiological outcomes might correlate in a way that could contribute to the debate about whether local or international HIV/AIDS policies are more efficacious.

In order to measure this, a system of international HIV/AIDS indicators was adapted from the Global Fund's 2009 Monitoring and Evaluation (M&E) Toolkit for HIV. The Global Fund was selected as the independent variable since it represented the largest direct-government donor in most Southern African countries. For instance, in Malawi, the Global Fund makes up 54.4 percent of total HIV/AIDS funding, and in Swaziland 31 percent of external funding comes from them (UNAIDS 2008). The government of Namibia also points to the Global Fund as their largest donor, as does South Africa.

The Global Fund M&E Toolkit contains 54 indicators, with a range of different measurements on prevention, treatment, care and support, collaboration

between tuberculosis (TB) and HIV, supportive environments, impacts, and outcomes. Of these 54 indicators, many are strictly epidemiological, such as Global Fund Indicator HIV-I1 “Young women and men aged 15-24 who are HIV infected (percentage) (HIV-I1)” (Global Fund 2009: 75). These were excluded from the use in this study, because these indicators do not tell anything about policy compliance or divergence, only about epidemiological realities. That is to say, other outcome indicators were included, since they related to a specific focus on particular interventions. 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: 75) was included, because adherence to this suggested policy focus on multiple concurrent partnerships. After careful review of the 54 indicators, 34 were selected for inclusion in this project’s framework. Therefore, the operationalization of the term “global policy” was narrowed down to mean 34 specific indicators from the Global Fund’s 2009 M&E Toolkit. Many of the Global Fund’s indicators are borrowed from UNAIDS Core National Indicators, while others are based on the World Health Organization (WHO) or PEPFAR M&E systems. Based on this framework, countries’ NSPs for HIV/AIDS are then measured against these indicators. Using a rigid nominal scale from 0 (where the Global Fund M&E indicator is not included in the NSPs at all) to 4 (where the Global Fund M&E indicators is detailed very precisely), Global Fund M&E indicator influence is measured. These values are applied based on a structured system of requirements of what constitutes each number. For instance, for an indicator to receive a value of 4, it must state the Global Fund M&E indicator language fairly exactly, include the age bracket (if required), and present data to support the policy. There are minor exceptions to this, where indicators are discussed at length in the policy’s text, without data, but still qualify for a scoring of 4 based

on the narrative emphasis. The author performed this method for each of the 34 indicators, across three national policies for each country in the study, to measure change in policy compliance over time.

The data was collected from NSPs, sourced online or through the National AIDS Councils. It was single-coded by the author at the University of Cape Town, then repeated six months later and reconciled. Some data sets were double-coded by an academic peer for a validity check. The logic is that a shift has been experienced in the policy making since 2008 (since global donor funding for HIV/AIDS levelled off and began to decline). In order to observe this, it was necessary to look at two NSPs before 2008—“time one” (T1) and “time two” (T2), and one after 2008—“time three” (T3). This was necessary because in order to confirm the hypothesis that policy influence changed since 2008, there needed the evidence that there was a directional shift. In other words, if a country has been moving away from Global Fund M&E indicators since 1993, it would be misguided to suggest that the new global politics of HIV/AIDS post-2008 were part of that process. On the other hand, if a country was moving toward Global Fund M&E indicators until 2008 (from T1 to T2), and then moved away after 2008 it would more stoutly confirm the hypothesis of a changing policy-making environment.

This method was carried out for Anglophone countries (since the author is not proficient in Portuguese) with HIV prevalence rates higher than 10 percent, the results of which are expressed as an aggregate score (the averages of all 34 indicators) out of 4 (see Table 1). For example, before 2008, Botswana’s NSP for HIV/AIDS complied with Global Fund M&E indicators at a score of 2.588/4, whereas after 2008 its NSP only scored 1.676/4. Higher numbers in Table 1 represent greater compliance with Global Fund indicators.

In addition, 50 face-to-face interviews were conducted in April-June 2012 with key informants in

**Table 1.** Compliance Scores of NSPs With Global Fund M&E Indicators

Country	NSP compliance with Global Fund M&E indicators (Score out of 4)		
	T1: Before 2003	T2: 2003-2008	T3: 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

Botswana, Malawi, Zambia, and Zimbabwe. Informants were selected based on membership of the Country Coordinating Mechanisms (CCMs) in each country. The CCMs are an in-country board which is responsible for designing country's proposals to the Global Fund, and for overseeing the implementation of Global Fund grants. These interviews were conducted to help inform the findings of the quantitative policy analysis, assisting in the explanation of why certain policy changes may have occurred. Ethics clearance was obtained from each respondent by way of a consent form. Further, each respondent was given the opportunity to review their interview transcript and make changes if they felt they were being misrepresented.

## RESULTS

The data in the Table 1 somewhat disrupt the hypothesis that the new global politics of HIV/AIDS is leading to a mass movement away from international policy norms. In fact, this only seems to be true of two countries—Botswana and South Africa. All the other English-speaking countries with HIV prevalence rates of 10 percent or higher continue to closely align their policy language with the language of Global Fund M&E indicators.

