ASCII Synthesis Paper

HIV/AIDS and State Fragility

‘States state.’


‘We now need studies of specific states in Africa, the Middle East, Latin America, Asia which show us how real states operate rather than analyses which take as their point of departure theories which were constructed for other purposes in another time. In particular, we need to examine the way in which the fact that “states state”—with all that that implies for the role of culture in politics—affects cultural construction and the actions of government in relation to the people who live within the boundaries of any particular state.’

Tony Barnett (1996)

Introduction

This document is the synthesis report of the ASCII research track on HIV/AIDS and fragile states. It provides an overview of twelve pieces of research carried out in 2007 and 2008 exploring relationships between HIV/AIDS and state fragility. It summarises and expands upon each study, draws in other related research, and frames the overall findings within analyses of the state and state fragility, and of the nature and trajectory of the HIV/AIDS epidemic, and draws conclusions for policy. The authors are the following:

- Indranil Dutta and Azusa Sato, who produced quantitative studies of HIV/AIDS and state fragility;
- Michael O’Keefe and Dennis Altman, who studied the epidemics in the Asia-Pacific region and their possible trajectories and impacts;
- Murray Feshbach, who studied the impact of the epidemic in Russia;
- Kondwani Chirambo, Claire Smith and Happymon Jacob each conducted an in-depth case study using multi-disciplinary methods;
- Erling Hög, Ohnmar Khin and Jonathan Weigel studied the responses to HIV/AIDS in challenging environments, including Mozambique, Myanmar/Burma and Haiti.
- Scott Naysmith who studied the HIV/AIDS-related emergency in Swaziland.

All studies deal with some of all of the following themes: democratic processes, health, education, military and conflict – and the impacts of HIV/AIDS on these, especially through the intermediary variable of human and social capital, and in particular with respect to effects on productive labour force. All researchers concur that any impact of HIV/AIDS on governance will be indirect, that is, mediated by
other factors. One difference among the researchers lies in whether they deem HIV/AIDS to be a *determining* threat to governance, and therefore if targeting HIV/AIDS alone will have any significant effect on sustaining state capabilities. In addition, the studies identify how different elements of governance, including the ability to establish effective public health policies and programmes, have an impact on HIV/AIDS epidemics, both through influencing patterns of vulnerability and risk, and through responses.

**AIDS and State Fragility: Changing Agendas**

This series of studies is framed by two exploratory overview studies, by Dutta (2008) and Sato (2008). These studies use quantitative methods to gain some purchase on the overall question of whether there is any evidence of a relationship in either direction between state fragility and HIV/AIDS epidemics. The two studies suggest that the evidence for any clear relationship between state fragility and HIV is thin to non-existent. These findings need to be placed alongside the conclusions of the other ASCI research tracks, which find that HIV/AIDS has not proven a disabling threat to the functioning of armed forces and that population-level HIV prevalence in conflict-affected countries is not higher than that in comparable populations elsewhere.

The robustness of this lack of association compels us to ask why there has been so much concern about the possible threat of HIV/AIDS to state survival? To answer this question we should delve back almost ten years to the first unpublished and published studies on this issue, notably the U.S. National Intelligence Council assessment of the infectious disease threat published in January 2000 (NIC 2000) to coincide with the historic UN Security Council debate on the issue, introduced by the U.S. This report argued, ‘the persistent infectious disease burden is likely to aggravate and in some cases, may even provoke economic decay, social fragmentation and political destabilization of the hardest hit countries in the developing world.’ (p. 10)

The NIC analysis drew upon two sources of evidence. The first was the fact that infectious diseases—which had just a couple of decades earlier been heralded as a concern for historians only—were apparently resurgent. In particular, the HIV/AIDS pandemic was spreading further and faster than had ever been anticipated. Even while HIV prevalence in southern Africa hit levels that public health officials had previously considered unthinkable, parts of Asia and the former Soviet Union were registering sharp increases. This led many to fear that it was just a matter of time before these countries followed a sub-Saharan trajectory, and the epicentre of the pandemic shifted to Asia. In 2002, the NIC published a new intelligence estimate which projected a ‘second wave’ of epidemics in some of the world’s most important and populous countries: China, India and Russia (NIC 2002; Eberstadt 2002). These projections have subsequently turned out to be mistaken, and even the most pessimistic estimates for HIV in these countries are far below the lower limit of rates forecast by the NIC (see Feshbach 2007).

The second source of evidence was the analysis conducted by U.S. political scientists in the aftermath of the Cold War, and especially the State Failure Task Force (SFTF) which reported in 1995 (Esty et al. 1995). The SFTF was guided by a belief in U.S.
policy circles that the next big threat to American interests was anarchy.\(^1\) It was also informed by the biggest analytical oversight in U.S. intelligence history: failure to foresee the collapse of the Soviet Union. In the aftermath of this epochal victory for the U.S., but embarrassing failure of intelligence analysis, one group of specialists emerged with unexpected credit: demographers.

In the late 1970s, evidence emerged of a rising infant mortality rate in the USSR. Some scholars argued that the figures were misleading, the product of changing data systems. Others contended that not only was there a genuine health crisis but that the failure of Communism to provide for the material basics of its citizens marked the bankruptcy of the system (Davis and Feshbach 1980; Eberstadt 1988\(^2\)). In 1994-95, when the SFTF processed its data to generate the best models for predicting state failure, it found three variables from among its list of 75 to be the most important: openness to trade, democracy, and infant mortality (Esty et al. 1995).

The SFTF study was quintessentially an exercise in mainstream north American political science, both in method and assumptions. It identified four kinds of state failure: revolutionary wars, ethnic wars, mass killings (genocides or politicides) and adverse or disruptive regime changes (involving extended periods of disorder and excluding ‘routine’ coup d’états or orderly government changes). An alternative political science tradition might have taken the systemic absence of welfare or presence of class exploitation as a ‘failure’ and a transformational change in such a static system as a ‘success.’

The following year, U.S. intelligence policy was reoriented to focus on the threats posed by emerging and resurgent infectious diseases, alongside issues such as humanitarian crises and climate change. Traditional security concerns were not abandoned but were supplemented by these human security issues. The twin ‘hard’ and ‘soft’ approaches to security converged in the issue of HIV/AIDS: it was at once a clear threat to human security and at the same time posed specific dangers to militaries and, so the SFTF implied, to state failure.

This was the political and academic context that shaped the seminal January 2000 NIC report and UN Security Council debate. Within little more than a year, this perspective was overshadowed by the ‘Global War on Terror’—which provided an ancillary justification for the concern with state fragility, and reoriented that concern towards the fear that terrorists would find safe haven in ungoverned spaces. With the George W. Bush Administration’s focus on the ‘war on terror’, the centre of gravity shifted sharply back to more traditional state security concerns, though focused on the threat posed by collapsed or rogue states such as Afghanistan and Iraq. But the ‘one percent’ doctrine of fighting terrorism meant that any factor that might contribute to state collapse—even if only at the margins of statistical significance—should be of concern to the U.S. (Suskind 2006). Hence, HIV/AIDS and its potential for...

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\(^1\) Bill Clinton was reportedly enthused by Robert Kaplan’s, ‘The Coming Anarchy’ Atlantic Monthly, January 1994, and ordered it faxed to all U.S. embassies around the world. It is notable that Francis Fukuyama, whose book ‘The End of History and the Last Man,’ (1992) helped define the intellectual paradigm of the era, switched his attention to the challenge of rebuilding failed states. See Fukuyama 2004.

\(^2\) Eberstadt’s 1988 book is a compilation of papers published from 1981 onwards.
contributing to state failure remained an intelligence concern, as evidenced by the 2002 NIC report and indeed by the 2003 announcement of PEPFAR.

