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Germs and Governments: Politics of HIV/AIDS in Developing Democracies

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Germs and Governments: Electoral Market Imperfections and the Politics of HIV/AIDS in Developing Democracies.

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An abstract of
A dissertation submitted to the Faculty of the James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of Doctor of Philosophy Political Science
2011

Abstract
Germs and Governments: Electoral Market Imperfections and the Politics of HIV/AIDS in Developing Democracies.
By Jakub Kakietek

Although well established theories in the scholarship on political economy and social policy suggest a link between democratic regimes and high quality of social policy, a closer look at the Caribbean suggests otherwise. In particular, it reveals considerable variation in the way developing democratic nations in the region responded to the epidemic. My dissertation addresses this puzzle by exploring the reasons similarly democratic countries can produce dramatically different policy outcomes. It attempts to answer two questions pertaining to the impact of democratic accountability of HIV/AIDS policy: 1) under what conditions institutions of democratic representation improve HIV/AIDS policy outcomes and 2) is the impact of democracy the same for policies affecting the general population (e.g. providing prophylaxis for the prevention of mother-to-child transmission of HIV) and policies affecting marginalized groups: men who have sex with men and commercial sex workers.

I argue that imperfections in electoral markets mediate the impact of democratic institutions on policy, including measures aimed at fighting HIV/AIDS. More specifically, *imperfections in the electoral markets*, defined as: 1) lack of access to information among the citizens, 2) ethnic polarization, and, 3) limited trust of the citizens in politicians, in particular the lack of trust that politicians deliver on their electoral promises, *suppress the positive impact of democratic accountability and lead to HIV/AIDS policy failures in democratic countries.* In countries where electoral market imperfections are more pronounced, policies and institutions aimed at fighting AIDS take longer to develop, spending on AIDS and the availability of services for those infected and at risk are low, and the effects of the efforts to fight AIDS, such as behavioral change in those at risk of infection, are limited.

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CHAPTER 1: INTRODUCTION, LITERATURE REVIEW, AND THEORY

"…There is now, therefore, a moral obligation for all of us to declare and to treat the HIV/AIDS pandemic for what it is – the greatest single threat to human security."

Owen Arthur, Prime Minster of Barbados

"As president, I am shy that I am spending millions of shillings importing those things [condoms]"

Daniel Arap Moi, President of Kenya

1. Introduction:

Worldwide**,** the Caribbean is second only to sub-Saharan Africa in terms of HIV prevalence (UNAIDS 2008). Despite this, the region is all but completely neglected in the literature on political economy of AIDS. Although well established theories in the scholarship on political economy and social policy suggest a link between democratic regimes and high quality of social policy, a closer look at the Caribbean suggests otherwise. (e.g. Bueno de Mesquita et. al., 2003; Lake & Baum, 2003). In particular, it reveals considerable variation in the way developing democratic nations in the region responded to the epidemic.

Public health scholarship tends to focus on specific strategies and programs aimed at fighting the diseases without any attention given to the factors shaping the policy response which would go beyond the nebulous notion of "political will". The structural

framework developed by Barnett and Whiteside (2004), explains why some countries are more susceptible to the spread of the disease, and more vulnerable to its impact, but fails to answer the critical question: why are some governments in the developing world more committed to fighting the disease than others?

Political science has remained largely silent on the issue of AIDS[1]. The studies, reviewed earlier, which have examined political and economic factors affecting HIV/AIDS policy in individual countries are largely descriptive (Fourie, 2004; Patterson, 2005; Poku & Whiteside, 2004; Misztal & Moss, 1990; De Wall, 2006) not based on any specific analytic framework (Patterson, 2007) and, with notable exceptions (Lieberman, 2007; Lieberman & Gauri, 2007) do not attempt to formulate any generalizable theoretical propositions. Also, even more so than the public health scholarship, political science literature on HIV/AIDS has focused almost exclusively on sub-Saharan Africa. This limited geographic focus limits the extent of the possible political inquiry. In particular, looking only at sub-Saharan Africa, where established democracies are virtually absent, makes a thorough study of the impact of democracy on HIV/AIDS policy-making – the focus of this project, especially problematic.

My dissertation addresses this puzzle in part through a close examination of HIV/AIDS policy in the Caribbean, specifically exploring the reasons similarly democratic countries can produce dramatically different policy outcomes. It also challenges another broad body of literature which focuses on differences in electoral

[1]The research on social political in comparative political economy has focused on highly visible "big ticket" items such as spending on health and education and comprehensive health care and education system reforms, which while important, happen rarely and constitute an exception rather than a rule in policy reform.

institutions - such as presidential versus parliamentary systems, size of electoral districts, or methods of translating votes into parliamentary seats - as key determinants of social policy outcomes (e.g. Persson & Tabellini, 2003). The two cases used in this project, Trinidad and Tobago and Barbados, have virtually identical electoral institutions: both countries adopted the Westminster model following their independence from Britain in the 1960s. However, in 2007, the government of Barbados spent more than two times more than Trinidad and Tobago on fighting AIDS (UNAIDS 2008), and per capita expenditures on treatment were almost three times higher in Barbados, despite comparable HIV/AIDS prevalence in both countries. Service provision also differs sharply: Barbados is one of only a few developing nations with free and universal access to anti-retroviral therapy (ART), and more than 95% of people with advanced HIV infection (including 100% of infected children) are currently receiving ART, whereas ART coverage in Trinidad and Tobago is only 49% (ibid.).

This chapter introduces the central theme of this dissertation, namely, the relationship between democracy and HIV/AIDS policy, and more broadly, between democratic government and good governance. I first review the extant political science literature, which considers the impact of democracy on social policy. In the next section I provide a critique of this approach and point to its empirical and theoretical shortcomings. From this I derive the central theoretical propositions of this research project: 1) Democracy is not a sufficient condition for ensuring policies that promote public welfare; 2) Imperfections in the electoral markets, defined as a) ill-informed citizens, b) social polarization, c) lack of trust in electoral promises made by political

candidates and parties lead to HIV/AIDS policy failures in democratic countries. The chapter concludes with a description of the methodology used in this dissertation project.

2. Democracy and social policy:

Political philosophers have long ago linked democracy with good governance and argued that democratic states value and foster the welfare of their citizens more than autocratic ones (Shumpeter, 1954; Sen, 1999). Recently, those normative arguments have been supported by theoretical and empirical research, which argues that democracies produce better social policy and provide more health and education services to their citizens (Bueno de Mesquite et. al., 2003; Lake & Baum, 2003; Avelino, Brown & Hunter, 2005; Brown & Hunter 1999; Stessavage 2005). This scholarship considers a broad spectrum of social policy areas, including primary, secondary and tertiary education (Brown, 1995, 1999; Brown & Hunter 2004, Lake & Baum 2001, Stessavage, 2004), social insurance (Bueno de Mesquita et al., 2005), and health (Bueno de Mesquita et al., 2005; Zwifel & Navia, 2000; Lake & Baum, 2001; Baum & Lake 2003) and different aspects of policy including spending, service provision, and educational and health outcomes such as literacy rates, and life expectancy. The emerging consensus in this literature is that democracies improve wellbeing of their citizens more than autocracies, even though dissenting voiced have emerged (e.g. Ross, 2007).

Some of the studies mentioned above are tentative as to the nature of the impact of democracy on social policy (Brown, 1999; Zwifel & Navia, 2000) but others propose very detailed causal micro-mechanisms, sometimes expressed as formal models (Bueno

de Mesquita et. al.; 2005, Lake and Baum 2001). Mechanisms suggested by the literature are summarized in Table 1.

Table 1.1.: Casual Mechanisms of the "Accountable Government" Thesis.

	Mechanisms						
Authors:	Elections	Coalition size	Civil Society	Individual liberties	Freedom of speech	Freedom of association	Property rights
Avelino, Brown, and Hunter, 2005	X						
Lake and Baum, 2001	X						
Baum and Lake 2003	X						
Boix 2001	X	X					
Brown 1999	X		X	X			X
Brown 2000	X						
Brown 2004	X		X	X			
Brown and Hunter 2004	X				X	X	
Brown and Hunter 1999	X				X	X	
Bueno de Mesquita et. al. 2003	X	X					
Zwifel and Navia 2000	X		X	X	X	X	

2.1. Electoral mechanisms:

All of the authors emphasize the role of elections and their impact on social policy and service provision and the following causal process can be extracted from this literature: All of the authors explicitly (Lake and Baum 2001; Bueno de Mesquita et. al, 2003) or implicitly (Zwifel & Navia 2000; Brown 1995; Brown and Hunter 2004; Boix 2001) assume that the main concern of all incumbent leaders is to stay in office. Therefore, all policy decisions are made with the goal of securing political survival mind (Bueno de Mesquita et. al. 2003). Providing social services and adopting policies that

foster public welfare is costly and only occurs when it helps the incumbents stay in power. Brown (1999) notes, that "democratic politicians are relatively more concerned than their authoritarian counterparts with broadening political support. Assuming democratic politicians wish to remain in office and that their survival depends on winning the elections, democratic politicians are driven to adopt survival strategies designed to widen their electoral base. Allocating government resources to programs such as housing, public works, health, and education all represents time-honored strategies of broadening one's base of support." (Brown, 1999, p. 696).

Lake and Baum (2001) argue that, by holding regular elections, democracies have lower entry and exit barriers and therefore, a more competitive political market. Therefore, in democracies more policy options are available, and the elections constitute a vehicle through which the citizens can choose the policy option they prefer. Incumbents know that, thanks to the low entry and exit barriers, they can be easily replaced and, therefore, strive to provide the optimal level of public goods. If they fail to do so, they are punished by the voters who vote them out of office and support the challengers instead.

For Bueno de Mesquita and colleagues (2003), elections affect the ratio of the selectorate to the winning coalition making governments more likely to provide public goods, or policy and services that benefit large groups of citizens. In a similar manner Boix (2001) argues that in democracies the median voter is more representative of the entire population (as more citizens have the right to vote and influence decision-making) and, therefore, public expenditures, which benefit the largest segment of the population in democracies will be higher than in non-democracies. Other authors propose similar

mechanisms (Avelino, Brown, and Hunter 2005; Brown and Hunter 2004, Zwifel and Navia 2000).

2.2. Other mechanisms:

Several authors note that democratic regimes grant their citizens greater individual rights and civil liberties than non-democratic ones (Brown 1999; Brown & Hunter, 2004; Zwifel & Navia, 2000). These liberties and rights enable citizens to monitor the actions of public officials and increase the supply of public services by a more efficient allocation of public resources (Brown, 1999). Freedoms of speech (including free press), which enables the citizens to express their demands (Brown 1999; Brown and Hunter 2004), and freedom of association, which enhances interest aggregation and articulation are often emphasized (Zwifel and Navia, 2000). Brown and Hunter, for example, hypothesize that increased education provision in Latin American democracies was caused by successful mobilization of teachers unions (Brown and Hunter, 2004).

A related argument emphasizes the role of civil society in improving accountability of public officials. Arguments liking civil society with quality of governance have a very long tradition in political science (Putnam, 1993). Authors who write about democracy and social policy argue that democratic regimes allow the emergence of a vibrant civil society, which helps citizen aggregate and express their preferences, and hold governments accountable (Zwifel & Navia, 2000; Brown, 2004). In the study of gender and education provision Brown argues that democratic institutions in

Latin America increased women's ability to organize and express their views in addition to influencing the ability to obtain and disseminate information (Brown, 2004).

It needs to be noted that these mechanisms are not necessarily distinct from the electoral mechanisms. They all emphasize that democracy increases the accountability of the government to citizens. However, for true accountability, an effective sanctioning mechanism is necessary. Therefore, all the arguments mentioned above rely on an assumptions that (through elections), citizens can hold the government accountable and punish those, who do not provide the desired level of public services.