A good example of global HIV policy compliance

gradually increasing over time is Lesotho's policy on sexual abstinence (see Table 2). The NSP for 2000-2003, which was written in September 2000, shows some level of compliance. There is the notion of youth, although the age bracket is 10-15 years old, not the 15-24 that the Global Fund M&E indicator requests. By November 2006, Lesotho's second NSP falls slightly more in line with the global indicator. Here, the concept of tracking abstinence before the age of 15 enters into the policy language, as do preliminary data targets. The revision of this policy in April 2009 is then completely aligned with the Global Fund M&E indicator on abstinence. Now, the age bracket of 15-24 is there, and there is data collected and presented to support the policy objective. At T3, Lesotho's policy on abstinence is completely parallel to the global indicator recommendation, which is the reason why it scores 4 out of 4.

Although Lesotho's abstinence policy does match up with its overall trend (compliance scores gradually increasing from T1 to T3), this is certainly not true of every indicator in Lesotho's NSP, or any other country in the study. The scores in Table 1 are aggregate scores reflecting the average of 34 different indicators.

It should be mentioned that deviation from Global Fund M&E indicators does not necessarily mean that a policy objective is omitted, or downplayed. A lot of

**Table 2.** NSP Language for Lesotho's Abstinence Policy

Global Fund M&E indicator HIV-O1 (Abstinence): "Young women and men aged 15-24 who have had sexual intercourse before the age of 15 (percentage)"			
Country: Lesotho	T1 National AIDS Strategic Plan 2000/2001-2003/2004	T2 National HIV/AIDS Strategic Plan 2006-2011	T3 National HIV/AIDS Strategic Plan 2006-2011, Revised April 2009
Policy language	Strategic aim of "Rate of delayed sexual activities by adolescents (10-15 years) increased by 30% by March 2003" (Government of Lesotho 2000: 18). Additionally, "These high rates of HIV infection in young men and women call for robust prevention measures among the youth before the onset of sexual activity" (Government of Lesotho 2000: 6-7).	"Promote formal teaching of HIV and AIDS with emphasis on abstinence" (Government of Lesotho 2006: 51). "To reduce the percentage of young men and women who commence sexual intercourse before the age of 15 to 15% by 2011 among men and to 10% by 2011 among women" (Government of Lesotho 2006: 52-53).	"The % of young men and women aged 15-24 who commence sexual intercourse before the age of 15 reduced from 27% for men and 15% for women in 2004 to 15% for men and 10% for women by 2011" (Government of Lesotho 2009: 11). "Baseline Men = 27% and Women = 15%" (Government of Lesotho 2009: 31).
Score	2	3	4

**Table 3.** NSP Language for Botswana's Youth Awareness Policy

Global Fund M&E indicator HIV-P1 (BCC Mass Media): "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"			
Country: Botswana	T1 Botswana National Policy on HIV/AIDS 1993	T2 National Strategic Framework for HIV/AIDS 2003-2009	T3 The Second Botswana National Strategic Framework for HIV/AIDS 2010-2016
Policy language	"More than 90% of interviewed youths had correct knowledge about HIV transmission; between 80 and 90% correctly stated 2 methods of prevention" (Republic of Botswana 1993: 7) and aims at "the development and broadcasting of programmes, spots and advertisements on various aspects of AIDS/STD" (Republic of Botswana 1993: 2).	"Percent increase of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission" is 36.3% in 2001 (Republic of Botswana 2003: 23). "Section 8.3 focuses on the Media" (Republic of Botswana 2003: 72-73).	"Proportion of young people aged 10-24 who correctly identify ways of preventing sexual transmission of HIV" is 42.1% (for 15-24 year olds) (Republic of Botswana 2009: 37). Additionally, "Mass media should be utilized in a positive manner to create and promote awareness on HIV and AIDS" (Republic of Botswana 2009: 18).
Score	3	4	3

policy language is subtle. An example of this is Botswana's shift in behavior change communication policy from its first HIV Strategic Framework to its second one (see Table 3). At T2, the language in the strategic plan is almost exactly that of the Global Fund's policy indicator (HIV-P1). At T3, the only difference is that the language in Botswana's Strategic Framework shifts the age bracket to begin targeting youth with prevention messages at the age of 10, rather than the international protocol of 15. While this is a minor change, it still represents a departure from

previous policy objectives, and a departure from the global indicator language.

## DISCUSSION: EXPLAINING POLICY CHANGE

Why do nations take such widely different approaches to the common problem of HIV/AIDS? In some ways, HIV/AIDS might be better observed as a political problem than a public health issue. Contributing factors include a host of variables to do with



government, civil society, economic strength, financial priorities, and more. When these variables may help explain HIV policy-making choices, they may also assist in efforts to improve them. For instance, if it is discovered that countries who invest more in healthcare are more inclined to devise unique HIV/AIDS policies, and these policies are effective, then this precipitating factor can be more heavily encouraged. In explaining the above data on HIV policy change, three key sets of explanatory variables were explored: economic situation, such as overall wealth and health spending; effectiveness of states, such as level of democracy and corruption indices; and epidemiology, such as HIV/AIDS prevalence and incidence. To test the relationships between policy compliance and explanatory variables, the NSP compliance scores at T3 (see Table 1) were correlated against the most recently available explanatory variable data.