The evidence compiled by ASCI and presented in this synthesis paper tells a different story. As the decade unfolded, the predicted impacts did not materialize and the more alarming forecasts were increasingly discounted. The NIC’s December 2008 report, ‘Strategic Implications of Global Health’ marks a considerable revision in the U.S. assessment. The focus has shifted to the economic impacts of disease and ill-health, including an additional focus on chronic conditions and accidents. For example, the 2008 report notes that poor health is costing Russia an estimated 1% of GDP annually and this may rise to as much as 5% by 2020, and conversely notes that reduction in disease burden contributes to economic growth. The governance impacts of health it suggests are ‘less pervasive’ and cites examples of how mis-handling of health issues can undermine governments’ credibility, citing Thabo Mbeki’s stand on AIDS and China’s dithering over SARS. (But the report does not dwell on the fact that Mbeki’s AIDS policies did not dent his electoral performance, nor that China’s rapidity in learning the lessons of SARS contributed to a sharp focus on HIV/AIDS and the threat posed by Avian influenza.) The NIC also references contrary cases of how the provision of basic health care by organizations such as Hezbollah in Lebanon or Hamas in Palestine, both of them considered security threats to American interests, contributes to building a political base. In terms of military readiness, the report points to the poor health status of army conscripts in Russia and North Korea, but also revisits the NIC’s earlier fears about how HIV/AIDS would undermine military capabilities in sub-Saharan Africa, suggesting that the risks had been over-stated and the responses effective.

Perhaps most significantly, the 2008 NIC report concludes with a section entitled ‘Health as Opportunity: A new look at a successful paradigm.’ Global health, it suggests, is a fruitful field for medical diplomacy, for effective engagement with rising powers, reconstruction and stabilization, and for smoothing relations with adversaries, for easing north-south tensions, and for advancing economic development. It hints that the response to HIV/AIDS may in fact have brought more social, economic and political benefits than the adverse impacts of the disease may have brought adversity.

The parallel with mainstream American political science analysis and policy influence on state failure, combating terrorism and military intervention is not hard to miss. The authoritative works on state failure by Robert Rotberg (2003), Francis Fukuyama (2004) and Paul Collier (2008) are not only accounts of what failed and fragile states are not, but also blueprints for how to turn them into what they should be—imitators of western models of governance. These and other analysts are preoccupied with how and when to intervene militarily, how to build western style political institutions—in short how state crises can be translated into opportunities for philanthropic or developmental diplomacy through humanitarian intervention and technical assistance. This is modernisation theory under a different name.

As part of the ASCI programme, Jon Weigel (2008) analysed the framework of ‘fragile states’. He begins by noting that the most widely applied definitions of ‘fragile state’ are those countries in which the state is incapable of putting international development assistance to good use. Partly as a result of this, most
fragile states receive only a fraction of the aid to which they would be entitled if equity criteria were employed, a discrepancy that helps explain the poor performance of many fragile states. In short, it is an instrumental definition, moving smartly on from analysis to policy recommendation.

It is against this background that the findings of the subsequent studies must be seen. These show the complexity of the notion of fragile states, explore some of their characteristics in relation to engaging with HIV (and potentially other infectious disease epidemics). None of them suggests that state fragility has its roots in the HIV epidemic; some of them suggest that state fragility may compromise responses to health issues in general and to HIV in particular. They all point towards a conclusion in a different direction, which is that the governance response to HIV/AIDS epidemics has the greatest potential to have an impact on state fragility, either by strengthening governmental institutions or by undermining them. And, just as the impetus for considering HIV/AIDS as an issue for state survival sprang from a particular framework and theory of the state and governance, so too the impacts on states and governance are determined by particular beliefs about what a state should be and how government functions should be performed.

The underlying and highly significant point here is as follows. There is an alternative tradition of state analysis to that which has seen the problem as one of governance in a limited technocratic sense, and the failure of these functions as defining state fragility. This alternative tradition is the older and extremely diverse European tradition with origins as far back as classical Greek philosophy (for example the work of Plato) through debates in the early epoch of European state formation (the work of Thomas Hobbes and John Locke as well as Jean-Jacques Rousseau is relevant here), through the nineteenth century in the work of Karl Marx and Friedrich Engels and also Max Weber, and on to the twentieth century ideas of among others Vladimir Lenin, Friedrich von Hayek, Karl Popper, Nicos Poulantzas and more recently those writers who have discussed the role of gender in relation to the modern state, notably Mary Daly, Katherine Rake (2003) and Lynne Haney (2003).

It is not appropriate to write about this tradition at length, merely to summarise some of its key themes, and to comment that their problematics do not figure in the governance/state fragility framework of mainstream ‘political science,’ which has been the governing framework for thinking and policymaking about HIV/AIDS and state fragility. This latter social science tradition appears to be quite unconcerned with the kinds of question raised by these thinkers, questions which might have saved the development of a misleading homogenising and apparently ‘technical’ discourse about ‘state fragility’ and governance. Instead, careful analysis of the diversity within and between states, of relations between classes and other significant social groups, of the role of various inequalities (including gender inequality) in relation to state structures and ideologies, all of these might have told more than generalised analyses which evidently informed intelligence analyses of states, analyses often informed by highly-generalised and heavily proxied quantitative analyses.

As for key themes in this alternative tradition in state analysis, these may be summarised as follows: (a) the earlier period focused on the relationship between the state and the individual; (b) the next period was truly concerned with the structures of the state and their relationships to significant social groups, notably classes and status
groups; (c) in the twentieth century, concerns were with strategic issues, the role of the states in radical social transformation, the falsity of such a view, the role and nature of ideology in states; and (d) most recently, the role of states in maintaining male domination via a mixture of ideological and structural-legal mechanisms.

This list of issues which tell us about how real states (rather than models of states or quantitative representations of states) work has been almost entirely absent from serious policy discussion over the last twenty years as the supposedly technical discourse of governance has come to the fore together with the ‘end of history’ (Fukuyama 1992).

What might these theories of the state tell us about HIV/AIDS, governance and state crisis? Several key themes emerge. One is diversity—implying that generalised indicators may actually mean different things in different situations (e.g. openness to trade). Related to this is the diversity of crises, some of which can bring about transformational socio-political change. A second is the remarkable ability of states to sustain themselves under circumstances in which their populations suffer severely; the weakening of communities is not to the disadvantage of national states. A third issue is the role of public health as a mechanism for bringing populations under control, both domestically and as an instrument of imperial policy or diplomacy. Lastly, the implied response to state fragility—more international engagement—which is axiomatic in the conventional paradigm, does not necessarily represent a ‘solution’ but can in fact be a mechanism for managing a crisis in such a way as to contain the threats it represents.

Quantitative Studies

In the light of the preceding observations, the two quantitative studies were commissioned to examine whether datasets showed any relationships in either direction between state fragility and HIV epidemic. These studies also point towards the need to reflect on the utility of current indices and definitions of state fragility, at least as far as the assessment of HIV/AIDS impacts is concerned.

The first of the two quantitative studies was carried out by Indranil Dutta (2007). His hypothesis states that countries with high HIV prevalence levels are likely to show high morbidity of the labour force, which is reflected in low productivity levels. When human capital is reduced, institutions experience a knock-on effect and public services are weakened. State fragility thus results. He uses three measures of fragility; the first is a weighted composite index composed of a) corruption and conflict and b) the ratio of military expenditure to GDP; the second composite index consists of i) the level of openness (effectively trade) ii) dependence on exports iii) dependence on imports and iv) how ‘insular’ a country is – whether the country is accessible to outsiders. This second measurement is named the ‘Economic Vulnerability Index’ (EVI) and is taken from Bruguglio and Galea (2003). Thirdly, a weighted composite index of macroeconomic stability, microeconomic efficiency, governance and social development is combined to form a ‘resilience index’ (RI) (Bruguglio et al 2004). Dutta takes the residual of this and defines fragility as the inability of a country to resist the full impact of various types of shock.
The majority of data are taken from the World Development Indicators and Human Development Reports. Dutta runs cross country regressions for the corruption-military expenditure and RI, where data for around 100 countries is available, whereas panel regressions for 86 countries are analysed for the EVI indicator. Controls include dummy variables for country and religious effects, GNI per capita, Human Development Index, the ratio of public health expenditure to GDP, the presence of Tuberculosis and an inflation variable.

Simple Ordinary Least Squares (OLS) regression results for the first measure suggest that when HIV prevalence increases, fragility also increases, and this appears statistically significant. However, once dummies and controls are added, these results are no longer robust. In fact, once a GNI variable is included, HIV is shown to decrease fragility. Dutta suggests that this could be because as HIV levels rise, a country makes more investments in health, or become more efficient in investing available resources, which leads to better public services and less fragility. In further tests, the HIV variable appears insignificant, showing that there are no relationships of interest between HIV and fragility. In general, it is found that GNI/capita has the most important role in determining fragility, and that religion is also possibly a significant determinant, with the dummy variable$^3$ for Islam showing significance. With OLS for the first measure of fragility, these mixed results suggest that there are no stable results across the different models, with both positive and negative signs on the coefficients, as well as the lack of robustness manifest once significance tests are performed.