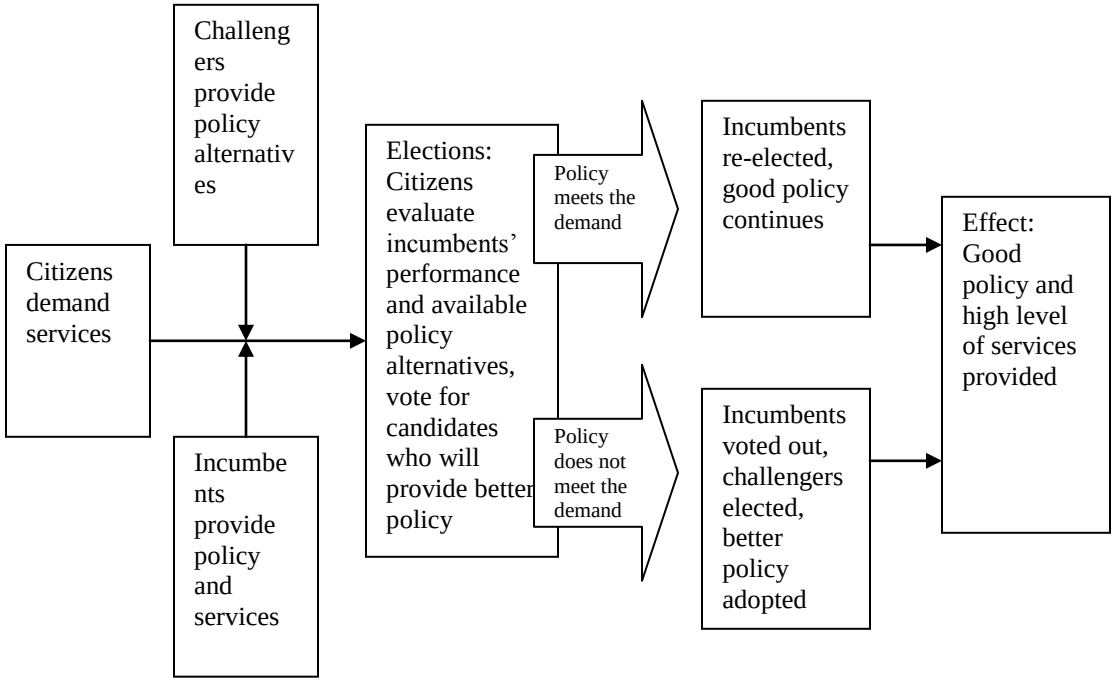
3. Democracy and AIDS:

In the context of HIV/AIDS the "democracy thesis" implies the following process: HIV/AIDS policy and services are assumed to be normal goods citizens always demand better HIV/AIDS policy and more services. This assumption is not unreasonable. Prevention efforts, such as education and information campaigns (EIC), are a classic public good in the sense they are non-rival and non-excludable. HIV/AIDS treatment is excludable (it is possible to provide anti-retroviral drugs to one person and withhold them from another) and rival (antiretrovirals taken by one person cannot be used by anybody else). However, is it also a public good: ART treatment lowers the viral load in the person who receives it and makes him or her less infectious to others. This lowered risk of transmitting the virus onto other people is non-rival and non-excludable. Since HIV/AIDS services are public goods, they should be in demand among rational citizens.

Incumbent governments respond to this demand providing certain quality of AIDS policy and certain level of HIV/AIDS related services. At the same time

challengers propose alternative policy and level of services. If the quality of policy and provision of services satisfies the demand of the citizens, they support the incumbents in the elections and the pre-election policy continues. If the quality of policy and provision of services does not meet the demand, the citizens vote the incumbents out and the challengers into office. The challengers adopt new policy and provide services at a different level. These policies and services are evaluated by the citizens at the next election and the cycle is repeated. The long term effect of the process is that the quality of HIV/AIDS policy and the level of services provided are always higher in democracies than in non-democracies. In non-democratic regimes incumbents have no incentives to provide good policy and high levels of services, since, by assumption, they are not benevolent, and all they care about is staying in power. Since there are no challengers who could provide better HIV/AIDS policy alternatives and higher level of services, incumbents will provide policy and services at minimal levels. The following figure summarizes the causal process implied by the electoral mechanism:

Figure 1.1.: The Electoral Mechanism

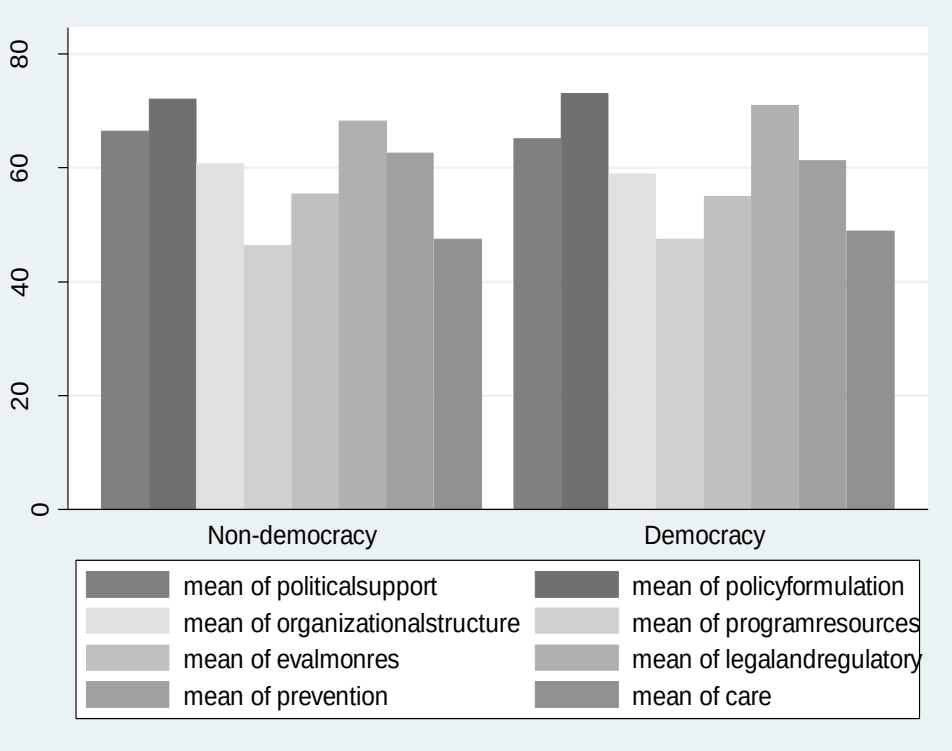


A cursory look at the empirical evidence challenges this model. The AIDS Program Effort Index created by UNAIDS[2] to quantify the quality of the overall response to the epidemic in different countries shows that while some of the developing-world democracies, such as Brazil or El Salvador score very high, others, such as Russia or Nicaragua, score very low, much lower, in fact, than most of non-democratic countries.

Simple bi-variate analysis shows that API scores do not significantly differ between regime types (see Figure 2).

[2] the UN agency created to coordinate the global fight against AIDS.

Figure 1.2: Components of API by Regime Type (Democracy ≥ 6)

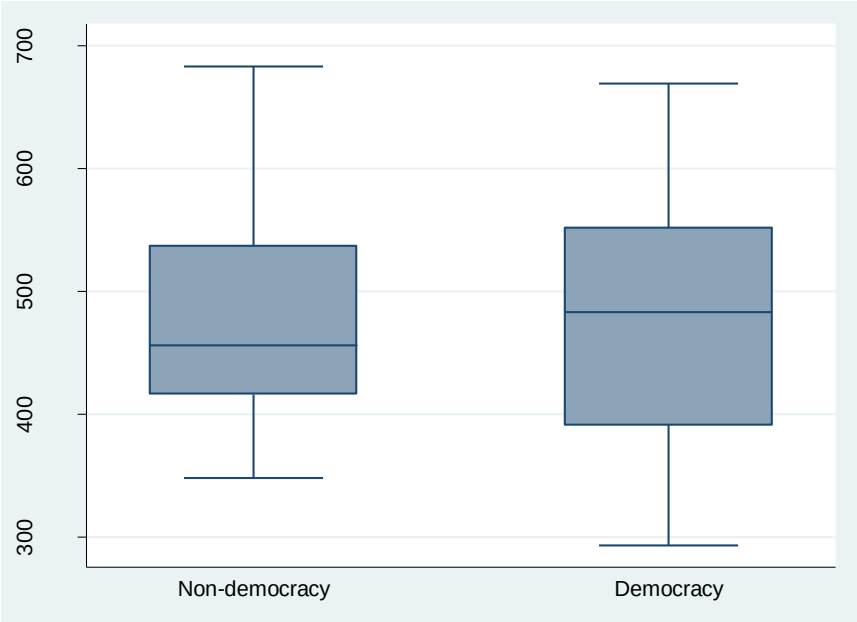


Also, multivariate regression models, which control for a number of potentially confounding factors, including HIV prevalence, wealth, and health spending reveal no significant differences in API scores between democracies and non-democracies (see Appendix A) (Kakietek, 2007).

More importantly, that data show significant variation in API scores among democracies. Figure 3 shows that while the mean of the sum across 8 dimensions of API

is slightly lower in non-democracies, democracies exhibit greater variance in API their scores.

Figure 1.3: API summary score by regime type (Democracy ≥ 6)



This preliminary analysis shows that the democracy argument is not supported by empirical data. In particular, this argument fails to explain why some democracies provide HIV/AIDS services at levels comparable to or even lower than non-democratic countries, where the governments are not accountable to their citizens and have no incentives to provide public goods. Put differently, it fails to explain why some democratic countries are successful in improving wealth and health of their citizens, while others suffer from public policy failures - "the underprovision of public goods and the overprovision of regulations and laws that benefit special interests at the expense of the whole society" (Keefer, 2003).

4. Critique of the democracy thesis and research hypotheses:

Examining the assumption of the "democracy thesis" can shed light onto the puzzling differences in HIV/AIDS policy performance among developing world democracies. In particular, four assumptions are critical:

4.1. Identity and policy preferences:

The first assumption is that factors that are not related to the distribution of public goods, such as individual characteristics of candidates, will not influence the political calculus of the electorate. This assumption ignores the impact of ascriptive identities, such as religion or race, on voting behavior. Extensive literature shows that identity voting, where voters support a candidate because she belongs to the same ascriptive grouping, rather than due to her policy platform, is a very common phenomenon (Keefer, 2005).

Empirical evidence shows that ethnic and religious polarization is associated with public policy failures and underprovision of public goods (Lutmer, 2001; Alsina, Baqir, & Easterly, 1999; LaPorta, Lopez-de-Silanes, Shleifer, & Vishny, 1999; Easterly & Levine, 1997; Alesina, Devleeschauwer, Easterly, Kurlat, & Wacziarg, 2002; Alesina & La Ferrara, 2000). Evidence from the U.S. shows that states, counties, and cities with higher levels of ethnic fragmentation spend less on education, welfare, police, and roads (however, the authors also found that increased fragmentation is association with *increased* spending on health) (Alesina, Baqir, & Easterly, 1999; Luttmer, 2001). Cross-

country comparisons show similar effects (LaPorta, Lopez-de-Silanes, Shleifer, & Vishny, 1999; Easterly & Levine, 1997; Alesina, Devleeschauwer, Easterly, Kurlat, & Wacziarg, 2002).

Several authors argue that ethnic heterogeneity inhibits the demand for public goods, that is, in ethnically heterogeneous societies the citizens prefer private over public goods (Alesina & La Ferrara, 2000; Lutmer, 2001) "When individuals have different preferences they want to pull fewer resources together for public projects (Alesina, Baquir, & Easterly, 1999; p. 1243)." In the U.S. context, there is evidence for an inverse association between reported support for welfare spending and ethnic fragmentation.

This mechanism is developed in depth in Alesina, Baquir, and Easterly (1999). The authors assume a two-stage budgeting process which determines how much should be spent on private versus private goods (first stage) and what public goods will be provided (second stage). Ethnic groups differ with respect to the type of public goods they prefer (for example, the ethnic minority may want a bilingual primary education while the majority group may not) and representatives of interest groups with an ethnic base are likely to value only the benefits of public goods that accrue to their groups, and discount the benefits for other groups (the authors assume that e ach ethnic groups' utility level is reduced for a given public good if other groups also use it (p. 1244); I address this assumption below). Since the voters foresee that they will not be able to agree on the type of public goods in the second stage, they prefer to spend less on public goods in general in the first stage.