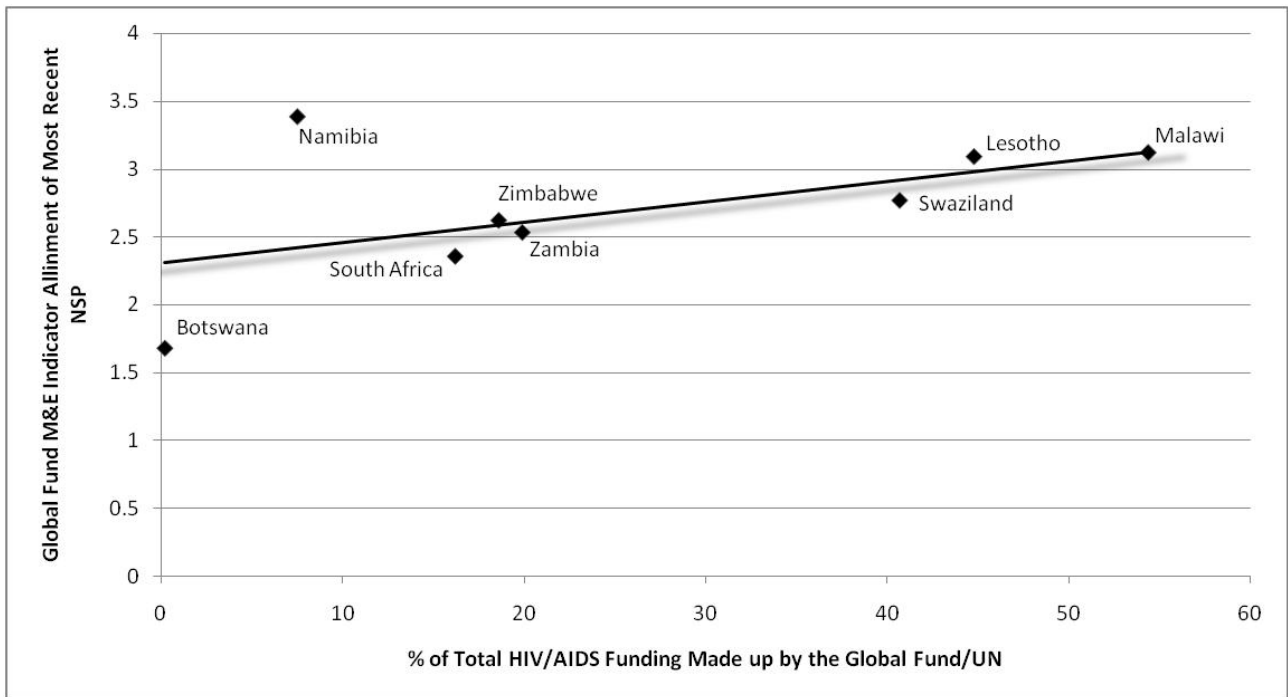
### *Economic Situation*

Based on the hypothesis that decreased global funding combined with increased African funding for HIV/AIDS, it will lead to local policy change, mapping the connection between policy change and economic indicators is paramount. Since the thinking is that money drives policy, it would be intuitive to assume that richer countries, which contribute more domestic funds toward their own HIV/AIDS programs, would be in a better position to direct their national HIV policies. As one might expect, the amount of money for HIV/AIDS that is sourced domestically (as a percentage of the total amount) 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 affected country, the less likely that country is to follow Global Fund M&E indicators ( $r = -.4098$ ). By the same token, the amount of funding that a country receives from the Global Fund and UN, as a percentage of their total HIV funding, they are more likely to adopt the policy language of

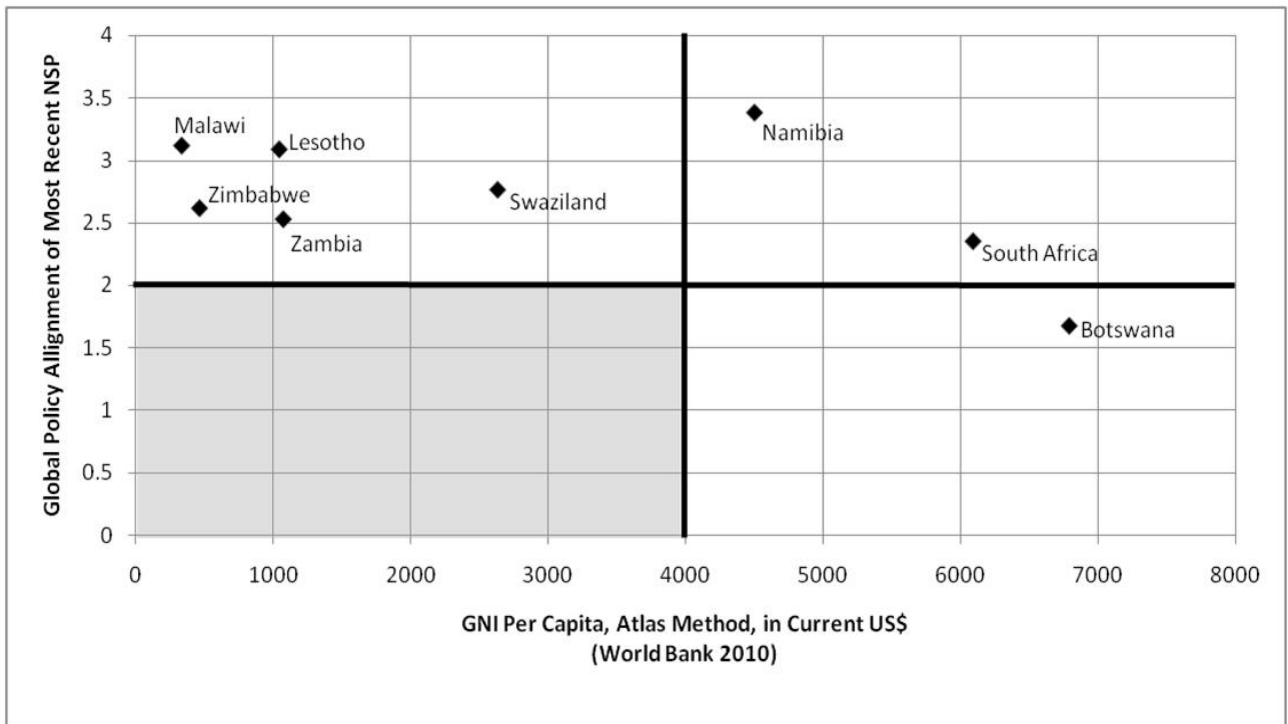
these institutions (see Figure 2). The correlation coefficient of this relationship is  $r = .5433$ .