Turning to the EVI, Dutta finds no significant effect of HIV on fragility, despite testing five different models. This result also appears to hold for the fixed effects model. Finally, the RI model produces the expected negative coefficient (whereby an increase in HIV is associated with a reduction in resilience levels), however, with no significance, the original hypothesis cannot be upheld. This points towards the need to examine the indices and models for governance and fragility, and the significance of alternative models of state functioning.

More interestingly, this model finds that TB is significantly correlated with state fragility indicators, and this association overrides any effect that HIV might have on fragility. This is an intriguing finding given the large co-variation between HIV and TB. It indicates that HIV is unlikely to be the only health factor that should be evaluated. It may point to the significance of the economic impacts of TB and Malaria, documented by Gallup and Sachs (2001).

Dutta’s study clearly shows how assessment of the impact of HIV may differ according to different measurements of fragility, type of data and controls. The $R^2$s obtained throughout reflect a great range of results and, in any case, it is difficult to establish a causal link from purely quantitative studies. It is suggested that an indirect

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$^3$ In regression analysis, a dummy variable (also known as indicator variable or just a dummy) is a variable which takes the values 0 or 1. It is used to indicate the absence or presence of some categorical effect that may be expected to shift the outcome. In this case, the dummy variable is that a society is either “Islamic” or “not Islamic”. This is a blunt instrument as while use of such dummy variables usually increases model fit (as measured by a coefficient of determination), this is at a cost of fewer degrees of freedom and loss of generality of the model which is being used. Thus in this case, the presence or absence of Islam is found to have a significant effect on state fragility.
link may be likely, but in contrast to the original hypothesis, it is interesting to note how several tests have shown the unexpected result of increasing HIV prevalence associated with lowered state fragility. The research gives no indication of why this may be the case, but it is interesting to note the finding of Paxton (2009) that transitions to democracy are associated with increases in HIV risk.

Asuza Sato’s study (2007) also shows variability of statistical outcomes. Like Dutta, she uses a quantitative approach by defining and measuring indicators of fragility, then using OLS, logit and multinomial logit regressions. Her sample size of 46 countries is much smaller than Dutta’s because she looks exclusively at countries defined by the World Bank as ‘fragile’. By using this approach, she attempts to look first at the overall picture of whether these fragile countries present any correlations with their HIV prevalence rates, and secondly, she attempts to divide the countries by their degrees of fragility. This is a necessary exercise because by definition they are already classed to be ‘fragile’, so merely looking at OLS will reveal little. Instead, by splitting the existing data into strata (first into two groups and then into three), it is possible to see whether those states with lower HIV prevalence rates are more or less likely to be fragile states, or, seen from a different perspective, whether those states with the highest HIV prevalence are classed as the most fragile of states.

Sato provides a literature review of five main areas often considered to be directly affected by HIV/AIDS; demography, the military and conflict, economics, politics, governance and democracy, and general societal impacts. It is noted that whilst traditionally the military and conflict take centre stage particularly within the realm of state fragility, it is as important to recognise there are likely to be linkages between all these areas.

The null hypothesis states that there are no statistically significant relationships between HIV prevalence and state fragility. Four dependent variables are chosen as proxies for fragility: a) state corruption, b) political rights, c) civil liberties, and the d) presence of conflict. Data are taken mainly from Transparency International, Freedom House and UNAIDS. Apart from HIV prevalence, seven control variables are used. These are: GNI per capita, school enrolment, migration rates, Gini Index, numbers receiving radio transmission and additionally, two African dummies.

From the OLS regressions, Sato finds a marginally negative relationship between HIV prevalence and the first three variables (a-c) of State Fragility. However, only the civil liberties coefficient is found to have any significance. After including control variables, any such significance disappears. A discrete count model (logit) is tested for the fourth variable, conflict. More precisely, the presence of conflict is indicated by the number 1, and countries without conflict are allocated a 0. Logit models ascertain the likelihood of whether HIV/AIDS is associated with conflict. In a multivariate regression, the GNI, migration rates, Gini and Radio all have negligible effects on conflict, as shown by odds ratios of 1. This shows that the variables represented are equally likely to be determinants of whether there is conflict or not.

Three major concerns are pointed out, namely data shortage; the possibility of reverse causality and sample bias; and in order to test these, models other than OLS and logit are invaluable. By splitting each dependent variable into three strata, it is possible to
analyse their intra-relationship, thereby finding out whether different levels of fragility can be accounted for by different levels of HIV/AIDS prevalence.

Results from the multinomial logit regressions are mixed but seem to support the results from the OLS – that there is a marginally negative relationship, but one that holds no significance. There were some surprising outcomes, whereby those with increases in HIV prevalence are associated with up to 74% less likelihood of being highly corrupt than least corrupt. Yet, analysis also revealed that a percentage increase in prevalence is associated with 16% more likelihood of being mid-level corrupt than least-corrupt.

Much like Dutta’s study, it is clear that the relationship between HIV/AIDS and state fragility can differ according to the variables chosen, data availability and the types of statistical methods and models used. Sato argues that qualitative and anecdotal evidence can sometimes be extrapolated into statistical ‘facts’ even where no statistics have been sourced. In addition to the political and intellectual context outlined above, there may well be a publication bias factor at work. Authors are keen to find or assert significant relationships for publication, which inevitably leads to a general consensus that a significant relationships exists because studies showing or arguing no such rigorous associations may remain unpublished.

Individual and national security, whilst interdependent, are not directly causative of one another. Sato puts weight on the demographic impacts of HIV/AIDS over economic, societal or political effects, and also urges a rethink of the role of institutions and ‘governance’ within state building. As less developed countries continue to suffer from the HIV crisis, it is not national security or international relations that policymakers should be worried about—rather, their key concern should be the state of the nation’s health.

Africa

Swaziland has the dubious distinction of having the world’s highest national HIV prevalence. Alan Whiteside and Amy Whalley (2007) describe the epidemic as a new kind of humanitarian ‘emergency’, which is characterized by its long-term and comprehensive nature, affecting an entire society over a generation or more. This can be seen as the limiting case or worst-case scenario, in which a small and vulnerable country suffers hyperendemic HIV and enters a crisis of chronic social reproduction as a consequence. Scott Naysmith (2009) investigated the extent to which the combination of very high HIV/AIDS rates and other stresses such as drought have combined to create a situation in which the basic economic life of the country is no longer sustainable. In particular, there is a deepening food crisis in Swaziland, with this formerly-self sufficient country facing recurrent food production shortfalls, to the extent that 40% of the population was dependent on food aid in 2007.

Naysmith’s study is also a review of the ‘new variant famine’ hypothesis, which posits that HIV/AIDS contributes to a loss of resilience in societies such that they are less able to respond to shocks and stresses and hence households are more likely to suffer destitution (loss of livelihood) and hunger. Naysmith concludes that there is evidence for this scenario in Swaziland. Elsewhere in the continent, the last decade has seen extensive study of the impact of HIV/AIDS on food security and livelihoods,
though disappointingly little investigation of the impacts on the nutritional status of populations. This is reviewed in the ASCI research cluster on HIV/AIDS, emergencies, conflict and post-conflict transitions (Carballo, Davenport and de Waal 2009). The general conclusion is that although individual households may be devastated by the illness or death of an adult breadwinner, the aggregate effects of HIV/AIDS on food insecurity are generally modest, and are most apparent when a high prevalence of HIV/AIDS intersects with other sources of stress alongside a lack of social and economic capacity.

The implication of Naysmith’s study is that, hyperendemic HIV/AIDS over a protracted period, in a very small country with limited human and economic resources, exposed to other shocks including drought and economic recession, can bring on a humanitarian crisis of significant dimension. Unlike most humanitarian emergencies, this is a protracted crisis without a clear exit. This warrants new national and international responses. However, it is also clear from the Swaziland study that it represents an extreme and limiting case that is not generalizable, especially to larger states. Whether or not it may be generalizable to small components of larger states is explored in the study of north east India which is presented below.