A crucial assumption that this argument relies upon is that ethnic groups are in conflict with one another and that providing goods and services benefiting members of

other groups results in utility loss. This assumption is problematic, since ethnic fragmentation does always lead to ethnic conflict (see e.g Posner 2004).

Another problem with the Alesina and colleagues' argument is that increasing the number of ethnic groups in a society would not necessarily lead to diminished demand for public goods, at least not in a linear fashion (that is, the demand in a country with two groups would be higher than in a society with three groups, which would be higher than in a society with four groups). In fact, the basic statistical property that the variance around the mean decreases as the number of observations increases would suggest that the variance in public good preference should diminish, rather than increase, with the increasing number of groups (assuming, like the authors do, that public good types are normally distributed).

A more persuasive explanation of the impact of ethnic heterogeneity on the provision of public goods is offered by Keefer (2005) who suggests that, in ethnically polarized societies demand for public goods is not diminished but is trumped by ascriptive identities and substantive representation considerations (Pitkin, ????). In other words, the identity of the candidate is more important to the voters than her policy program. Rich and Owens (1999) show that this mechanisms operates in US cities, where African American candidates get re-elected even though they pursue the policies that do not benefit their electoral ethnic base.

Keefer argues that in highly polarized societies, it is easy for the majority to disregard the interests of minorities (Keefer 2003a). Snyder and Ingram (1993) show that public policy measures in the United States were unlikely to benefit a minority group if the group was perceived in a negative way by the majority. In South Africa, ethnic

polarization impeded governance and the establishment of effective fiscal policies and institutions (Lieberman, 2001). Empirical research on HIV/AIDS shows that less ethnically fragmented countries produce better HIV/AIDS policies (Lieberman 2007, Lieberman & Gauri, 2007) regardless of the type of political regime. I argue that the impact of social polarization should be most pronounced in democracies. In fact, autocratic governments are often able to overcome this problem by imposing strict measures of social control on their populations (Barnett and Whiteside, 2006).

In democratic countries with a high degree of ethnic polarization, the response to the epidemic is slow, policies and institutions aimed at fighting AIDS take longer to develop, the availability of services for those infected and at risk is low, and the effects of the efforts to fight AIDS, such as behavioral change, are limited.

An important caveat to the argument liking ethnic fragmentation and public policy failures is that the extant literature is based on the assumption that ethnicity always constitutes a politically salient cleavage. Literature on cultural and historical construction of ethnic conflict cautions against such a simplifying assumption (e.g. Laitin, 1996). For example, Posner (????) shows that ethnic cleavages in Rhodesia were not "primordial" but rather were created by the colonial administration. Similarly, Madrid argues that, in Latin America, party systems have no divided along ethnic lines and, until recently, "ethnic parties were virtually unknown…- the first significant ethnic party in the region did not emerge until 1996. (Madrid, 2005; p.3)". In Bolivia, ethnic identities created a rift between white and indigenous citizen, but ethnic difference among different indigenous

groups (Quechua, Aymara, Guarani, Chiquitano, Mojeňo, and others) were not politically salient (ibid).

The extant country-level measures do not capture political saliency of ethnicity, which greatly diminishes their construct validity and may distort the finding in the quantitative section of this project. However, political saliency of ethnic identity in Trinidad and Tobago - a case study used in this project (see below) has been well documented (Ryan, 1972, 1995, 2003; Meighoo, 2003, Premdas, 2007). Thus, the qualitative portion of the project allows me to avoid this measurement error.

4.2. Information:

Another assumption underlying the democracy thesis is that citizens are able to evaluate the performance of the incumbent governments and promises of the political challengers with respect to social policy. In reality this is not necessarily true. In fact, it is often not clear which particular policy measures (and thus which particular incumbents) are to be credited for improvement in the health status of a nation. This is particularly the case in more complex and long-term policy tasks, such as those involved in decreasing infant mortality or increasing the educational attainment. Empirical data confirm that citizens do not assess accurately their governments' performance. Bratton and Cho (2006) report that in 2005 "two-thirds of all adults approve of government performance in [the HIV/AIDS] sector; they give governments better grades for HIV/AIDS management than for any other social policy; and these grades rose steadily, up by 8 points over the last six years" (p. 37). However, this assessment does not reflect the

reality of the disease: "[O]nly three African countries – Uganda, Kenya and Zimbabwe – have actually managed to reduce HIV prevalence rates. Everywhere else, sero-positivity continues to rise. Thus, public opinion on this subject may be misinformed, due to the relatively low rates of HIV infection in West Africa, the recent introduction of antiretrovirals for some (but not all) communities in Southern Africa, and the persistence of social taboos, including among policy makers, against admitting the full scope of the AIDS crisis" (ibid).

Empirical studies have shown that lower levels of newspaper circulation – a measure of the level of information among the citizens, are associated with more corruption (Andrea, Boix, & Payne, 2003), poorer rule of law, lower bureaucratic quality, and lower secondary school enrollment (Keefer 2003b). Theory suggests that citizens who lack information cannot effectively evaluate the performance of the government and express their dissatisfaction in the elections. However, the impact of the lack of information on the democratic process, public policy, and governance in democracies has not been systematically addressed.

In democratic countries, where the access to information is poor, the response to the epidemic is slow, policies and institutions aimed at fighting AIDS take longer to develop, the availability of services for those infected and at risk is low, and the effects of the efforts to fight AIDS, such as behavioral change, are limited.

It needs to be emphasized that, within the theoretical framework of this dissertation the general term "information" refers quite narrowly to the *information citizens have about*

the actions of the politicians, that is, about what the government is doing and not doing. It relays on a simple premise that the more and citizens know what the politicians are doing, the better they are able to hold politicians accountable for their actions[3]. "Information" does not refer to how much the citizens know about the topic at hand; in this context, about HIV. Political-economic literature considers provision of social services including public health within the context of public goods and normal goods (see e.g. Bueno de Mesquita et al., 2003). Therefore, it is assumed that citizens always know what is good for them and what policy options should be pursued to best suit their interests. As I show in the following sections of this chapter, this assumption is often problematic. However, I see the issue of the source of demand for policy as analytically distinct from the issue of access to information and therefore address the two separately.

2.1. Lack of trust in electoral promises:

In an environment where elected officials notoriously fail to fulfill their electoral promises, the citizens have no incentives to support a candidate, even if her electoral platform includes their preferred policy options. Furthermore, when the citizens do not trust electoral promises, "even if incumbents do badly, citizens have no reason to believe that challengers will do better" (Keefer 2003a, p. 318). This insulates incumbents from pressures to reform. Commitment problems have been identified as one of key

[3] In game theory, perfect information refers to all players of the game knowing the moves all other players in the game are making. In the context of AIDS policy, this means that all political actors. In particular this means that the voters know what policy options politicians propose to implement if elected. In macro-economics, perfect information refers to consumers knowing prices and quality of products offered. In the context of this project, voters are buyers, politicians are sellers, and the product is the HIV policy political parties and candidates put forth. Perfect information does not address the preferences of the buyers, that is, why and whether the voters should want a particular good. Political-economic literature deals with the issue of demand by assuming that social service provision are normal goods and that the citizens always want tore and better services.

impediments to successful economic growth (North & Weingast, 1989). The lack of credibility is also linked to clientelism: in political systems based on patron-client relations politicians fulfill only the promises they make to their patrons, but not to the rest of the society (Keefer 2007). This "partial credibility" gives politicians incentives to underprovide public goods and to extract large rents (ibid). Easterly shows that in Pakistan, patron-client relationships between elected officials and tribal leaders had a detrimental impact on the availability and quality of primary education (Easterly, 2003).

In democratic countries where the voters do not trust electoral promises, the response to the epidemic is slow, policies and institutions aimed at fighting AIDS take longer to develop, the availability of services for those infected and at risk is low, and the effects of the efforts to fight AIDS, such as behavioral change, are limited.

3. Research hypothesis:

I have argued above that the critical assumptions of the democracy thesis are problematic. This is not to say that these assumptions are never true. In fact, there are several democracies that have well established mechanisms for preference aggregation and expression, informed citizens, ethnically homogenous societies, and where politicians usually deliver the policies they promise. The goal of this project is to problematize the relationship between democracy and social policy and move toward a more "contingent"

generalization. I argue that the imperfections of the electoral markets increase the likelihood of public policy failures.

There is empirical evidence that, in the context of HIV/AIDS and social policy in general, the extent to which citizens are informed about the actions of their governments and can evaluate their performance varies greatly and in some instances citizens have difficulty in accurately assessing governmental performance. Also, there is evidence that identity based cleavages expressed in identity politics often trump rational cost-benefit calculations and policy choices. Finally, the ability of the governments to deliver on their electoral promises is often very limited, despite their good intentions. I argue that the impact of democracy on social policy is conditional upon those factors.

Figure 1. 4: Path Model with Electoral Markets Imperfections:

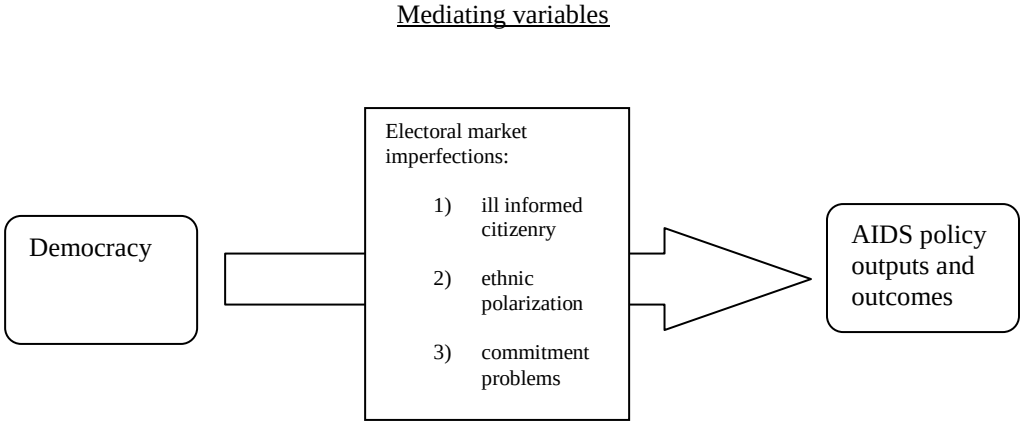


Figure 4 summarizes the theoretical argument developed above. The impact of democracy on AIDS policy is mediated by the imperfections of the electoral market.

Based on the arguments presented above, this dissertation project seeks to test the following hypothesis:

Research hypothesis 1: In countries with ill informed citizenry, high degree of ethnic polarization, and the voters do not trust in electoral promises the beneficial effects of democracy will be suppressed; the response to the epidemic will be slow, policies and institutions aimed at fighting AIDS will take longer to develop, the availability of services for those infected and at risk will be low, and the effects of the efforts to fight AIDS, such as behavioral change - limited.

AIDS was first identified in gay men in the United States (MMWR, 1981) and the initial designation of the disease, both colloquial (e.g. "gay cancer") and clinical (gay compromise syndrome (Brennan & Durack, 1981), GRIDS, or Gay-Related Immuno-Deficiency Syndrome (Altman, 1982)) illustrate how closely the public discourse linked the disease with socially and politically controversial groups. Even though the majority of the HIV positive people world-wide have acquired the virus through hetero-sexual contact, because of the biology of anal intercourse, mechanics of injection drug use, and power disparities inherent to transactional sex, the incidence and prevalence of the disease continue to be high among men who have sex with men, injection drug users, and commercial sex workers (UNAIDS, 2010). In the context of AIDS, hose groups have often been referred to as "most-at-risk population" or MARPs, even though the issue of connecting risk of contracting HIV to specific social groups, rather than to behaviors, has often been challenged as problematic (Pisani, 2008; in the context of the Caribbean see Gosine, 2009, Murray, 2009).