This is also largely true with indicators such as Gross National Income (GNI) per capita, where richer countries are more likely to devise locally-informed HIV/AIDS policies. In many cases, gaps in data points and trends can be just as telling as those that are apparent (see Figure 3). In this instance, there are many poorer countries that comply relatively strongly with Global Fund M&E indicators, 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 2 represents that there are no poor countries in this sample that do not align their NSPs with Global Fund M&E indicators, which is a telling trend in itself. Perhaps there is a threshold of wealth ( $> \$4,000/\text{GNI}$  capita) that a country must reach before it has the freedom to choose the design of its public health policies, without fear of detrimental retribution from overseas donor agencies.

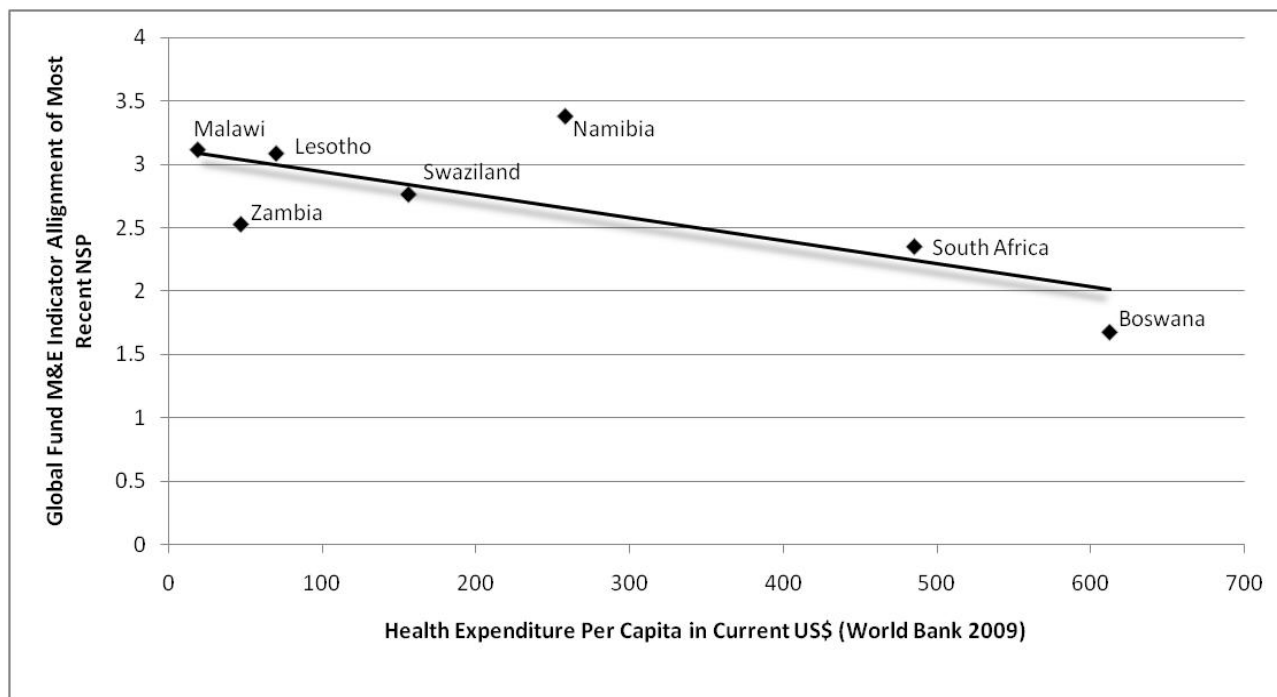
In contrast to the relationship between policy compliance and GNI, Official Development Assistance (ODA) is not significantly correlated with the degree to which a country follows global HIV policy norms. With almost no correlation at all, this seems to indicate that general aid does not affect HIV policy making, but HIV-specific aid does. The odd thing here is that the relationship between Global Fund M&E indicator compliance and domestic spending priorities seems to be the opposite; general health spending correlates much stronger with HIV policy-making trends than HIV-specific spending does. Put more clearly, while the amount of domestic funds that make up a country's HIV budget correlates negatively with policy compliance to a certain degree, a country's health expenditure per capita correlates much more strongly (see Figure 4). The correlation coefficient for this relationship is  $r = -.7311$ . Perhaps countries that more heavily prioritize health in general are more inclined to devise more locally informed and



**Figure 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. Source: UNAIDS (2010).



**Figure 3.** The Compliance of NSPs With Global Fund M&E Indicators and GNI per Capita. Source: World Bank (2010).



**Figure 4.** The Relationship Between the Compliance of NSPs With Global Fund M&E Indicators and Health Expenditure per Capita. Source: World Bank (2009).

less indicator-based policies, whereas domestic HIV spending may not necessarily represent such a commitment. If domestic funds for HIV are higher, as a percentage of that country's total, it may just be that that country is not regarded favourably by bilateral or multilateral donors. Zambia is a slight outlier here, with relatively low health expenditure per capita, and a relatively low (the lowest, next to Botswana and South Africa) level of Global Fund M&E indicator compliance.