Price-Smith’s (2007) discussion of Zimbabwe makes a similar argument for that country, and assembles data to argue that “… HIV exerts moderate to significant negative effects upon Zimbabwe’s economy, social stability, structures of governance, and ultimately its national security.” While the argument seems plausible, it is very hard to untangle the HIV effect from all the other deleterious factors affecting the country and more solid evidence would be necessary before a strong conclusion could be reached. Thus, if there is such a case of HIV resulting in a downward spiral, the study of Swaziland can be seen as an extreme and limiting case.

South-East Asia and the Pacific

In the first of several studies on south-east Asia and the Pacific, Dennis Altman (2008) explores the political dimensions of responses to HIV/AIDS in South-East Asia. Given the diversity in political, religious and wealth dimensions, it is not surprising to read of the great range in HIV prevalence and modes of transmission across the region. Burma, Malaysia and Vietnam all experience high needle and injecting drug use; men having sex with men is common in Singapore; Thailand and Cambodia have epidemics which have affected different sectors and strata of the country. In general, it is believed that blood transfusions are now given relatively safely within this region.

In looking at HIV prevalence figures, Altman suggests that they are not as high as official statistics suggest. In Thailand, prevalence has fallen in the last fifteen years and it is likely to stay fairly low ‘in the foreseeable future’. Altman then looks at the relationship between wealth and HIV and insecurity and doubts either correlation. Additionally the Jaipur paradigm (whereby social cohesion and level of wealth are determinants of the trajectory of HIV/AIDS epidemics) is mentioned, but Altman concedes that he cannot find a definitive measure of social cohesion. Overall, the prevalence figures that have been recorded in this region are attributed to socioeconomic and cultural practices, as opposed to politics and economics. For example, in Thailand, religion, sexuality and its large sex industry are suggested as
primary drivers of the epidemic. However, politics is much harder to explain because systems have changed so frequently. Similarly, he suggests that Catholicism in the Philippines and Timor Leste and Islam in Indonesia and Malaysia are ‘obstacles’ to condom programmes. Thus, diversity of states and their cultural underpinnings is shown to be of importance in this context.

Altman then uses three case studies of Thailand, Vietnam and Indonesia to determine their political responses to the epidemic. Altman attributes most of Thailand’s achievements to the government, not NGOs or donors. Key to this was the setting up of the National AIDS Commission and its 100% condom policy and the cross sectoral stance with robust civil society support. In Vietnam, early government responses may have hindered programme efforts because commercial sex work and drug use were labelled as ‘social evils’, which encouraged stigmatisation against those with HIV. Eventually, the government’s provision of needles and syringes, along with a more open economy, are believed to have triggered changes in behaviour. It is interesting to note that Vietnam is the only Asian country to have been given grants by the US government through the PEPFAR programme. Altman explains that this is because Vietnam is a highly cooperative country of interest to U.S. foreign policy. Vietnam’s additional resources have helped to increase access to ARVs. Indonesia’s political response was slow and most of its programme efforts were as a result of external pressures, despite its growing epidemic. Hence, awareness came late to this country, and some commentators suggest a generalised epidemic may result by 2025. Any efforts, however, were seriously hampered by economic and political crises of the late 1990s.

From these case studies, Altman questions whether community or government pressure matter more in reducing HIV prevalence. In most countries studied, it was found that leadership comes from community level organisations and on top of this, support from external agencies was accepted. He warns, however, that governments may provide perverse incentives in supporting HIV/AIDS programmes as it is a ‘fashionable’ topic and one that is almost certain to attract funds into their country. Five elements affecting responses to HIV/AIDS are summed up as: a) the size, or the perceived size, of the epidemic; b) bureaucracy; c) non national governmental, external pressures, including that of civil society and the media; d) international pressure; and e) social and sexual cultures. It is argued that these factors must be analysed – bearing in mind inter-country variations – in order to gain a full picture of political responses in South East Asia.

Of these countries, only Burma, Cambodia and Timor L’Este could be considered as fragile and in none of these cases is it possible to argue that HIV is a causal factor in that fragility. Neither is it possible to argue the converse, that fragility has resulted in elevated HIV epidemics.

Also investigating this region, Michael O’Keefe (2008) looks at the relationship between AIDS and state fragility in the South Pacific. The South Pacific region has seen a rise in HIV prevalence since the late 1990s from a low base. By 2004, an estimated 10,000 people had contracted HIV, and if one includes Papua New Guinea, this number rises to 20,000. Fully 95% of all cases are believed to be concentrated in five areas: French Polynesia, Guam, New Caledonia, Fiji and PNG. In line with this,
O’Keefe argues that HIV/AIDS should not be considered a South Pacific epidemic but rather, that there are numerous smaller distinct epidemics within this region.

A number of similarities between the South Pacific and Africa have led some analysts to describe the putative ‘Africanisation of the South Pacific’ and to argue that the region will suffer some of the same syndromes as sub-Saharan Africa, including state crisis and hyperendemic HIV (Reilly 2002). This case is superficially attractive and gained immediate resonance among policymakers, especially in Australia, concerned with both security and development assistance. For example, both regions still have remnants of pre-colonial societies and colonial administrations, as well as the effects of decolonisation. Most have poor governance and low human development. O’Keefe first elaborates and then critiques the ‘Africanisation’ hypothesis. Drawing from Reilly’s (2002) work, he looks at four inter-related factors shared by the two regions; a) tensions between civil regimes and military forces; b) ethnic tension and diversity; c) weak institutions; d) state weakness. He adds HIV/AIDS, missing from the original ‘Africanisation’ hypothesis, into the picture. In analysing this, it is made clear that South Pacific states have become neither model Westphalian states nor model democracies, leading O’Keefe to argue that it is important to distinguish between different forms of state failure, which have differing impacts on state sectors and the population.

Whilst HIV/AIDS has had discernible impacts on the quality of life in the worst-affected country of Papua New Guinea, its effects on economic growth and state capacity cannot be readily identified in any country. The scale of the epidemic and the nature of the societies, states and economies are far too different. The notion that there has been an ‘Africanisation’ of either the epidemic or the nature of state in the South Pacific can be rejected. There is no evidence for a causal relationship between HIV/AIDS and state fragility in the region.

Papua New Guinea is a special case within the South Pacific. It has a cluster of characteristics which include a generalised HIV/AIDS epidemic (the only one in the region), very low status of women and high levels of sexual and gender-based violence, and a very weak state that has failed to exercise effective authority over traditional forms of socio-political organisation, O’Keefe ponders whether Papua New Guinea can be compared to Africa. However, even this judgement presents insuperable difficulties. It is a sui generis case, in which a functioning state was never created in the first place, with an HIV/AIDS epidemic associated with specific forms of social organization and sexual networks deriving from a combination of unique cultures and the impacts of accelerated urbanization, mining and trade in certain areas of the country.

O’Keefe concludes with a thorough rebuttal of the ‘Africanisation’ thesis. Not only is the South Pacific not headed in the direction of widespread state crisis and generalised epidemics of HIV/AIDS, but the caricature of sub-Saharan Africa embedded in the ‘Africanisation’ hypothesis is not accurate either.

O’Keefe expresses concern that the analogy has proven counterproductive among policymakers. The differences (including the history and character of the epidemic, political and social contexts, sectoral prevalence, the impact of conflict on AIDS and government resources and demographic movement) between the states outstrip the
commonalities. Further, the region itself is not well-served by descriptions of its states as having ‘failed.’ O’Keefe argues that such typologies are unhelpful, especially as it implies ‘applying a scale based on deeply embedded assumptions about Westphalian statehood’, such as the perceived Weberian state gold standard. He argues that rather than looking at the subject of state fragility and HIV/AIDS through what are essentially ‘western’ lenses and ideals, there is a desperate urge for us to rethink the origins of fragility, to understand that a weak state is not a state that is falling apart, but one that was never fully created in the first place.

The relevant fragility is the South Pacific governments’ failure to act in response to the epidemic. These states have not ‘stated’ in a way which has resulted in action, either through ineffectiveness or through unwillingness or as a result of some combination of both of these. This is much like Erling Høg’s argument (to be presented below) that there is a failure in the public health system that prevents the attainment of better health capacity in Mozambique. Similarly, O’Keefe believes that AIDS will impact households and communities more than states, let alone the whole region. Better surveillance and measurement efforts are needed to examine the relationship between HIV/AIDS and fragility, but at this moment, O’Keefe concludes; ‘there is little evidence to link HIV with state fragility in the South Pacific.’