Extant literature on social policy in democratic countries has shown that, in democratic contexts, the way policy targets are socially understood and constructed has a

critical impact on the likelihood of the adoption of policies that benefit them (e.g. Ingram and Snyder, 1996). To address this issue, in this project, I distinguish between HIV/AIDS related policies aimed at the general population and those focusing on socially marginalized groups, such as men who have sex with men, commercial sex workers, and intravenous drug users. Because those marginalized groups are often politically controversial, the effects of democracy and electoral market imperfections on policies perceived as benefiting those groups will be different than on policies perceived as benefitting the general population. Scholarship on gay rights has shown that direct democratic process, such as popular ballot initiative have often been used to limit the rights of sexual minorities (Keck, 2009; Heider - Markel, Joslyn, and Kniss, 2000).

Research hypothesis 2: The impact of democracy, mediated by the level of electoral market imperfections, will be different for policies targeting the general population and policies targeting socially marginalized groups. Specifically, the impact of democratic accountability on AIDS policy targeting marginalized groups will be less pronounced in countries with a low level of political market imperfections.

4. Conceptualizing AIDS policy:

The literature on policy adoption and diffusion exhibits a general and significant shortcoming: most of the studies mentioned above consider only a single dimension of policy. A number of scholars have looked at the adoption of a single policy document such as state lottery bill (Berry and Berry 1996), privatization of pensions (Brooks 2006), democratic electoral institutions (Gleditsch and Ward 2006). Other studies compared changes in the level of a continuous indicator of interest. For example, the level of public

spending is a central measure in welfare state literature (see e.g. Lindert 2004) and a common measure in policy diffusion literature[4]. (Swnak 2006, Nooruddin and Simmons 2006) Other studies have looked at other continuous measures including percentage of population with access to public services (e.g. primary enrollment rates, population with access to potable water, percentage of vaccinated infants) (Baum and Lake 2003, Brown and Hunter 2004, Stessavage 2004) or percentage of population employed in the public sector (Lee and Strang 2006) .

The general tendency in the literature is to concentrate on a single policy indicator and single policy dimension. The authors who analyze levels of spending do not look at discrete policy measures and service provision; scholars who look at policy documents do not analyze service provision and so forth. Such approach assumes that policy is uni-dimensional, and that the factors which affect policy adoption, also affect the way in which it is implemented (e.g. organizational structures created for implementation) and the outputs it produces (e.g. services provided). However, this does not need to be the case.

In order to address this shortcoming of the existing literature I propose to compare HIV/AIDS policies across four different dimensions. The first one is the dimension of policy and institutional environment created to combat the disease. In particular, I want to focus on two specific indicators: 1) the adoption of a national multisectoral policy to fight AIDS and 2) the establishment of a national AIDS committee that coordinates the

[4] The level of spending is a particularly weak measure of policy. It tells us nothing about the content of policy, that is, what the money is really spent on. Let us compare two countries which both spend $200 on healthcare a month. In the first country the money is allocated to and spent on drug procurement while in the other county the money is allocated for and spend on the salary for health minister's driver. Clearly, with the same level of spending, the content of policy, as well as its effect, are very different. Therefore, I do not think that spending, as an outcome measure, gives us a lot of leverage in comparing HIV/AIDS policy in different countries

national response. In policy jargon such bodies are often referred to as NACs or national action committees.

The multisectoral approach has been identified in public health as the most effective policy strategy to address HIV/AIDS in the developing countries. (see UNAIDS 2001). Compared to the policy-as-usual approach, which limits the response to the health sector, adoption of a multisectoral policy signals that the government has identified HIV/AIDS as a salient issue and that it is committed to fighting the disease. Drafting of the document must involve line ministries other than the ministry of health, as well as a range of stakeholders from the private sector and civil society, which involves significant costs in time and labor. It also requires considerable effort in identifying and negotiating tasks and responsibilities of line ministries and their agencies. However, national policy documents need not to translate automatically in an increased effort to fight the disease. While such documents usually identify objectives, strategies, and targets they do not deal with implementation or earmark resources, and thus, entail no financial costs, other than the ones necessary to draft the document.

NACs are usually set up as governmental agencies within the executive branch and are mandated to coordinate policy formulation and implementation, coordinate activities among different ministries, governmental agencies involved in the HIV/AIDS response, as well as the private sector, civil society, and international aid organizations. In its 2003 recommendation UNAIDS identified establishing of a NAC as part of the "three ones", that is the three policy elements necessary for an effective national response to HIV/AIDS.

The second dimension is AIDS spending, both total and disaggregated into spending on prevention and treatment. The third dimension is service provision, in particular, the provision of anti-retroviral therapy (ART). The final dimension is the outcomes of the prevention efforts, operationalized as the behavioral change in the most-at-risk groups (e.g. condom use and STD testing among commercial sex workers).

Table 1.2.: Operationalization of HIV/AIDS Policy.

Policy dimension	**Indicator**
Policy and institutional infrastructure	Policies adopted (e.g. National Strategic Plan to Control AIDS, National Non-Discrimination Policy); Institutions established (NACA)
Spending	Amount of funds spent on programmatic activities (prevention, treatment, care etc.)
Service Provision	HIV/AIDS -related services delivered (e.g. antiretroviral drugs)
Outcomes	Intended outcomes of programmatic activities, e.g. behavioral change in the target populations.

This general operationalization of the policy response will be used throughout this dissertation. Individual indicators and data sources used in the qualitative and qualitative analyses will be presented in the following chapters.

In addition to disaggregating AIDS policy into the four policy areas described above, I will also disaggregate it based on its intended targets. Specifically, in this project, I distinguish between HIV/AIDS related policies aimed at the general population and those focusing on socially marginalized groups, such as men who have sex with men, commercial sex workers, and intravenous drug users, and, in the empirical analyses in the

following chapter, I separate the policy measures aimed at the general and non-problematic majority population and the more problematic minorities

5. Research design:

5.1. Quantitative analysis:

In order to assess the validity of the argument developed above in explaining the variation in HIV/AIDS policy among developing-world democracies, I employ both quantitative and qualitative methods. I use a large sample statistical analysis and examine whether electoral market imperfections mediate the association between the measures of democracy and a range of indicators of various aspects of AIDS policy discussed above, including AIDS spending (total and disaggregated by spending categories), policy and institutional environment, service provision, and behavioral outcomes – an indirect measure of the success of the national prevention effort. Data source, statistical techniques used, and the results of quantitative analysis are presented in Chapter 2.

The advantage of quantitative methods is establishing the generalizability of the theory. However, quantitative analysis can only establish associations between variables and does not allow the researcher to determine whether the causal processes, which the theory identifies, are indeed at play, that is, whether the statistical association is driven by causation. The validity of the causal links - the internal validity of the theory, can best be established through an in-depth qualitative analysis.

5.2. Qualitative Section: HIV/AIDS Policy in Barbados and Trinidad and Tobago

The qualitative portion of the project involves what Charles Ragin (1996) has called a "most similar with different outcome (MSDO)" design using two cases from Eastern Caribbean: Barbados and Trinidad and Tobago. This analytic technique is based on Mill's method of difference, also known as the negative method (George and Bennett, 2005), where the researcher selects two cases with the same configuration of potentially confounding variables she wants to control for, but with different outcomes. The MSDO design allows the researcher to draw causal conclusions by identifying a new set of independent variables (the variables associated with the research hypothesis/es) that co-vary with the outcome (ibid.).

As noted in the introduction to this chapter, the Caribbean offers an excellent opportunity for comparing response to HIV/AIDS among developing democracies in a region which has been deeply affected by the epidemic and has the second highest prevalence level in the world. It also allows me to select two country cases where potentially confounding factors can be held constant (the same in both cases).

In the context of this research the most important control variable is the regime type. The comparison between Barbados and Trinidad and Tobago allows me to evaluate the null hypothesis derived from the literature on democracy and social policy, namely, that once regime type is held constant, we should expect minimal, if any, policy variation, all else being equal. Both Barbados and Trinidad and Tobago have had democratically elected governments consistently since their independence from Great Britain in the early 1960s. However, as shown in Table 2, there are significant differences in HIV/AIDS policy outcomes and outputs between the two countries.

Another factor held constant across the cases is the constellation of political institutions. The veto player literature, links the nature of the institutional set up with policy stability and the likelihood of reform (Tsebelis, 1999, 2000, 2002). This scholarship argues that the number of institutional veto points, as well as the number and configuration of political actors who populate them, affect the likelihood that policy changes will be adopted. The greater the number of veto points and players, the more stable the status quo and the more difficult a reform (ibid.). Empirical research on health policy has shown that a high number of veto points prevented the a comprehensive health care system reform (Immergut, 1994). The Database of Political Institutions (DPI, World Bank; Beck et al 2000; 2001; Keefer 2005) reports the average number of veto players from 1977 to 2004 in Barbados and Trinidad and Tobago to be almost the same (3.75 and 3.82 respectively).

Another important body of literature – the scholarship on policy diffusion has pointed to the geographic clustering of policy and has argued that national governments take cues from the actions of other governments and policies adopted in one country influence the likelihood of adoption in other countries (Walker 1986, Gray 1973, Weyland 2004, Simmons, Dobbin, and Garrett 2006). Policy diffusion may occur through a number of different channels. Countries can emulate policies of their neighbors (Gleditch, 2006, Gleditsch and Ward, 2006, Kil and Strang, 2006), of countries with whom they share the same linguistic tradition and colonial origins (Swank, 2006) or membership in the same international organizations, which create a platform for the flow of information and dissemination of new ideas (Simmons and Elkins, 2004). Comparing Barbados and Trinidad and Tobago allows me to control for diffusions effects. Not only

are both countries geographically contiguous and share a maritime border, but they also share the same colonial origin and belong to the same international organizations (out of 41 international organizations Barbados belongs to, 40 also include Trinidad and Tobago as a member) (CIA World Fact Book).

Another set of factors that needs to be controlled for concern the magnitude and characteristics of the AIDS epidemic and the effects of structural factors which drive the spread of the disease and affect policy responses. In both countries the principal mode of transmission of HIV is heterosexual sex and both face a generalized epidemic with prevalence exceeding 5% in high risk groups and 1% in the general population (HIV prevalence in the adult population is estimated to be 1.4% in Trinidad and Tobago and 1.2% in Barbados[5])(UNAIDS, 2008).

The literature has shown that two structural factors – poverty and lack of social cohesion facilitate the spread of AIDS and make an efficient response more difficult. While the lack of social cohesion – social polarization - is part of my main theoretical argument, the impact of wealth on AIDS policy needs to accounted for. Even though the difference in the estimated GDP per capita between Trinidad and Tobago and Barbados is quite significant - almost $7,000, contrary to the expectation, Barbados, where the AIDS policy and its outcomes are better, is actually poorer than Trinidad and Tobago (CIA World Factbook).

While both cases are quite similar on a number of potentially important independent variables mentioned above, they sharply differ with respect to their citizens' access to information, the age of political parties - a proxy measure for the level of trust in electoral promises (see Chapter 2) and levels of ethnic polarization (see Table 3).

[5] 2007 estimates.

Table 1.3.: Imperfections in Electoral Markets and HIV/AIDS Policy Response Indicators

Variables	Indicators	Barbados	Trinidad and Tobago
Independent variable			
Citizen information	Internet users per 100 people (2009)	95	16
Social polarization	Ethnic fragmentation*	0.14	0.65
	Religious fragmentation*	0.62	0.79
Trust in electoral promises	Age of the largest government party	45.5	22.2
	Age of the largest opposition party	40.2	28
Electoral market imperfections		Low	High
Dependent variable			
AIDS spending (per capita)	Total	23.34	11.79
	Treatment	11.69	3.77
ART coverage (%)	(2009)	87	51
Policy and institutions	Years a multisectoral policy in place	10	7
	NAC established in	2001	2004

*Scores of ethnic and religious fragmentation from Alesina et al. (2003)

With newspapers becoming increasingly displaced by electronic media, the internet use is an appropriate measure of the degree to which the citizens are informed about the governmental policy and politicians' actions. The number of internet users per capita in Barbados is more than three times higher than in Trinidad and Tobago (CIA World Factbook, data for 2007). Barbados, where Africans constitute 90% of the

population, is also much more ethnically homogenous than Trinidad and Tobago, where the society consists of 40% Indians (South Asians), 37.5% Africans, 20.5% people of a mixed race, with other ethnic groups constituting the remaining 2% (ibid.). Alesina and colleagues (2003) measure ethnic fragmentation by calculating the chance that two randomly selected people from a given country will not belong to the same ethno-linguistic group. This chance in Trinidad in Tobago is 64% but only 14% in Barbados. A similar score of religious fragmentation – the chance that two randomly selected people will not belong to the same religious group is 79% in Trinidad and Tobago and 69% in Barbados (ibid.). Finally, the age and, thus also credibility of political parties is higher in Barbados, where the largest government party- the Democratic Labour Party - has been in existence for almost 66 years, than in Trinidad and Tobago, where its equivalent - the People's National Movement – is more than two decades younger (Database of Political Institutions, World Bank).