As part of this research, key informant interviews were conducted in Southern Africa in April-June 2012. A key informant from the World Bank in Zambia, who was a member of the Global Fund Country Coordinating Mechanism, suggested that Zambia has never thought that policies had to change as a result of funding changes:

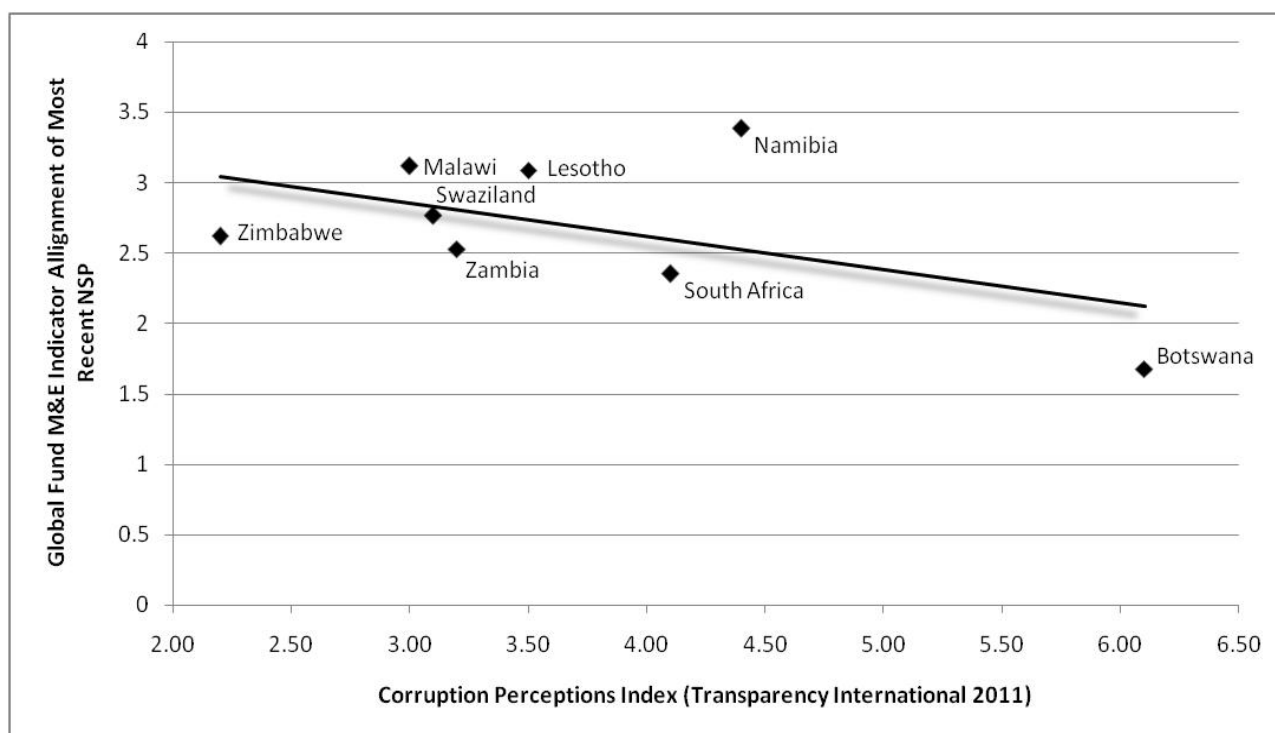
[N]o they do not have to change. We just have to look at how do we implement that same, and achieve the same, for less. So, that is what we are trying to refocus them on. How

can they be able to, for example, integrate services, and be able to implement the same policy.

This key informant was also previously with the Ministry of Health in Zambia, so her perspectives helped to colour the interpretation of the data correlation in Figure 3.

### *Effectiveness of States*

In the past, others have made connections between poor governance and HIV prevalence (Menon-Johansson 2005), but not about the missing link of policy in the middle. Contrary to these previous findings, World Bank governance indicators (Government Effectiveness, Voice and Accountability, Political Stability, Regulatory Quality, Rule of Law, and Control of Corruption) are not very strongly correlated to this paper's data on HIV policy compliance. Voice and Accountability only correlates at  $r = -.1678$  with the NSP policy compliancy scores



**Figure 5.** The Compliance of NSPs With Global Fund M&E Indicators and the Corruption Perceptions Index. Source: Transparency International (2011).