**Russia**

Concern with the USSR and analysis of Soviet data was the starting point for the health-state failure paradigm. Murray Feshbach, one of those who sounded the alarm on Soviet infant mortality rates more than a quarter century ago, updated his analysis for ASCI. Feshbach (2007) evaluates the interdependence between demography, health and the military in Russia. Taking data from 1987 onwards, he shows that dramatic changes in the health of Russia’s population has adversely affected the military and therefore has had grave impacts on governance. In particular, the fall in births has meant a reduced cohort of labour supply and recruitment into the military services. Alongside HIV/AIDS, Feshbach explores TB, mental health problems, drug addiction and alcoholism as being additional burdens on the population.

Population data are taken from the Russian Federal State Statistical Service, Ministry of Economic Development and Trade and the United Nations Population Division. Although data inaccuracies and discrepancies exist, there are irrefutable trends; average life expectancy for males and females is amongst the lowest in Europe and North America, with around 50% of 16 year old males not surviving to the age of 60, and the divergence between sexes can be as large as 13 years. Looking at labour force trends, it is anticipated that ‘due to the decline in labour force, only an increase in labour productivity can compensate for the numerical realities’, needing around 6 or 7% boost in productivity.

Such grim prospects are rooted in the health status of the population. Feshbach turns to the status of the young, taking data for children aged between 0 and 17 from the Child Health Census report. This report accounts for around 30.4 million of 31.6 million children – and as this is the next cohort to be recruited by the military, it is arguably the generation holding Russia’s security in its hands. Almost every disease investigated by the Child Health Census report was reported to have increased since the tail end of the 1980s. This includes tuberculosis, psychological disorders,
alcoholism, cancer, cerebral palsy, bone and skeletal illnesses, chronic disability, nutrient and vitamin deficiencies. Further, undercounting is believed to be more than likely; in reality, the statistics may be even worse.

The quality and quantity of potential and existing recruits are argued to be detrimental to Russia’s military. Low life expectancy and poor health, and in particular, mental disorders, account for a large number of rejections and deferments from the services. In 1988, 54.6% of hopefuls were successfully recruited. By 2006, this number had dropped to 9.7%. If one looks at the ‘absolute number rejected, by selected cause’ table on page 11 of Feshbach’s paper, it will be seen that of the four reasons of drug addiction, HIV, mental disorders and TB, HIV has the smallest number accounted for. For example, in the year 2000, drug addiction accounted for 21,000 rejections; mental disorders for 130,000, TB for 3,000 and HIV for a relatively small 2,100. It is possible that these numbers are minimized by secrecy and denial; Feshbach suggests that numbers may be inaccurate due to selective testing, or lack of testing, but diseases and disorders other than HIV/AIDS are also plaguing the Russian population.

Feshbach’s study suggests that disease reporting in Russia is highly sensitive and therefore quite inaccurate. No one will ever know the true extent of most diseases, let alone HIV/AIDS. However, existing statistics reveal serious issues of concern for the whole population and especially for the younger cohorts who are Russia’s next military generation. Both quality and quantity of recruits are argued to be dwindling, but at this moment, there is no danger of Russia becoming unstable. Indeed, combat capabilities will undoubtedly be weakened but these could to some degree be compensated for by recruitment of ‘overseas Russians’ and people from other parts of the former USSR. It is projected that by the end of 2010, an estimated three million people (2% prevalence) will be infected with HIV/AIDS and in the coming years a rise in female and heterosexual patients will be seen. The main driver of this is injecting drug use, with secondary transmission to sexual partners. Among this subcategory of the population there is a danger of very high rates of HIV, but the best estimates are that this will not translate into a generalised epidemic. Feshbach’s projection and evaluation suggests that whilst HIV/AIDS is a worrying problem, there are many other health concerns to combat in order to re-strengthen Russia’s military and general population. His analysis implies that although Russia is unlikely to face any form of state crisis on account of HIV/AIDS—or indeed other diseases—these will be major constraints on the ambitions of the Russian government as it strives to reassert itself on the global stage.

Local Government

South Africa

Most of the work on HIV/AIDS and state fragility has focused upon national or state level impacts. One of the hypotheses investigated in the following three pieces of research is that the impacts are also felt at local government level. As well as being inadequately studied, these impacts may be more significant in terms of the affecting how government authorities provide essential services to their populations.

Kondwani Chirambo and Justin Steyn (2008) investigated evidence for increasing levels of premature death among local government councillors in South Africa and the
impacts of this on the efficacy of service provision and the legitimacy of local authorities. One rationale for the study was to fill an important gap in our understanding of the implications of South Africa's hyperendemic HIV/AIDS. Another is that South Africans tend to judge the efficacy of government with reference to local service delivery, and in particular on the basis of the performance of local councillors. As well as the dual challenge of HIV/AIDS—increased tasks with fewer human resources—local government in South Africa faces loss of professionals to other sectors of the economy and the high aspirations of a recently-liberated populace. The study focuses on three dimensions of local government, namely accountability, effectiveness and legitimacy.

Chirambo and Steyn sampled twelve municipalities in different parts of the country. They found a consistent pattern of elevated death rates among councillors aged 29-42. This raises the threat of communities being unrepresented in local government through the absence of their elected councillors. Mechanisms exist to compensate for these absences, which are widely applied, at the cost of putting additional burdens on other officers including the speaker of the council.

By-elections for council seats saw net gains for the ruling African National Congress, reflecting the party’s superior ability to mobilize resources for electoral campaigns. The reduction in opposition councillors reduces the level of democratic scrutiny and hence the extent of accountability of the government. The costs of by-elections are also considerable and place additional financial and administrative burdens on already overstretched councils.

Chirambo and Steyn found a high level of stigma around AIDS among councillors. There is a widespread fear that disclosing HIV positive status would ruin one’s political career. The study found only one councillor openly living with HIV from among a sample of 3,895. Apart from the element of denial that will certainly influence wider social attitudes towards HIV/AIDS, this contributes to councillors living with HIV and AIDS withdrawing from public duties rather than admit the challenges they face in carrying out their tasks while living with the virus. However, the survey focus groups also found that voters were not averse to electing councillors living with HIV.

Elevated mortality among voters causes problems in maintaining updated electoral rolls. However, the data obtained by the study did not allow this issue to be addressed in detail, and hence it was not possible to assess the likely impacts of out-of-date voters’ rolls on the legitimacy of electoral results.

Chirambo and Steyn investigated absenteeism and productivity among local council workers. Consistent with other studies of the impact of HIV/AIDS on institutional functioning, they found some evidence for workers taking more sick leave and becoming less productive, especially at low pay grades. Uptake of ARVs was reported to be poor. Although the Department of Local Government has developed a framework for how councils should adapt to the challenges of HIV/AIDS, none of the twelve councils had actually applied the framework to their activities. Employee assistance programmes and VCT were available but uptake was disappointing, under the influence of stigma and discrimination.
Overall, Chirambo and Steyn found that local government in South Africa was showing definite ‘cracks’ that contribute to the problem of poor service delivery to the general public. The skills and leadership capabilities needed for local government to function to meet the aspirations of citizens is eroding due to a number of factors, of which HIV/AIDS is one. However, South Africa has the economic capacity to fill the gaps and meet its needs, where necessary by importing skilled personnel from other countries or by the government’s Joint Initiative on Priority Skills Acquisition.

**Indonesia**

Focusing on Indonesia, Claire Smith (2008) notes that the late 1990s saw two changes in HIV prevalence rates. Infection rates rose amongst two very different groups: injecting drug users in the major urban centres, and the remote rural population of the Papua region. (The Papua region is understood to include West Irian Jaya and Papua provinces, collectively known as Irian Jaya province until 2001). Infection rates between the Papua region and the rest of Indonesia diverge greatly, with the Papua region having the worst rates in the country. This is generally explained by the behavioural and risky sexual practices of indigenous Papuans residing in the area. These include high levels of commercial sex work, and men who have sex with men and women. The region also has the highest rates of violence against women in Indonesia, and women are considered to have the lowest overall status. Smith offers an alternative explanation through exploring the dynamics of socioeconomics, namely high levels of in-migration to the region, related to fast-expanding natural resource extraction, severe poverty among the indigenous population, poor education and health standards, all linked to a weak and transitional governance system.