This configuration of independent variables corresponds with the responses to AIDS in both countries. In 2007, the government of Barbados spend more than two times more on fighting AIDS than the government of neighboring Trinidad and Tobago (UNAIDS 2008) and per capita expenditures on treatment were almost three times higher in Barbados. Service provision also differs greatly between the two countries: Barbados is one of a few developing countries with a free and universal access to anti-retroviral therapy (ART) and more than 87% of people with advanced HIV infection (including 100% of infected children) are currently receiving ART (Government of Barbados, 2010). The ART coverage in Trinidad and Tobago is only 51% (Government of Trinidad and Tobago, 2010).

The MSDO research design provides *prima facie* support for my contention that the divergence in the policy responses was caused by variation in the imperfections of the electoral markets. The in-depth comparison of the two cases based on secondary and primary sources will help me better establish a pattern of associations between the imperfections in electoral markets and the HIV/AIDS policy. In addition, to generate more nuanced and credible causal conclusions, I intend to interview the key informants in both countries to confirm that those imperfections indeed affected the political calculus and the HIV/AIDS policy-making in the ways I suggest through a method known as "process-tracing" (George & Bennett, 2005). I will conclude that the causal process identified by the theory is indeed present in the evidence from process tracing confirms that:

1) the *temporal sequence* of the events leading to policy adoption is indeed as the causal process specifies.
2) the *perceptions* and situations assessments of the actors leading to the decisions they make are as the theory predicts.
3) the *motivations* of the actors leading to the decisions they make are as the theory specifies.

Only if all three conditions are fulfilled will I conclude that the internal validity of the theory has been confirmed. By employing conditions 2 and 3, I explicitly reject the "as if" notion used by some formal theorists (see Achen, 2000).

The data used in the case studies were collected during nine months of fieldwork from July 2009 through March 2010. I spend four months in Barbados and five months in

Trinidad and Tobago, conducting interviews with key informants: career politicians, civil servants, health care professionals, staff members of international, community-based and faith-based organizations and international funding agencies, academics, who were either directly involved in or who first-hand witnessed the policy making process. In addition, I collected primary and secondary sources such as policy drafts and documents, internal memos, public statements, and press coverage pertaining to AIDS policy specifically and to HIV in Both countries in general. The fieldwork research was made possible by the International Dissertation Research Fellowship from the Social Science Research Council with the funding provided by the Andrew W. Mellon Foundation.

6. Dissertation outline

In this chapter, I reviewed the relevant literature and laid out the theoretical framework of the dissertation project. In the next chapter, I present the results of quantitative analysis of secondary country-level data. In Chapter 3, I discuss the historical evolution of HIV/AIDS policy in Barbados and in Chapter 4 - I compare with the HIV/AIDS policy making in Trinidad and Tobago. In those two chapter I that electoral market imperfections affected service delivery, in particular in the area of the provision of anti-retroviral treatment. However, they had less of an impact of policy adoption, and the transition from the medical model to a multisectoral approach. In Chapter 5 I return to the analysis of the data form Barbados to show some unexpected findings regarding policy measures pertaining to socially marginalized groups: men who have sex with man and commercial sex workers. I show that while the high degree of accountability of

elected official and public servants resulting from the low level of electoral market imperfections helped Barbados in improving its response to AIDS and , in particular successfully scale up its treatment program, it also had a negative impact on the part of the national response targeting socially marginalized groups. In the final chapter (Chapter 6) I summarize the evidence from all the empirical chapter (2 through 5) and discuss conclusions, limitations implications of the dissertation for further research.

CHAPTER 2: QUANTITATIVE ANALSYSIS

1. Introduction:

In the previous chapter I reviewed relevant literature on the relationship between democracy and social policy and human development and presented a theoretical argument which posits, that imperfections in electoral markets limit the positive impact of democratic accountability on governance and social policy, including policies pertaining to HIV/AIDS. I argued that *imperfections in the electoral markets*, defined as: 1) lack of access to information among the citizens, 2) ethnic polarization, and, 3) uncertainty about the commitments made by political elites, *suppress the positive impact of democratic accountability and lead to HIV/AIDS policy failures in democratic countries.* In countries, where electoral market imperfections are more pronounced, policies and institutions aimed at fighting AIDS take longer to develop, spending on AIDS and the availability of services for those infected and at risk are low, and the effects of the efforts to fight AIDS, such as behavioral change in those at risk of infection, are limited. The goal of this chapter it so establish the generalizability (external validity) of the theoretical propositions outlined above. Quantitative analyses carried out in this chapter test the following research hypotheses:

H1: In countries with low levels of electoral market imperfections, democracy will be positively associated with the indicators of HIV/AIDS policy.

H2: In countries with medium and high levels of electoral market imperfections, the association between democracy and indicators of HIV/AIDS policy will be either less strong or not significantly different from zero.

2. Data and measures:

2.1. Dependent variables:

Policy and institutional infrastructure:

The "Three ones" variables assess whether the country is compliant with UNAIDS' recommendations regarding setting up the best-practice institutional response to HIV/AIDS (UNAIDS, 2001). The "Three ones" recommendation stipulates that, in order to successfully respond to the epidemic, a country needs to have one national coordinating body, one multi-sectoral strategic framework outlining a comprehensive long-term plan of fighting the disease, and one national monitoring and evaluation framework. Data on compliance with the "Three ones" recommendation was obtained from the National Composite Policy Index (NCPI) reports submitted by countries to UNAIDS as part of the UN General Assembly Special Session on AIDS reporting process (UNAIDS, 2008). Compliance with the recommendation was assessed based on the answers to three questions included in the NCPI instrument:

- Has the country developed a national multisectoral strategy/action framework to combat AIDS?
- Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

- Is there a budget for the M&E plan?

A country was coded as compliant with the "Three ones" recommendation if it had a multisectoral strategic framework, established a national management/coordination body, and formulated and allocated a budget to an M&E plan. The question about budget allocation rather than the question whether the country has a M&E plan was used because allocating a budget to monitoring and evaluation of AIDS-related activities signifies a higher degree of commitment and stronger compliance with the recommendation than simply developing a M&E plan, which may or may not be implemented.

It needs to be emphasized that NCPI data are self-reported and the validity of the measures based on the NCPI is problematic. First, the definitions of the indicators are rather vague and the countries have a lot of discretion in deciding how to interpret them. For example, even though both Argentina and Uganda have indicated that they have implemented a multisectoral response, the number of sectors involved in HIV policy development and implementation in each county is dramatically different. In Argentina, only 4 sectors are involved (health, labor, education, and justice). In Uganda, 13 sectors are involved (health, education, labor, transportation, women's affairs, youth, agriculture, finance, justice, minerals and energy, public works, as well as representatives of uniformed services). Furthermore, government officials have strong incentives to misrepresent the state of their response to HIV/AIDS, because compliance with the "Three ones" recommendations is often a requirement in determining eligibility for international aid specific of HIV/AIDS. However, despite their low construct validity, the NCPI reports are the most recent and the most comprehensive data source regarding

HIV/AIDS related policies. The data on compliance with the "Three ones" recommendation were available for 130 observations for 2007 only.

Spending:

Data on HIV/AIDS-related spending was obtained from the AIDS Financing and Economics Division of the UNAIDS (UNAIDS, 2008). Three spending-related variables were used in the quantitative analyses: 1) per capita spending on AIDS, 2) domestic public spending as the percentage of the total spending on HIV/AIDS, and 3) spending on programs targeting most-at-risk populations (MARPS): men who have sex with men, commercial sex workers and their clients, and intravenous drug users as the percentage of the overall spending on AIDS. The rationale for including the government spending as percentage of total AIDS expenditure was that it captures governments' financial commitment to fighting the disease better than overall AIDS expenditure. It is plausible to assume that the governments which have prioritized fight against AIDS are willing to finance it from their own coffers, and thus, a large percentage of the overall expenditure on AIDS comes from domestic public sources . In contrast, government which have not prioritized the fight against the diseases will finance their response largely through foreign assistance and international funds. The rationale for including spending on programs for men who have sex with men, sex workers and their clients, and on programs for harm reduction for intravenous drug users was that, since such programs are usually very contentious (Pisani, 2008), spending on those programs was a good indicator of the government's willingness to take political risks to fight AIDS even in the face of potential domestic opposition, and thus, a good measure of commitment. Data on per

capita AIDS spending and spending on programs for most at risk populations were available from 2005 through 2007 for a total of 145 observations. Data on domestic public spending as percentage of total AIDS spending was available for the same time period for 136 observations.

Service provision:

The first service provision indicator was the percentage of people in need to anti-retroviral therapy (ART) who were receiving it. Data on access to ART were available from 2004 through 2007 for a total of 440 country years. The second indicator was the percentage of HIV positive pregnant women receiving AZT in order to prevent mother-to-child transmission (PMTCT). Data on PMTCT were available from 2004 through 2007 for a total of 379 country years. The third and forth indicators were the percentage of commercial sex workers and men who have sex with men accessing HIV prevention programs. Data for those indicators were available for 2007 only for a total of 49 and 36 observations respectively. The data were obtained from the Millennium Development Goals Database and from the World Health Organization and downloaded from http://data.un.org .

Outcomes:

Outcomes of HIV/AIDS prevention programs: knowledge of HIV/AIDS risk behaviors and modes of transmission in the general population, and condom use in high-risk groups: MSM and CSWs were the final category of indicators used in the quantitative analyses. Data on AIDS knowledge was available for 2003 and 2007 for a

total of 120 observations. Data on condom use in MSM and CSWs was available for 2005 and 2007 for a total of 82 and 99 observations respectively. The data were obtained from the UNAIDS Data database downloaded from http://data.un.org .

Number of observations and years for which data were available are summarized in Table 2.1.

Table 2.1. Data Availability for HIV/AIDS Policy Indicators

Variable	Total observations	Years available
Institutional infrastructure		
Three ones	130	2007
Spending		
Per capita AIDS spending	145	2005-2007
Domestic public spending as proportion of the overall spending on AIDS	136	
Spending on MAPRS as proportion of the overall spending on AIDS	145	
Service provision		
% of persons receiving ART	440	2004-2007
% of HIV positive pregnant women receiving AZT	379	2004-2007
% of CSW accessing prevention programs	49	2007
% of MSM accessing prevention programs	36	2007
Outcomes		
AIDS knowledge	120	2003, 2007
% of CSW reporting to have used a condom with the last sex partner	99	2005, 2007
% of MSM reporting to have used a condom with the last sex partner	82	2005, 2007

Using a range of indicators was necessary to capture multiple dimensions and areas of HIV/AIDS policy. In addition, the indicators presented above can be thought of

as representing a range of policy outputs and outcomes from the most proximal, that is the most directly subjected to government's control and influence (complying with the "Three ones" recommendation, spending on AIDS) to the most distal ones, that is the least directly influenced by the government (behavioral outcomes, such as condom use). Using a range of indicators enabled me to examine whether the associations between the dependent and the explanatory variables hold across the range of government's influence or whether those associations hold for proximate but not for distal outcomes.

2.2. Independent variables:

Imperfections in electoral markets

Following the theoretical framework developed in the preceding chapter, the measure of the imperfections in electoral market is based on three component indicators: ethnic fragmentation, access to information, and uncertainty about the commitments made by political elites.

Ethnic polarization: In order to capture ethnic polarization I used the average value of ethnolinguistic fractionalization - an indicator developed by Alesina, Devleeschauwer, Easterly, Kurlat, and Wecziarg, (2003) which measures the likelihood that two randomly selected individuals in a given country will belong to the same ethnic group. This measure ranges from 0 to 1. For the time period between 2002 and 2007, 1128 observations were available. The data were downloaded from the Quality of Government data set (Quality of Government, 2010).