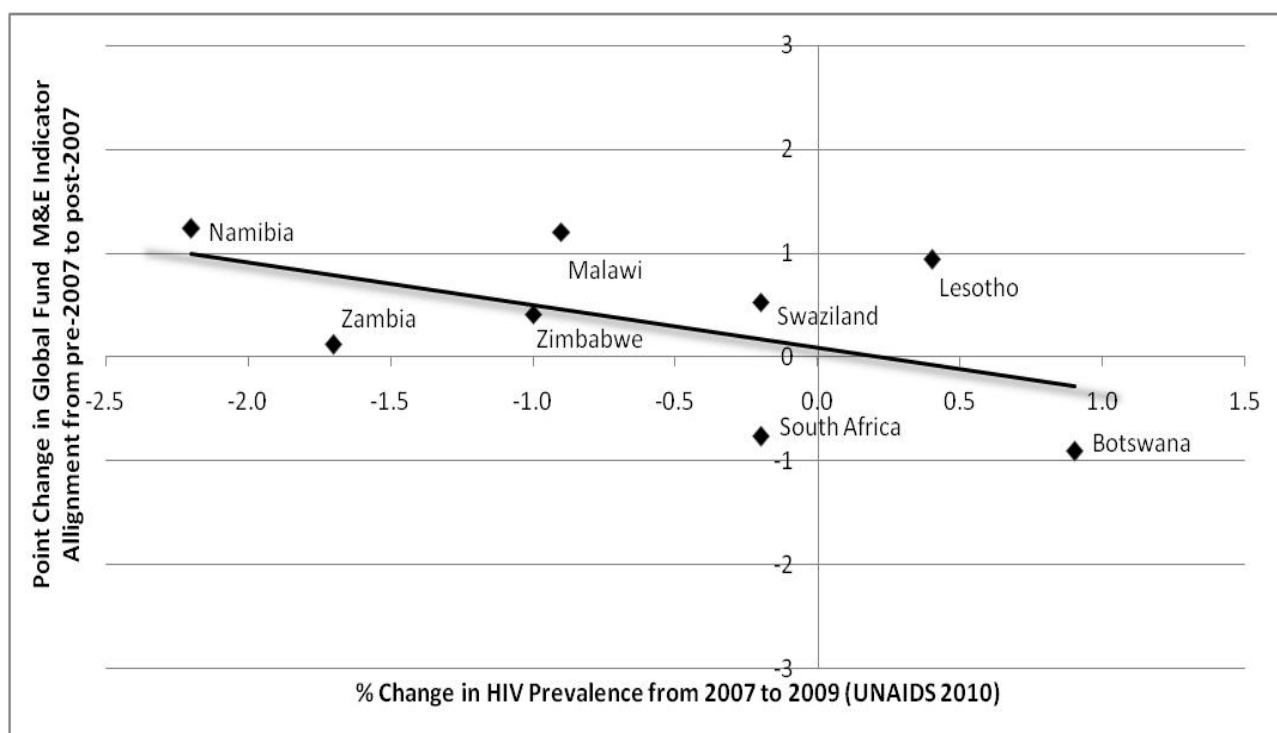
at T3, and political stability only explains policy adherence at  $r = -.1093$ .

There is, however, a noteworthy link between how well a country complies with global HIV policy indicators and their Perceived Corruption Index, as defined by Transparency International (see Figure 5). 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  $r = -.5241$ , suggesting that countries that are perceived to be more corrupt, adhere more rigidly to global HIV indicators in their NSPs. There could be a potentially logical explanation here. The largest direct-government donor for all of the countries in this study is either the Global Fund or the UN, which means that appeasing these organizations is important for sustained funding. The Global Fund in particular has

been known to have a “zero tolerance” toward corruption, cancelling grant rounds after corruption scandals in Zimbabwe, Zambia, Uganda, and Mauritania. As a result, perhaps countries that are aware of their global reputations around corruption in the past are more inclined to tailor their HIV NSPs to pander to Global Fund M&E objectives.

A key informant in Zimbabwe gives testimony to how financial ownership (see Figure 4) and corruption (see Figure 5) are intricately related to how much flexibility a country has to exert policy autonomy within a Global Fund partnership:

[T]here are so many issues where we feel we are not appropriately being heard. 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



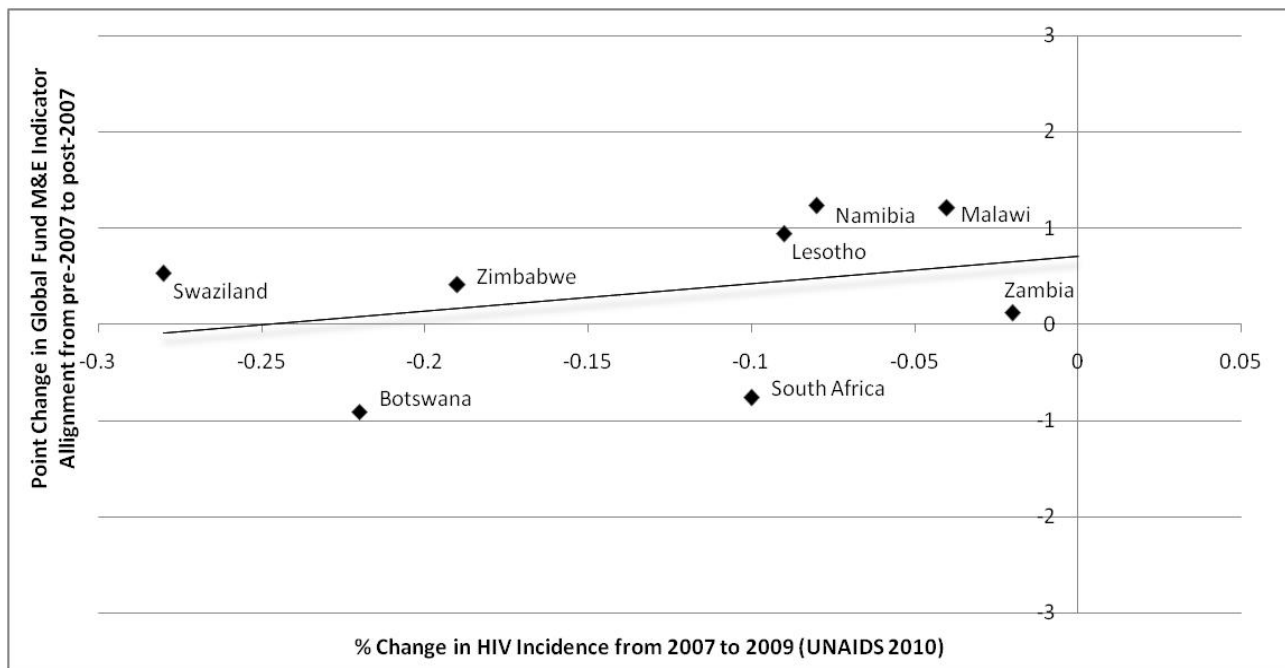
**Figure 6.** The Change in Compliance of NSPs With Global Fund M&E Indicators From pre-2008 to post-2008 and the Change in HIV Prevalence From 2007 to 2009. Source: UNAIDS (2010).