Three inter-related hypotheses are put forward to explain the high HIV rates in the Papua region. First, recent decentralisation and other local government reforms have encouraged infrastructure development and consequently inter and intra migration in the Papua region, without similar investments in education and health, which has hampered the spread of HIV/AIDS knowledge, prevention and treatment to the groups most at risk. Secondly, electoral reform has attracted local government budgets towards elections and campaigns, and away from education and health spending. Thirdly, such political changes have led to administrative difficulties and hampered capacity building and the setting up and staffing of HIV/AIDS commissions. All tenets are investigated against the region’s historical background, before the logic behind government and electoral reform and its links to HIV/AIDS in the Papua region are discussed.

The Papua region’s historical and socio-economic background is divided into three keys stages. The first stage, the pre-colonial and colonial era, saw the foundations in New Guinea being built, whereby the island was initially cut off from the rest of the world, with the periphery slowly penetrated by traders and later colonialists. Owing to its geographical characteristics, a unique pattern of human settlement evolved, its diversity reflected in its numerous languages and tribes. By the late colonial era, the Dutch and their Indonesian counterparts had colonised the coastal areas, and Protestant and Catholic missions were penetrating the lowland coastal and highland areas. Missions provided public services, and continue to do so today, heavily influencing Papuan culture on education and health.
The second phase, or the post-colonial era, in particular the thirty years of the New Order, between 1967 and 1997, saw the intensification of Indonesian power over the region, which had major developmental impacts for the region, and related negative consequences on the indigenous population. Major changes in employment and settlement patterns went hand-in-hand with the development of the extractive industry and infrastructure sectors and the fastest growth rates in the country. The revenues generated by these sectors were then channelled back to the Papua region through central government transfers. These economic developments triggered a range of social and economic changes at the local level, with the benefits accruing solely to the migrant and non-indigenous sectors of the population.

The third phase, or the democratic era, followed the fall of Suharto in 1998. From this point dramatic political changes affected the Papua region. In the new era of democratic reforms, free elections, the formation of new parties, and the rolling back of the military and the state in political and civil life were encouraged across Indonesia, with a watered-down version for Papuans. Lobbying for an independent Papua intensified, with the government enacting new autonomy laws for the Papua region in 2001 to discourage this. At the same time, the enactment of decentralisation – also in 2001 – aimed for a more equitable distribution of government resources to the indigenous and poorest population groups. Both government reform efforts have been complicated by the growth of more administrative and executive bodies of government (from nine to 29 districts since 1999) – the so-called ‘pemekeran’ process. As such, local government has changed dramatically, with much greater powers but much less oversight and capacity to deliver services. Simultaneous electoral reforms, whereby elections have shifted from parliamentary election of executive positions to direct popular elections, have also taken place. With respect to HIV/AIDS, this has transferred responsibility of donor and governmental money to district and municipal administrations from centrally administered provincial government budgets. The bulk of coordination and allocation of resources is thus predominantly carried out by the local government, in theory to improve service delivery. Public services, however, remain of poor quality and there is little evidence to show improvements for the indigenous population in the Papua region.

The disparity in HIV/AIDS prevalence seen between indigenous and non-indigenous Papuans is stark, with the former group revealing rates twice as high as the latter group. Similarly, the female population generally exhibits higher prevalence, in particular among the indigenous population. As such, these issues of ethnic and gender inequality are of great concern to policymakers but they remain poorly understood and are thus in need of further in-depth research. In sum, it is believed that government and electoral reform has encouraged an increase in HIV/AIDS prevalence levels. Training and monitoring of overall health facilities are thought to have been negatively impacted following reform, with the indigenous population benefiting the least from social and economic changes brought about by the new government structures.

If Smith’s three hypotheses are not refuted, the implications for policymakers are immense: the first and third hypotheses would raise the notion that any rapid decentralisation giving rise to technically-weak new administrations must be monitored carefully when complex public health programmes are implemented. Further, if it is the case that governance systems are corrupt and/or weak, funding may
be misallocated towards election campaigns rather than public services. Finally, given that local government cannot – or will not – be put in charge of HIV/AIDS control programmes, what is the scope of NGOs to act in their place? Using historical evidence, Smith emphasizes the dangers of faith-based organisations operating in the Papua region which hold incomplete pictures of local communities and are likely to be unsuccessful in tackling HIV/AIDS. The paper encourages further research in testing the robustness of these hypotheses through fieldwork in Indonesia, in particular in the Papua region. It probably also has relevance to understanding the response in Papua New Guinea which is also situated within a highly devolved system of government.

**India**

In contrast to the findings of Chirambo, Happymon Jacob (2007) does not find local governance to be significantly shaped by HIV/AIDS in Manipur and Nagaland, north-east India. He argues that the threat HIV/AIDS poses to the governance structure in both states must be seen in conjunction with one another. Without doing this, statistics cannot be compared and moreover, they are likely to present alarming results. His assessment looks at four aspects argued to significantly affect governance; law enforcement, education, health and democratic processes at both local and regional levels. His hypothesis is that if these determinants of governance are negatively impacted by HIV, the state’s ability to ‘govern’ well is impeded. By way of evaluation he looks at the frequency of by-elections, number of deaths and illnesses whilst in service, and further, rates of premature retirement in the education/health sectors.

Data are taken from official statistics, NGOs and personal contacts and interviews. A crucial point of concern is that HIV/AIDS is aggravated by many other factors including armed insurgency and counterinsurgency (with the Indian army recently admitting to 500 AIDS cases among army units stationed there), narcotics trade, corruption and underground organisations. On top of this, inaccurate figures, missing and unreliable data are likely to undercount the true numbers obtained. For example, variation in the education sector, the number of days taken off by teachers is assumed to be solely attributable to the effect of illness due to AIDS. Results suggest that HIV moderately affected the ability of states to govern through the education and health sectors, with the former having the greater impact. The electoral sector remained relatively little affected.

A regional description of north east India and separate assessments of Manipur and Nagaland are given. Since the 1960s, there has been increased violence and displacement owing to ethnic tensions in the post colonial era. Delhi’s attempts to reduce this violence have inadvertently led to corruption and a breakdown in law and order. In Manipur, there are over thirty tribal units each trying to assert its identity and dominance; similarly, Nagaland has experienced insurgency which has negatively impacted the growth of industry. Their geographical locations have made north east India a prime drugs trade route and for locals an increase in injecting drug use has triggered further HIV outbreaks. In an attempt to reduce consumption, the state banned needles and syringes – however, the sharing of needles, or the use of ink fillers as substitutes, increased instead. This drug use is also connected to violence and social crimes that affect all strata of society. Drug trafficking money associated
with the trade has also reportedly encouraged corruption and the hiring of mafias for protection. On a macro level, the economy has suffered a loss in tourism and a high cost economy whereby arable land prices have artificially increased as poppy and marijuana demand soar.

Together, the drugs trade and insurgency create a weaker economy and environment for the control of HIV/AIDS. Drop-in centres have been shut down and road blockades have severed transportation links. Donor-funded NGOs are avoiding the area for fear of conflict. The growth in underground groups has made central government wary of giving any more monetary support to the local Manipur government in a bid to curtail leakages in the economy, which in turn has lessened the ability of local governments to control their health, education and other investments.

Jacob compares his data with official education statistics in Manipur to show high institution-to-population ratios and similarly high education expenditure. However, he argues that in fact, there are high rates of premature retirement and patchy teaching practices in the region. On health, there has been a dwindling in the number of doctors and nurses over the last few years, but no signs of premature retirement. Politically, there seems to be modest impacts of HIV/AIDS; elections are held frequently and there is generally a high voter turnout.

The picture in Nagaland is similar to that of Manipur, and if anything, a little worse. Yet, education and health expenditures per capita are high and there are no signs of premature retirement for doctors and nurses. Issues of teacher truancy exist in the same manner as Manipur, but politically, elections and voter turnout show no reason to believe that HIV/AIDS is negatively affecting governance.

In sum, Jacob’s findings show HIV/AIDS to have slightly affected governance in Manipur and Nagaland, the largest impact owing to poor education from irregular teaching practices and premature retirement. Secondly, the health sector shows minor signs of affecting governance, but evidence is mixed. Thirdly, in the electoral sector, it is believed that HIV/AIDS has next to no impact. Issues of security provided by the Indian Army are also considered; within the military, HIV/AIDS is the fifth largest killer and as such, there needs to be more work carried out on this front to amass more accurate data. It is commented that ‘the disease and its political/bureaucratic elite can act as force multipliers in a situation wherein HIV/AIDS is rapidly weakening the governance apparatus of the state’, and if the narcotics trade remains uncontrolled, the future may be very bleak. At the moment, however, the impact of HIV/AIDS on governance in Manipur and Nagaland is limited and it would take a much larger epidemic to destabilise these states, especially directly, and it is currently inconceivable that such impacts would destabilise the whole of India.