One caveat in using this indicator is that it captures ethnic fragmentation rather than ethnic polarization (Collier, 2006). In particular, it does not tell us whether ethnicity is a politically relevant cleavage and how much it impacts local politics (Baldwin & Huber, 2010). Unfortunately, indicators of politically relevant ethnic fragmentation have been created only for Africa and for limited number of years (Posner, 2004; Collier 2006).

Uncertainty about the commitments made by political elites: Following Keefer (2007), the age of the largest government party was used as a proxy measure of the extent to which voters are uncertain about the future performance of the politicians they elect. The intuition behind this measure is that the longer a given party has been on the political arena the more predictable it is, and the easier it is for the voters to assess whether it will fulfill its electoral promises or not. The assumption the measure is based on is that the age of the largest government party is representative of the country's party and political system as a whole. The age of the largest government party was obtained from the World Bank Database of Political Institutions (DPI). For the time period between 2002 and 2007, 735 observations were available. The data were downloaded from the Quality of Government data set (Quality of Government, 2010).

Availability of information: Availability of information was measured using the percentage of the population with access to the Internet. Pointing to a close relationship between governments, business interests and media, such as printed newspapers and television, political philosophers argued that such traditional media stifle, rather than

strengthen, the public sphere and the ability of citizens to truly participate in governance (e.g. Habermas, 1987, 1989). On the other hand, electronic media, especially those enabling participatory information formation, have been theorized to strengthen the "lifeworld", to borrow Habermas' term, and strengthen the quality of democracy (Kellner, 2000). As recent developments in Iran, China, and other countries have shown, social media such as Facebook and Twitter are becoming increasingly important as conduits of political information and drivers of political participation (e.g. Time, June 17, 2009 "Iran Protests: Twitter, the Medium of the Movement").

Since this study focuses on the extent to which voters are able to evaluate political candidates and parties based on their past political performance and since governments have relatively less control over the Internet than on other traditional media, it seems appropriate to use access to Internet as a proxy indicator of the level of information about politicians, parties, and their policy performance that is available to voters. The data on the percentage of population with access to the Internet were obtained from the World Bank World Development Indicators (WDI) data base and 1071 observations were available for the time period between 2002 and 2007. The data were downloaded from the Quality of Government data set (Quality of Government, 2010).

Imperfections in electoral markets - a composite score: All three indicators described above: ethnic fragmentation, percentage of Internet users, and age of the largest government party, were entered into factor analysis in order to assess whether they should be combined into a single score or whether they should be used as separate measures in the multivariate analyses. Confirmatory factor analysis showed that all three

indicators loaded up to only one factor (only one factor was retained), which justified combining them into a single score of imperfections in electoral markets (IEM). The results of factor analysis are presented in table 2.

Table 2.2.: Factor Analysis of the Components of the Electoral Market Imperfections Components

Variable	**Factor 1**	**Uniqueness**
Access to Internet	0.53	0.71
Age of largest government party	0.45	0.79
Ethnic fragmentation	-0.4	0.84
N	1705 *	
Retained factors	1	

*in order to assess the measurement properties, all available observations were used.

Access to Internet and age of the largest government party were scaled so that they ranged from 0 to 1. The percentage of Internet users was divided by 100 and the age of the largest government party - by 191 (the age of the oldest government party in the sample). In addition, the scaled scores were subtracted from 1, so that the higher value of the component score corresponded with higher level of electoral market imperfections. The final score of the electoral market imperfections was obtained by adding the three component scores: ethnic fragmentation, proportion of population without access to the Internet (1-(percentage of population with access to the Internet/100)) and the scaled and inverted age of the largest government party. The combined score could range from 0 to 3, with 0 indicating no imperfections and 3 indicating the maximum level of the

imperfections. A total of 715 observations were available for the composite IEM score for the time period between 2002 and 2007.

Democracy:

The imputed Freedom House/Polity score was used as the indicator of democracy. The measure is calculated by averaging the Polity II democracy score and two Freedom House democracy indicators: political rights and civil liberties (Quality of Government, 2010). The score ranged from 0 to 10. In cases where Polity values were missing, they were substituted with predicted values from a model that regressed Polity score on the average Freedom House score[6]. The imputed Freedom House/Polity score had fewer missing data points than Polity II score (1150 compared to 785 for 2002-2007). Furthermore, it has been shown to perform better than the Polity II score in terms of validity and reliability (Hadenius & Torell, 2005). The data were obtained from the Quality of Government data set (Quality of Government, 2010).

[6] Both Freedom House and Policy scores focus on the institutional dimension of democracy and do not include indicators that capture electoral market imperfections. The Polity score is an index based on the following five components: 1) competitiveness of political participation, 2) regulation of participation (p_parreg), 3) openness of executive recruitment, 4) competitiveness of executive recruitment, 5) constraints on the chief executive. Most of the components capture the institutional features of the political system. Only one element - regulation of participation, captures, to a limited extent one of the elements of the electoral market imperfections - ethnic polarization. The regulation of participation variable, which captures how political participation is "regulated to the extent that there are binding rules on when, whether, and how political preferences are expressed" (Quality of Government Institute, 2010, p. 56) assigns countries to one of five categories: 1) unregulated, 2) multiple identities, 3) sectarian, 4) restricted, 5) regulated. The "Sectarian" category includes a reference to ethnicity: " Political demands are characterized by incompatible interests and intransigent posturing among multiple identity groups and oscillate more or less regularly between intense factionalism and government favoritism, that is, when one identity group secures central power it favors group members in central allocations and restricts competing groups' political activities, until it is displaced in turn (i.e., active factionalism). Also coded here are polities in which political groups are based on restricted membership and significant portions of the population historically have been excluded from access to positions of power (latent factionalism, e.g., indigenous peoples in some South American countries)" (Quality of Government Institute, 2010, p. 56). However, the variable as a whole does not focus on the ethnic polarization of the political system. The other two components of the electoral market imperfections: access to information and the level of trust in electoral promises/age of political parties is not captured in any of the Polity score components.

Interactions between imperfections in electoral markets and democracy:

The key question of this dissertation is whether and to what extent the imperfections of the electoral markers mediate the association between democracy and social policy. In order to address this question, the continuous measure of democracy (imputed Freedom House/Polity score) was interacted with the tertiles of the composite score of the imperfections in electoral markets (IEM). Using thresholds rather than continuous IEM score for modeling interaction and creating multiplicative terms with the democracy measure allowed for much easier and intuitive interpretation of the results. Equally important, it also allowed me to address explicitly non-linearity in the way the imperfections in the electoral markets could mediate the relationship between democracy and AIDS policy.

2.3. Control variables:

HIV prevalence:

While the literature on democracy and social policy assumes constant demand in that services offered are considered normal goods, in the case of HIV we can measure the potential demand for policy responses directly through HIV prevalence. It seems plausible that the higher the prevalence the greater the demand for a response and the more compelled a government will be to respond to the epidemic. On the other hand, it is also plausible that government in countries with very high prevalence of HIV will feel overwhelmed by the magnitude of the problem they have to respond to, be unsure how to respond and whether their response will be effective, and thus prefer to do nothing and ignore the issue altogether. In order to model this non-linear relationship between HIV

prevalence and policy responses, in addition to HIV prevalence figures, squared prevalence for each country was included in the regression models. HIV prevalence data was obtained from UNAIDS data reported in the World Development Indicators. Prevalence figures were available only for 2001 and 2007 and linear interpolation was used to supplement the figures from 2002 through 2006. A total of 938 of observations was available for this time period.

Policy heritage and path dependency in policy making:

Scholars of HIV politics have argued that polices aimed at fighting the disease did not emerge in vacuum. Rather, they were continuation of earlier public health practice and policies aimed at fighting other diseases (Baldwin, 2007). More broadly, scholars have argued that health policy and social policy are path dependent and the direction of policy reforms is informed by previous policy choices (e.g. Boychuk, 2006). Government expenditure on health as percentage of the total government expenditures was used as a proxy for policy heritage in order to control for path-dependency in HIV/AIDS policy making. It is plausible to assume that governments which have focused more on health issues would be more willing to scale up their response to HIV/AIDS than governments which have not prioritize health. Data on health expenditure were obtained from the World Health Organization Statistical Information System (WHOSIS) data base. For the time period between 2002 and 2007, a total of 915 observations was available. The variable was lagged by one year in all models.

Wealth:

It is plausible that wealth affects HIV/AIDS policy making with wealthier countries being able to afford to provide HIV services that poorer countries cannot provide. In fact, poverty and lack of resources has often been mentioned as the reason why developing countries were not able to establish ART programs until the early 2000s when cheap generic drugs and international aid for treatment programs became available (Epstein, 2007, Marquez, 2001).

The argument this project seeks to test is that electoral market imperfections decrease democratic accountability and negatively affect governance, including social and health policy, but also economic policy. Therefore, we should expect a close statistical association between the imperfections in the electoral markets and the level of economic development, and, as a result, high degree of multicollinearity in the regression models. In order to address the issue of multicollinearity, the indicator of wealth – per capita GDP, was transformed (King, Keohane, & Verba, 1996). Specifically, the continuous measure of per capita GDP was dichotomized and the sample was divided into two categories based on their per capita GDP: poorer countries (below the mean of the per capita GDP in the sample time period) and richer countries (above the mean of per capita GDP in the sample time period). The dichotomous indicator of wealth was included in all the multivariate models. GDP per capita data was obtained from the World Bank World Development Indicators (WDI) data base. For the time period between 2002 and 2007, a total of 920 observations was available.

Political institutions:

The makeup of electoral institutions such as presidential versus parliamentary systems, size of electoral districts, or methods of translating votes into seats, has been shown to affect social policy and related outcomes (e.g. Milesi-Ferretti, Perotti, Rostagno, 2002; Persson & Tabellini, 2003; Lizzeri & Persico, 2001). Dichotomous indicators of two variants of the presidential systems: president elected in direct elections and president elected indirectly, were included in the multivariate regression models. The indicators were constructed based on a variable from the World Bank Database of Political Institutions (DPI). A parliamentary system was the reference category for both of the indicators. In the sample time period (2002-2007), 864 observations were available. In addition, a dichotomous indicator of whether the country had an electoral system based on proportional representation or not was included in all of the regression models. It was obtained from the DPI data base and data were available for 736 observations. The data were downloaded from the Quality of Government data set (Quality of Government, 2010). Because the sample included non-democratic countries with no elections and no electoral districts, indicators of electoral district magnitude were not included in the regression models.

3. Methods:

In order to assess the association between the imperfections in electoral markets and HIV policy while controlling for potential confounding factors identified in the extant research, multivariate regression models were estimated. For the dichotomous indicator of compliance with the UNAIDS "Three ones" recommendation, a logistic

regression was used (Long, 1997). For the remained of the outcomes, ordinary least squares (OLS) regression models were estimated (Agresti & Finley, 1997; Fox, 1997).

In order to address autocorrelation problems resulting from repeated observations for the same country, models with robust standard errors were estimate for the percentage of HIV positive people receiving ART, the percentage of pregnant women receiving prevention of mother to child transmission prophylaxis, three indicators of AIDS spending, and the percentage of commercial sex workers and men who have sex with men reporting using a condom at last sex (Fox, 1997). All analyses were performed using STATA 10 (SATA Corp., College Station, TX).