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. But when our own contribution is not very significant, and we are found wanting in our own side of the house, it makes it very difficult.

The lack of principal recipient (PR) status that this informant mentions means that the Zimbabwean government is suspended as a primary recipient of Global Fund money as a result of misappropriation of funds. All Global Fund money is now channelled through the United Nations Development Programme (UNDP) in Zimbabwe. This speaks to the notion that corruption perception is a significant explanatory variable in the degree to which countries comply with Global Fund M&E indicators in the domestic policies and programs.

### *Epidemiology*

While variables to do with economic strength or the effectiveness of states are more logically understood as causal factors in policy making, epidemiology is not so clear cut. If there are correlations, there are also hurdles of chicken-and-egg logic; are policies created in response to epidemics or do epidemics change as a result of policy? The correlations between the change in global HIV policy alignment and the change in HIV prevalence, since 2008 (the theorized point of inception of the new global politics of HIV) are really the crux of this paper’s message. Exhibiting a strong negative correlation of  $r = -.5796$  (see Figure 6), this suggested that the countries that more closely aligned their NSPs with Global Fund M&E indicators, witnessed larger HIV prevalence decreases than those that complied less, or deviated.



**Figure 7.** The Change in Compliance of NSPs With Global Fund M&E Indicators From pre-2007 to post-2007 and the Change in HIV Incidence From 2007 to 2009. Source: UNAIDS (2010).

There are certainly many factors that cloud the pathway between policy change and HIV prevalence decline (civil society, international stakeholders, medical intervention, etc.), yet the significant correlation between the two may serve to destabilize certain conventional wisdoms about locally devised, culturally relevant policy making. If countries that design their policies more closely in line with global indicators experience larger declines in HIV prevalence, perhaps this contests the arguments that lambast “UN cookbooks” or “one-size-fits-all” policies. For instance, post-2008 Botswana has drastically shifted its NSP to move away from global indicators like free condom distribution and blood safety, toward more locally devised policies on alcohol abuse and prevention among HIV positive people. Since 2008, HIV prevalence in Botswana has increased by 0.9%. Conversely, post-2008 Namibia has sharply aligned its NSP with Global Fund M&E indicators. Since 2008, HIV prevalence in Namibia

has decreased by 2.2%. Where Botswana represents the least compliant country with Global Fund M&E indicators, and Namibia the most, these relationships are intriguing.

However, declining prevalence can mean a few different things. It certainly does not always indicate improved performance. It can mean prevention of new infections, but it can also mean that a lot of people are dead. For instance, countries like Botswana or Lesotho, may have experienced increases in prevalence rates as a result of more effective ARV treatment programs. A good way to examine what is actually going on is to also look at the relationship between policy change and HIV incidence (the number of new infections). UNAIDS is clear about the limitations around collecting incidence data, noting that actual incidence data does not really exist. Instead, they use youth (15-24) prevalence data of women attending antenatal clinics as a proxy measurement.

Interestingly, while larger declines in prevalence

are associated with larger Global Fund M&E indicator compliance, it seems that the opposite is true to HIV incidence (see Figure 7). The correlation coefficient here is  $r = .3168$ . This means that countries which comply less with global HIV policy, have experienced fewer new infections since 2008. While the negative correlation with HIV prevalence and the positive correlation with HIV incidence may appear to be contradictory at first glance, this may not be true. It may be, as stated above, that countries which comply less with Global Fund M&E indicators—or indeed, deviate—are proving themselves to be both better at preventing new infections (declining incidence) and better at treatment and care programs (increasing prevalence, or smaller decreases in prevalence).

Admittedly, the relationship between policy change and HIV prevalence and/or incidence change could potentially mean very different things. The important thing to consider is that there are changes happening: changes in policy, changes in HIV prevalence, and changes in HIV incidence. The correlations between these changes are a potentially invaluable testimony to policy efficacy and HIV governance in general. However, the logic behind any kind of causal link behind these variables deserves considerable scepticism.