Responding to HIV/AIDS in Challenging Environments

Noting that a ‘fragile state’ is conventionally defined as one incapable of putting international assistance to good use, Jon Weigel (2008) addresses the question of how health can best be delivered in such situations, especially looking at HIV/AIDS. He finds that most donors prefer the ‘short route’ to accountability, namely providing their resources to international agencies, rather than the ‘long route’ of building up state institutions capable of delivering.
Focusing on a case study of Partners in Health (PIH) in Haiti, Weigel examines whether it is possible to deliver high quality HIV/AIDS programmes in settings of severe resource constraints and low governance capacity. He concludes that the answer is yes, it is possible. Haiti fits the classic definition of a ‘weak-weak’ fragile state, that lacks both state capacity and state willingness to act. The PIH model is context specific but three main elements stand out, namely 1) local partnership, 2) investment in Ministry of Health infrastructure and 3) accompagnateur roll-out—the training of community members as paramedics who have the specific role of accompanying patients to their homes to attend to the barriers that too often prevent patients from utilizing available healthcare.

The successes of the PIH model in Haiti raise questions about whether it can be replicated at scale and in other settings. The achievements in Haiti relied heavily on the availability of funds, especially at an early stage, and strong personal ties between PIH leaders and members of the government. Critiques of the PIH approach contend that the most valuable element in the project is personal leadership that can overcome many of the obstacles to operating in such constrained environments, and that such leadership and the protection and facilitation it affords is an extraordinarily scarce resource that cannot, by definition, be replicated across different countries. However, there is no doubt that, within its working environment, PIH has confounded its critics and demonstrated that, with sufficient resources and skilled project leadership, there is no reason why effective HIV and AIDS projects cannot be extended in countries without state capacity or willingness.

**Mozambique**

Erling Høg (2008) investigates HIV/AIDS in relation to state fragility in Mozambique with a special focus on the health care system. Høg analyses issues of treatment access and delivery, fragility and absorptive capacity using ethnographic method. He argues that rather than being a ‘fragile state’, Mozambique is in fact a ‘weak but willing’ state, open to international support and partnerships. However, its public health system is weak, and private healthcare is denied government support. It is fragile for a very specific reason, which is government determination to maintain a state health system without making use of foreign technical assistance, an exercise that is well beyond its existing capacity. In considering measurements of state fragility, he advocates the inclusion of a ‘with and without AIDS’ indicator to fully understand its relation to the HIV epidemic.

Høg utilises case studies of both patients and health workers to shed light on health system fragility in Mozambique. Even though the majority do not come forward for testing or lack access to hospital treatment, all ART sites are already running at full capacity. Thus, demand outstrips supply, with the main constraints identified as infrastructure and human resources. At all levels, the response to HIV/AIDS has been insufficient and asynchronous; citizens do not come forward for testing and treatment owing to ‘complex, interrelated individual, social and systems barriers’; insufficient health infrastructure; and there are not enough trained health workers to deal with the epidemic. In turn, the speed and quality at which treatment is accessed and delivered has been affected.
An epidemic evolution model is presented to understand state fragility within the context of long wave events (Barnett and Whiteside 2006). This ideal model shows how epidemic evolution affects populations and health services at different prevalence levels, as well as its impact and the responses needed to sustain human resources and institutional capacity. Høg adds a real-type model based on fieldwork by showing eight phases of responses by people living with HIV, the public health system, the government and the international community over time since epidemic inception in the 1980s. This is an epidemic evolution model in context, applicable to many countries. The model is ‘non-linear’, given the staggered responses by these actors at different points in time, caused by global and local politics and circumstances.

Høg visits a health centre in a Maputo City shantytown and describes what he sees: overworked staff, crowds of people waiting for their treatment, and those who come for food provided by the World Food Programme. It is strongly emphasised that food must complement ART treatment, as most people living with ARVs are poor and many of them take ARVs on an empty stomach. Success stories of ‘ARV coverage’ tend to overlook social conditions.

He also notices that only about 5 percent of the adult population have tested for HIV in 2006. There are several explanations for this low level of uptake of testing and counselling. Høg argues that we must understand this in terms of interrelated individual barriers (fear, shame, denial), social barriers (stigma, discrimination) and systems barriers (limited capacity, low expectations, and the length of time between taking a test and obtaining the result). It is also caused by the fact that HIV testing is voluntary, that is, individuals have to make up their minds about testing, and this can be difficult under the given circumstances. Improved health system capacity will indeed lead to increased testing and disclosure, but causality is not always so simple. Why do people stay away from available health services or drop out of treatment, where there is plenty of supply? Many demand-supply phenomena remain poorly understood.

The number of people on treatment has increased from around 11,000 in mid-2005 to more than 54,000 by February 2007. This is a success story in a so-called ‘resource poor setting’. However, a consistent patient tracking system is not in place, pointing to a particular kind of health system fragility, exacerbated by the fact that many organisations with different work philosophies and resources support the Mozambican public health system.

The Mozambican ARV model shows Mozambique’s unique attempt to move from HIV exceptionalism towards HIV normalisation. First, it is a stepwise model by which they announce treatment locally as it becomes available. Second, AIDS activists and community health workers do this by way of ‘gentle citizen sensitization’. Third, instead of ‘Voluntary Counselling and Testing’, the government introduced ‘Counselling and Testing for Health’, which covers all aspects of health, not just HIV. This increases the number of people coming forward for testing and it decreases stigma and discrimination. However, the public health system remains a overstretched, as it is evident that the minority of people who have tested HIV positive already push the health system beyond its capacity. This minority is less than 10 percent of the estimated 1.8 million Mozambicans with HIV. The need for infrastructure and health workers is enormous.
Høg shows that fragility indexes – the World Bank LICUS index, the Failed States Index, the Corruption Perceptions Index, and the DFID Index – do not consider Mozambique a fragile state. This is justified through Mozambique’s capacity, willingness and resilience, demonstrated by its lasting peace, political reform and economic growth. In contrast, Høg argues that fragility indicators must consider two key factors: time and politics. The time factor questions the appropriateness of measuring state performance on the basis of how states have performed on other continents at different points in history. Fragility seems to be traditionally measured against a given standard of ‘strong’ states, a yardstick of development. The political factor questions the appropriateness of measuring state fragility in light of a specific country’s own history and previous state performance. Did the state do better or worse in the past? What are the assumptions and expectations for successful state performance in poor countries in light of context specific political history? In other words, ‘developed’ and ‘developing’ countries do not compete on equal terms. Both factors suggest that indices that look merely at static data may be hiding myriad interesting and critical issues.

The term ‘fragile stability’ is adopted for Mozambique to capture the ‘contradictory nature of improvement, stagnation and deterioration’ (Beall et al. 2005, Høg:36). This describes that whilst the country has stabilised politically and economically, a host of social problems remain to be dealt with, including poverty, illiteracy, unemployment and diseases. This is reflected in its minimal spending on both public and private health – 2.9% and 1.8% of GDP respectively in 2003. Yet, the government refuses to welcome private healthcare and the goal is to see international organisations leave the country as the government aims for a free, unique and integrated healthcare system exclusively for and by Mozambicans. Privatisation is seen as a threat to achieving this; ‘health care is the most highly prized asset that Frelimo refuses to privatise’. The consequence is felt most by patients who fail to receive ARVs, and partners who have no choice but to work with the government.

Thus, it remains to be seen when Mozambique will move from ‘weak but willing’ to a stronger state, independent of foreign healthcare support. One major challenge is the absorption problem, whereby money disbursed is greater than money spent, in addition to resource challenges (especially human). By political choice, the expansion of infrastructure has to occur within the governmental framework. This avoidance of private healthcare is arguably another form of fragility in an already high prevalence country.

Finally, Høg argues that fragility must be measured in a way that goes beyond conventional methods and indicators to include scenarios ‘with and without AIDS’. He recommends a ‘states of HIV fragility correlation’ (which assembles HIV and ART statistics against health systems capacity, state fragility measures and funding sources) as a starting point. Mozambique is shown not to be a fragile state by conventional standards, but a state suffering from social weaknesses especially within the public health system.