In all regression models the interaction between democracy and the imperfections of the electoral markets was operationalized by including in each model interactions terms of the Freedom House/Polity score and the tertiles of the distribution of the imperfections' score. Specifically, each model included the following arguments:

outcome = 2nd tertile of the IEM + 3rd tertile of the IEM + democracy score

+ 2nd tertile of the IEM*democracy score + 3rd tertile of the IEM*democracy score

+ controls

4. Results:

4.1. Descriptive statistics:

Descriptive statistics for all variables included in multivariate models are presented in Table 3. Seventy one (55%) countries out of 130 for which NCPI data were

available were compliant with the “Three ones” recommendation, that is, have adopted a multi-sectoral approach to fighting AIDS, established one national coordinating body, and allocated a budget for monitoring and evaluation. Average per capita spending on AIDS was 5.96 US dollars. On average, countries in the sample covered about 49% of the expenditures on fighting AIDS from domestic sources and about 2% of total expenditure has been allocated to programs for men who have sex with men, commercial sex workers and their clients, and intravenous drug users. About 26% of people in need to anti-retroviral therapy were receiving it, on average, in countries for which data were available, and some 29% of HIV positive pregnant women where receiving AZT to prevent vertical transmission from mother to child. 55% of CSWs and 47% of MSM reported having accessed HIV prevention programs in countries for which data were available. About 30% of the population could correctly identify routes of HIV transmission and prevention methods. 78% of CSWs and 57% MSM reported using a condom the last time they had sex.

In the time period under analysis (2003-2007), on average, about 17% of the population had access to the Internet. The average ethnic fragmentation score was 0.44, and the average age of the largest government party was 35.5 years. The average value of the electoral market imperfections composite score was 2.07 and the score ranged in the data from 0.62 to 2.87. The average imputed Freedom House/Polity score was 6.62.

The mean value of the imputed HIV prevalence was 2.26%. The average per capita GDP in the sample was 11,569 US dollars and some 34% of the observations were classified as wealthier (per capita income above the sample mean). On average, governments in the sample spent some 11% of their overall expenditure of health. Some

60% observations had electoral institutions based on proportional representation. 34% of the observations in the data were classified by the DPI as having a parliamentary system, 57% - as a presidential system with the president elected in direct elections, and 9% - as presidential systems with a strong presidency with the president elected in indirect elections.

4.2. Multivariate analyses:

Results of the multivariate regression models are presented in Table 4.

4.2.1. Note on interpreting multivariate models with interactions:

The magnitude of association between democracy and the outcome variables in multivariate models with interactions was calculated the following way:

1st tertile of the imperfections in the electoral markets (IEM):

$\beta_{\text{democracy score}}$

2nd tertile of the imperfections in the electoral markets (IEM):

$\beta_{\text{democracy score}} + \beta_{\text{democracy score*2nd tertile of IEM}}$

3rd tertile of the imperfections in the electoral markets (IEM):

$\beta_{\text{democracy score}} + \beta_{\text{democracy score*3rd tertile of IEM}}$

While it is customary to call the combined coefficients of the terms included in an interaction "marginal effects" (Fox, 1997; Aitken & West, 1991; Brambor, Clark, & Golder, 2006), this description may unduly imply a causal relationship between the variables. In order not to overstate the causal claims, in the reminder of the chapter I will use the term "marginal association" instead of "marginal effects".

In order to assess statistical significance of the marginal association, the variance of the sum of the two coefficients: $\beta_{\text{democracy score}} + \beta_{\text{democracy score* tertile of IEM}}$ needs to be calculated. The variance can be calculated using the following formula: $Var(x+y)=Var(x) + Var(y) + 2\,Cov(x,y)$, where x is the coefficient of the democracy score ($\beta_{\text{democracy score}}$) and y is the coefficient of the multiplicative term: democracy score x tertile of the IEM score ($\beta_{\text{democracy score*2nd tertile of IEM}}$)[7].

Table 5 presents marginal associations and their standard errors estimated in the multivariate models.

4.2.2. Results of the multivariate models:

[7] Note however, that this variance will depend on the level of the other covariate included in the multiplicative term. Specifically, the formula full formula for calculating the variance of the marginal association is as follows: $Var(x+ay)=Var(x) + a^2Var(y) + 2aCov(x,y)$ where a is the value of the given IEM level (Bambor, Clark, & Golder, 2006). Because the level of IEM can only take on values of 0 or 1 and because we calculate the marginal association for a given level of the IEM when the dichotomous indicator for this level of IEM equals to 1, the above expression simplifies to $Var(x+1y)= Var(x) + 1^2*Var(y) + 2*1*Cov(x,y)=Var(x) + Var(y) + 2\,Cov\,(x,y)$

Therefore,

$Var(\beta_{\text{democracy score}} + \beta_{\text{democracy score* tertile of IEM}})= Var(\beta_{\text{democracy score}}) + Var(\beta_{\text{democracy score* tertile of IEM}}) + 2Cov(\beta_{\text{democracy score}}, \beta_{\text{democracy score* tertile of IEM}})$

The interaction between medium and high level of imperfections in electoral markets and democracy was statistically significant for the provision of ART to HIV positive people in need of antiretrovirals and for the provision of vertical transmission prophylaxis (PMTCT). Tables 5.a. and 5.b. present the association between ART and PMTCT (respectively) and the democracy score at different levels of the imperfections of the electoral markets.

Table 2.5.a.: Association Between ART and the Democracy Score at Different Levels of the Imperfections in the Electoral Markets.

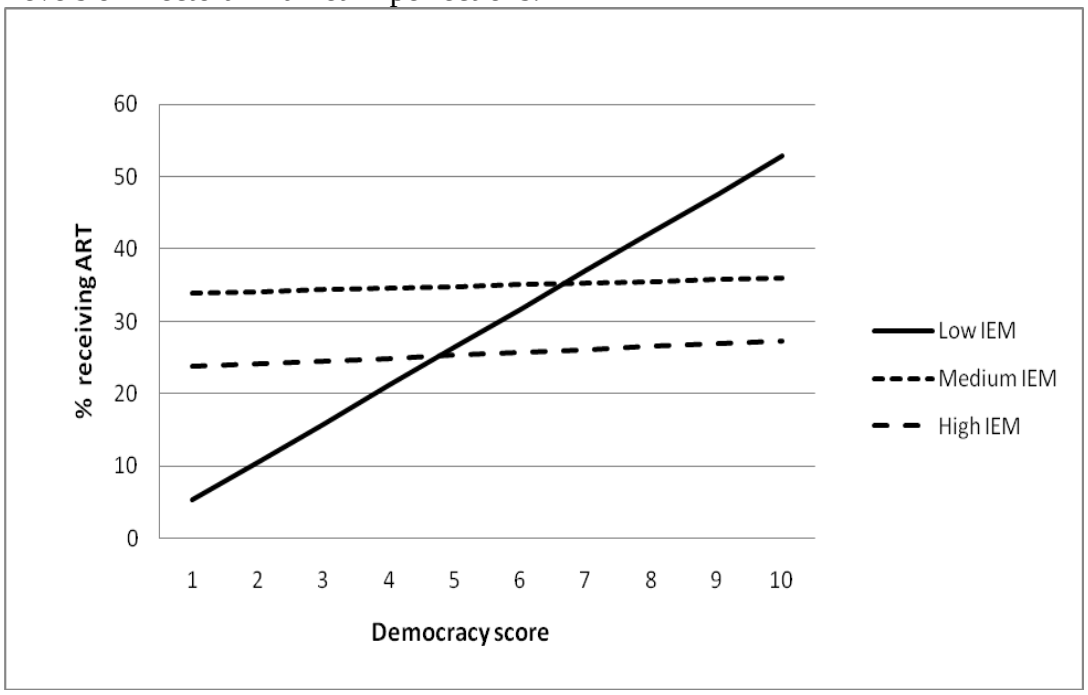
	% of people in need of ART receiving ART	
	B	(95% CI)
Democracy score at the:		
1st tertile of IEM	5.28	(3.15 - 7.42)
2nd tertile of IEM	0.22	(-1.64 - 2.09)
3rd tertile of IEM	0.4	(-1.26 - 2.05)

In the ART model (Model 1), at the lowest level of the imperfections in the electoral markets (1st tertile of the IEM distribution), an increase of one point on the democracy scale was associated with an increase of about 5.3 percentage points (β: 5.28, 95% CI: 1.77-6.17)[8] in the percentage of people receiving ART. At the medium and high level of the imperfections (2nd tertile and 3rd tertile, respectively), the association between democracy score and the outcome variable was not significantly different from 0

[8] Confidence intervals are presented in the text only for the key explanatory variables. For other significant covariates, only standard errors (S.E.) are reported in the text. For control variables not significantly associated with the outcome variable, neither the coefficients nor standard errors are reported.

(β: 0.22, 95% CI: -0.37-3.08; β: 0.4, 95% CI: -0.68-2.6, respectively). The coefficients for the 2nd and 3rd tertile of the IEM were also statistically significant. Being in the 2nd tertile of the imperfections' distribution was associated with 33.67% more people having access to ART than being in the first tertile (reference group) and being in the third tertile - with 23.31% percent more people having access to ART (β: 33.67, S.E.: 11.72; β: 23.31, S.E.: 9.07, respectively). Figure 1 illustrates the association between democracy and the provision of ART at the three levels of the imperfections in electoral markets.

Figure 2.1.: Association Between Democracy Score and the Percentage of HIV Positive People in Need to Anti-retroviral Therapy (ART) Receiving ART at Three Different Levels of Electoral Market Imperfections.



The association between HIV prevalence and HIV prevalence squared and the provision of ART was statistically significant which indicated non-linear relationship between the

two variables (β: -2.28 (S.E.:0.85); β: 0.09(S.E.:0.04). Government expenditure on health as percentage of the total government spending was also significantly and positively associated with the provision of ART (β: 1.83(S.E.: 0.035)). Other control variables showed no statistically significant associations with the dependent variable at the 95% confidence level.

Table 2.5.b.: Association Between PMTCT and the Democracy Score at Different Levels of the Imperfections in the Electoral Markets.

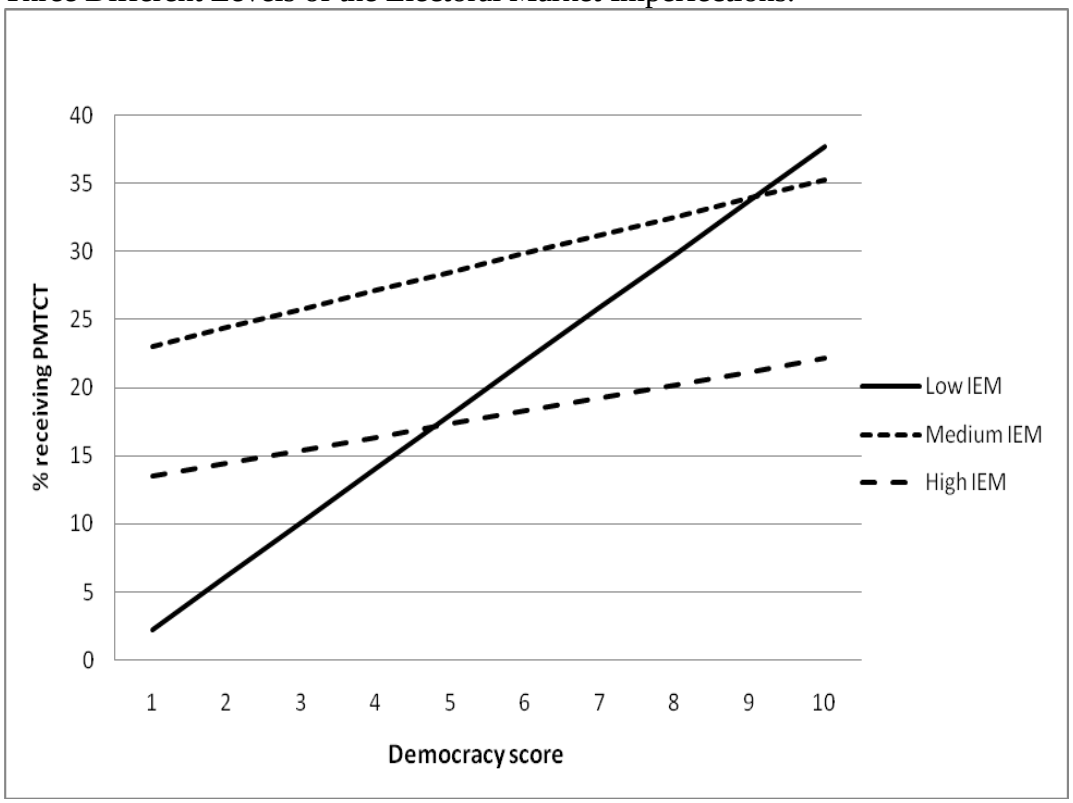
	% of HIV positive pregnant women receiving PMTCT prophylaxis	
	β	(95% CI)
Democracy score at the:		
1st tertile of IEM	3.95	(1.73 - 6.17)
2nd tertile of IEM	1.36	(-0.37 - 3.08)
3rd tertile of IEM	0.96	(-0.68 - 2.6)

In the PMTCT model (Model 2), like in the ART model, at the lowest level of the imperfections in the electoral markets (1st tertile of the IEM distribution), an increase of one point on the democracy scale was associated with an increase of about 3.95 percentage points (95% CI: 1.77-6.17) in the coverage of PMTCT. At the medium and high level of the imperfections (2nd tertile and 3rd tertile, respectively), the association between democracy score and the outcome variable was not significantly different from 0 (β: 1.36, 95% CI: -0.37-3.08; β: 0.96, 95% CI: -0.68-2.6, respectively). The coefficients

for the second tertile of the IEM was statistically significant and countries in the 2nd tertile of the imperfections' distribution had 23.4% more HIV positive pregnant women receiving PMTMC prophylaxis than countries in the first tertile (reference group). The coefficient of the second tertile was not statistically significant at the 95% confidence level (β: 14.29, S.E.: 7.78).