### **IMPLICATIONS: DOES POLICY MATTER?**

Even with the recognition that there is a new global political environment for HIV/AIDS, and that this climate has brought about certain changes in HIV/AIDS policy making in affected countries, it does not necessarily follow that these changes have any relevance for epidemiological outcomes. There is a body of evidence that permits the reasonable notion that HIV policies play a role in behavior change outcomes. Many have pointed to the “Zero Grazing” policies in Uganda as having a strong impact on behavioral results. Some also contended that these policies were what led directly to declining HIV

incidence and prevalence rates in the country (Green et al. 2006). Other studies have demonstrated that voluntary testing and counselling policies directly affected behavioral outcomes, in which those, who discovered that they were HIV-positive, engaged in less risky sexual behavior than they did before they knew their status (Weinhardt et al. 1999). Condom use has also been shown to increase, especially among men who have sex with men, as a result of certain behavior change communication and social marketing policies (Wang, Gao, and Zhang 2005; Hearst and Chen 2004). Lastly, policy impact work has been done in countries where policies were implemented in some regions and not others, such that “control groups” existed. Here, too, it was found that epidemiological results—such as under-five mortality—fell more sharply in regions where the policy was implemented, versus those where it was not (Glick, Younger, and Sahn 2006).

It is also not universally true that policies are always successful in exacting behavioral results. There is a host of other examples that illustrate examples like declining condom use after the implementation of behavior change communication policies (Wang 2008). This idea was articulated particularly well by President Robert Mugabe in the 2006-2010 Zimbabwe National HIV Strategic Plan, where he said “While I acknowledge that knowledge levels in relation to HIV are now very high, it has to be noted that awareness does not necessarily translate to behaviour change”. He is right. The connection between policy and behavior is a tenuous one. That is to say, it is not altogether invaluable information if there is a notable correlation between shifts in policy and shifts in HIV prevalence. Some policies are surely more straightforwardly related to behavioral outcomes; needle exchange programs or routine circumcision are much easier to measure tangible results than policies that focus on de-stigmatization or gender mainstreaming. In addition, it is important to highlight that a framework of human rights values and

prioritizes certain policies. For instance, the policy for MSM (men who have sex with men) populations is regarded as necessary from a human rights perspective, even if those populations are relatively small in terms of overall prevalence rates in Southern Africa. Taken together, the concept of policy environments or broader social and structural factors that affect policy making are increasingly argued to be partly responsible for declining (or increasing) HIV prevalence rates (Aids2031 2010). Thus, while direct causality between policy and prevalence rates is nearly impossible to prove, a correlation between the two may still reveal itself to be a useful tool in evaluating policy efficacy.

Indeed, it may also be true that countries which are less compliant with Global Fund M&E indicators have made that decision because of their high prevalence rates and their disillusionment with internationally designed strategies. Alternatively, perhaps it is too soon to see the impacts from the more locally informed policies out of Botswana and South Africa. They may prove to be the most effective, 10 years down the road. Then again, does *Zeitgeist* follow policy or does policy encode *Zeitgeist*? Maybe written policies represent approaches that have been in practice for years preceding. The nature of UNAIDS prevalence statistics is also a point of uncertainty. These numbers are constantly adjusted and revised based on more advanced systems of estimation.

It is also true that countries with more globally aligned policies are more heavily funded by global institutions and are therefore more motivated to present prevalence data that impresses their donors. The relationship shown here, between policy change and HIV prevalence decline, may illustrate any number of causal relationships. However, despite of the muddy nature of the causal relationship between HIV policy and HIV prevalence/incidence, one can still make robust inferences based on data and say something meaningful about its potential implications. This means that while this data cannot explicitly

conclude that certain policies are more efficacious than others, it can still meaningfully suggest that the trends are worth considering. It is still a worthwhile exercise to think about what this could mean for efforts to combat the epidemic in Southern Africa.

It is important to continue closely monitoring the connections between policy and epidemiological outcomes, over time, so that this political scaffolding may become a more fruitful analysis for policy efficacy. It may well be too soon to draw assertive conclusions about the policy changes that have begun to occur since 2008. Additionally, any association with outcomes in HIV prevalence and incidence must be part of a longitudinal study that traces these relationships over longer periods of time. This data here serves as a platform for this kind of policy monitoring. It also works as an incentive since it is evident that changes are occurring in the policy-making process, as well as in the epidemiological trends of HIV in Southern Africa.

## CONCLUSIONS

It is clear that the new global politics of HIV/AIDS is beginning to have an effect on policy making in affected countries, with Botswana and South Africa being the first Southern African countries to adjust their NSPs away from Global Fund M&E rhetoric. Evidence from declining donor funding and shifting political emphasis on HIV/AIDS seems to have begun around 2008. However, the ramifications of this statement did not really begin to emerge in funding crises until 2010. Now, with the Global Fund cancelling Round 11 of its grants due to lack of funds from contributing countries, this initial donor retreat may only be the very beginning of a larger change. Therefore, the policy changes that are now emerging may also be the very first symptoms of a much larger movement away from Global Fund M&E indicators as policy benchmarks.

Additionally, the results of this research seem to



suggest that compliance with Global Fund M&E indicators is correlated with larger drops in HIV prevalence, but also with larger drops in incidence. At this early stage in donor retreat and African policy change, perhaps the focus should be to gather a more complete picture of what HIV policy looks like, at the micro-level. There is a great need for a more detailed understanding of country-specific HIV/AIDS policy. Without this kind of rigorous policy mapping, measurements of policy efficacy will be conjecture, at best. The answer to this paper's question—who governs?—must be central in any evaluation of policy change and epidemiological outcomes. If it turns out that the conceptions around domestic versus foreign or African versus Western policies are needed to be recalibrated, then the real political battle of HIV/AIDS has not even begun.

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## Bio

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