Policy makers must pay attention to the complexity of fragility meanings, especially in a high prevalence country like Mozambique, which faces an enormous and perhaps unattainable challenge in terms of responses needed against the HIV epidemic. ARV
expansion and other accomplishments in Mozambique make it a success story, but there is a need to keep an eye on the mosaic of responses over time to understand epidemic complexity and emerging and persisting fragilities in order to make wise and sustainable policy choices.

Burma

Ohnmar Khin (2008) investigated the challenge of responding to HIV/AIDS in a very different context, namely Burma/Myanmar, which is a military dictatorship rather than a weak government with insufficient authority. It is ‘fragile’ in the instrumental sense that it is resistant to international aid. The popular depiction of Burma is of an anachronistic authoritarian regime that controls all aspects of society using severely repressive tools. This is broadly correct, but misses the ways in which citizens including local officials are able to navigate the oppressive system in order to secure specific goods. Khin uses the metaphor (derived from Michel Foucault) of a ‘reverse panopticon’ to describe the way in which the repressive apparatus and its operation are visible to those on the receiving end, who are thereby able to exploit the crevices in the system. For example, low-level officials in local government and security know the importance of health programmes and educational efforts, and as a consequence are keen to have NGO activities in their localities. They discreetly advise NGO staff on how they should label and present their programmes in order for them to be acceptable to the higher-up authorities, thereby securing the projects and their benefits, while also being seen to satisfy the needs of the government apparatus.

In Burma, HIV/AIDS programmes and projects are constrained not only by governmental sensibilities but also cultural norms that are extremely conservative, and which are exploited by the regime to enforce social conformity. Official policy is hostile to any form of sex education or condom promotion. On the other hand, harm reduction programmes for IDUs are tolerated or even encouraged.

This is not an ideal environment for HIV/AIDS activities by any means. Nonetheless, Khin finds that there are more opportunities for projects and programmes by local actors provided they operate according to a discreet code of collusion between them and local officialdom.

Conclusions

One of the principal findings to emerge from these studies is the sheer diversity of the world’s HIV/AIDS epidemics, of the states which are supposed to be ‘fragile’, and of the relationships between these things. This is a very important conclusion indeed. It points to the danger of superficial and homogenising analyses when social science is used in the service of politicians and policy makers who seek simple and even simplistic solutions. The analysis in this paper shows that: (a) states cannot easily be classified as “fragile” or “robust”, each state reflects local circumstances, cultures and political traditions; (b) HIV epidemics are diverse and also reflect local circumstances and histories.

In recent years, UNAIDS has adopted the mantra ‘know your epidemic’ (UNAIDS 2007), insisting that thorough epidemiological analysis should be the first step towards mounting effective prevention and treatment responses. In the light of the
present discussion we would add, ‘know your social, economic and political context.’ Any assessment of the societal impacts of the epidemic, and any analysis of the interaction between the epidemic and state fragility, require a thorough political ethnography of the country in question. Generalization is remarkably difficult beyond the observation that the issues are diverse and complex.

What does it mean to demand, ‘know your social, economic and political context’? It begins with the observation that a behaviourally- or epidemiologically-focused mode of classification of epidemics is insufficient. Using individual behaviours as generic categories fails to grapple with the range of socio-political, institutional and economic factors which influence how an epidemic develops, how it may be controlled and what implications it may have.

This research arrives at two main general conclusions:

1. **There is no significant link between HIV and state fragility**

The single major finding of this research is the absence of any causal linkage between HIV/AIDS and state fragility. As a general rule, the epidemic is not making states fragile. There is no direct relationship between the epidemic and state fragility, and neither is there evidence of intervening factors exerting sufficient influence to determine the viability of states. Twenty-five years into the AIDS pandemic, there is no evidence that the disease is contributing to crisis or collapse at state level. It is theoretically possible that the next 25 years of the pandemic will witness a different scenario, perhaps because of the accumulation of impacts over a long time period. However, it is remarkable that none of the dire predictions made a decade ago, of state collapse, conflict, regression to dictatorship, governance paralysis, social crisis brought about by an unmanageable burden of orphans, crime wave, economic collapse or famine have yet materialized, and that the authors of these forecasts have either fallen silent or revised their views. Those who fear ‘African-style’ AIDS crises in south-east Asia, the Pacific or central Asia, are wrong on two counts: first that these countries are unlike sub-Saharan Africa in many respects including the epidemiology of HIV, and second in that African countries do not in fact resemble that cataclysmic AIDS-ravaged image.

It is possible that the limiting and exceptional case is Swaziland, a very small country which has a prior history of poor governance and an exceptionally high level of hyperendemic HIV. But what may be true for Swaziland is unlikely to generalize even to a medium-sized African country, let alone a large country such as South Africa and still less a major power such as India or Russia.

Nonetheless the studies do indicate important impacts that unfold in specific ways, particularly at the level of local government. The stress and attrition placed on local government institutions, in small but significant ways, by hyperendemic HIV/AIDS is contributing to poor quality services and less responsive and effective local government. These impacts are discernible in South Africa. Comparable stresses on service provision in different sectors (education, health, agricultural extension) have been noted elsewhere in sub-Saharan Africa, but such impacts are unlikely to be evident outside the continent.
By contrast, state fragility and/or repressive government can influence the HIV/AIDS epidemic and pose immense challenges to effective programmes and policies. Studies from places as diverse as the Indonesian region of Papua, Mozambique, Haiti, northeast India and Burma all demonstrate these influences. It should be noted that these case studies are mostly not of states classified as ‘fragile’, but rather of conflict-riven or unstable regions of larger countries, or of countries with forms of government that deviate markedly from the ‘good governance’ norm promoted by the international community. The research shows the difficulty, but not the impossibility, of mounting HIV/AIDS programmes under these challenging circumstances. It also shows that, in states that deviate in these ways, locally-specific knowledge about structures and ideologies is essential for an effective response.

2. The concept of “state fragility” leads to inappropriate analyses

In the period after World War II, the experience of the Marshall Plan in Europe led to the idea that similar aid processes could be successful in the newly decolonising societies of Africa and Asia. This was the period of “modernisation theory” where “development” became identified with “modernisation”. In political terms, this pointed to the establishment of western style democracies as an alternative to the then competing Soviet model. Key theorists of this approach influenced aid policy, particularly that of the USA. Such theorists included David Easton (1964), Shmuel Eisenstadt (1966), Szymon Chodak (1974), Bert Hoselitz and Wilbert Moore (1966). While such theories were soon seen to be inadequate accounts of what was actually going on in the “third world”, they were not replaced in foreign policy thinking and analysis by careful and detailed analyses of local circumstances. Instead, with the end of the cold war, they were replaced with a branded and barely different version of the same, theories of “governance” which could be deployed as part of the conditionalities of structural adjustment. In short, the response of countries to aid injections could be monitored partly at least in relation to the degree that they had achieved good governance as opposed to poor governance. This approach permitted managerial techniques of performance to be applied to entire polities – while at the same time failing to take into account the local complexities and traditions. Such theories of governance exclude such analyses by definition. The earlier tradition of analyses of states to which reference has been made earlier in this paper had severe limitations often twisted social and cultural particularities to enable identification of pre-conceived notions of “class” (Shivji 1978) which might explain what was going wrong (Arrighi and Saul 1973). Despite this, their frames of analysis did at least offer the possibility of more careful contextual analysis of the behaviours of real states rather than of abstracted proxy variables processed through regression analyses. We should learn from these two very different traditions that in relation to the social epidemiology of infectious disease and its effects, elements of both approaches may be required. Quantitative manipulation of data sets does not tell us the detail and may be distorted by hidden or hard to identify ideological assumptions but may all the same clear away complexities and provide a basis for seeing patterns. On the other hand, ethnographic analyses may be limited by their opaque methods but can provide insights into state and political processes which might avoid homogenisation of very different societies and states. This diversity has been apparent throughout the present discussion. The challenge raised by this paper is that when analysing a topic as serious as infectious diseases and their relation to states, elements of both approaches are necessary: although the problem remains one of how to bring the two methods to
bear in ways that their evidential status and limitations can be clearly understood by those who would allocate resources to responding to major humanitarian problems.

Bibliography