Wealth was the only control variable that showed a significant association with the provision of PMTCT. In wealthier countries about 16% more HIV positive pregnant women were receiving PMTCT prophylaxis than in poorer countries (β: 16.18(S.E.: 5.64)).

Figure 2.2: Association Between Democracy Score and the Percentage of HIV-positive Pregnant Women Receiving Prevention of Mother-to-child Transmission (PMTCT) at Three Different Levels of the Electoral Market Imperfections.



The interaction between democracy and the medium level (second tertile) of the IEM, but not between democracy and the high or low level of IEM, was statistically

significant in Models 4 (HIV per capita spending), 5 (domestic public spending as % of the overall HIV/AIDS expenditure), 6 (percentage of the total expenditure on AIDS spent on programming for men who have sex with men, commercial sex workers and their partners, and intravenous drug users) and 10 (percentage of commercial sex workers reporting using a condom at last sex).

Table 2.5.c.: Association Between Domestic Public Spending as the Percentage of Total Spending on AIDS and the Democracy score at Different Levels of the Imperfections in the Electoral Markets.

	Domestic public spending as % of the overall spending on AIDS	
	β	(95% CI)
Democracy score at the:		
1st tertile of IEM	-2.32	(-8.56 - 3.91)
2nd tertile of IEM	4.4	(1.3 - 7.5)
3rd tertile of IEM	-1.6	(-4.86 - 1.63)

In the model where domestic public spending on AIDS as percentage of total spending on AIDS was the outcome (Model 5) , at the medium level of the imperfections in the electoral markets an increase of 1 point on the democracy scale was associated with an increase of about 4 percentage points in the percentage of the total spending on AIDS coming from domestic public sources (β: 4.4., 95% CI 1.3-7.5). At the low and the high level of the imperfections, however, there was no statistically significant association between democracy score and the outcome variable (β: -2.32, S.E.: 3.14 and β: -1.61, S.E.: 1.61 respectively).

In this model, health expenditure as percentage of the total government spending and wealth were significantly associated with the outcome variable. Governments in wealthier countries contributed on average about 30% more to the overall spending on AIDS than governments in poorer countries (β: 30.24, S.E.: 7.31). An increase of 1 percentage point in health expenditure as percentage of the total government spending was associated with about 2 percentage point increase in the government's contribution to the overall spending on AIDS (β: 1.6, S.E.: 0.82).

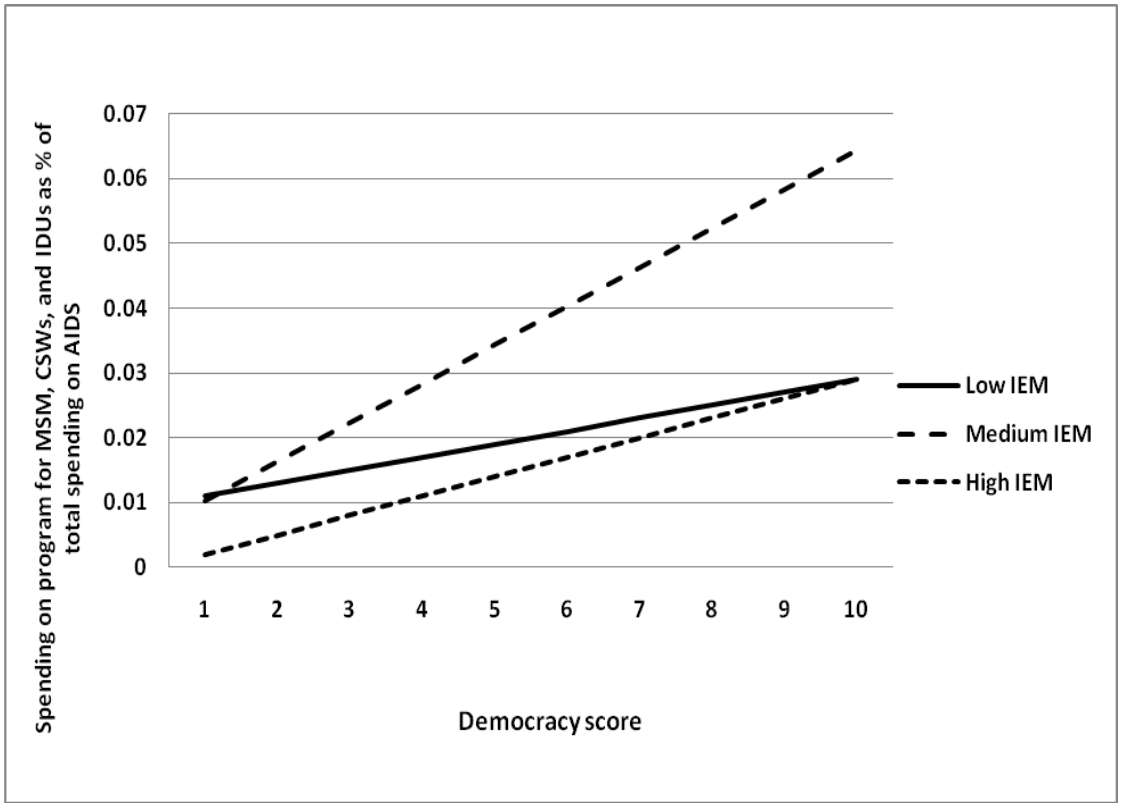
Table 2.5.d.: Association Between the Percentage of the Total Expenditure on AIDS Spent on Programming for MSM, CSWs and Their Partners, and IDUs and the Democracy Score at Different Levels of the Imperfections in the Electoral Markets.

	Spending on program for MSM, CSWs, and IDUs as proportion of total spending on AIDS	
	β	(95% CI)
Democracy score at the:		
1st tertile of IEM	0.002	(-0.002 - 0.007)
2nd tertile of IEM	0.006	(0.002 - 0.011)
3rd tertile of IEM	0.003	(-0.001 - 0.007)

In the model with the percentage of the total expenditure on AIDS spent on programming for men who have sex with men, commercial sex workers and their partners, and intravenous drug users (Model 6), democracy score was significantly associated with the outcome variable at the medium level of the imperfections of the

electoral markets (2nd tertile of the IEM score) but not at the low or the high level of the imperfections. At the medium level of the imperfections, an increase of one point on the democracy scale was associated with 0.006 percentage point increase in the percentage of total AIDS expenditure spend on programming for men who have sex with men, commercial sex workers and their partners, and intravenous drug users (β: 0.006, 95% CI: 0.002-0.011). At the low and the high level of the imperfections, the association between democracy score and the outcome variable was not significantly different from 0 (β: 0.002, 95% CI: -.002 - 0.007; β: 0.003, 95% CI: -0.001 - 0.007, respectively). In this model, none of the other variables were significantly associated with the outcome at the 95% confidence level.

Figure 2.3: Association Between the Percentage of the Total Expenditure on AIDS Spent on Programming for MSM, CSWs and Their Partners, and IDUs and the Democracy Score at Different Levels of the Imperfections in the Electoral Markets.



In the model where the percentage of the commercial sex workers who reported using a condom the last time they had sex was the outcome, at the medium level of the imperfections in the electoral markets, an increase of 1 point on the democracy scale was associated with a associated with an increase of 3.5 percentage points in the percentage of commercial sex workers who reported using and condom the last time they had sex (β: 3.51, 95% CI: 1.31 - 5.71). At the low and the high level of the imperfections, the association between democracy score and the outcome variable was not significantly different from 0 (β: -1.45, 95% CI: -4.51 - 1.61; 2.19, 95% CI: -1.05 - 5.43, respectively).

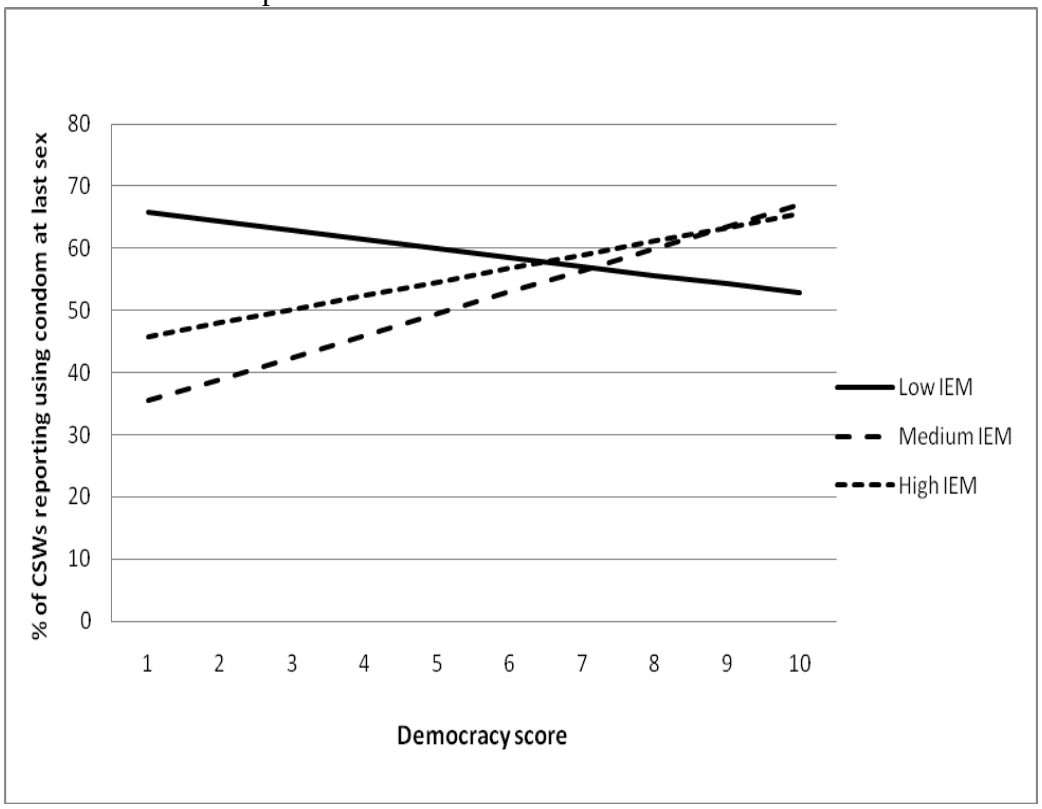
Table 2.5.e.: Association Between the Percentage of Commercial Sex Workers Reporting Using a Condom at Last Sex and the Democracy Score at Different Levels of the Imperfections in the Electoral Markets.

	% of CSW reporting using condom at last sex	
	β	95% CI
Democracy score at the:		
1st tertile of IEM	-1.45	-4.51 - 1.61
2nd tertile of IEM	3.51	1.31 - 5.71
3rd tertile of IEM	2.19	-1.05 - 5.43

In this model, like in the ART model and per capita AIDS spending model (Models 1 and 4), HIV prevalence showed a non-linear relationship with the outcome, with both raw and squared prevalence indicators being significantly associated with the

outcome variable (β: 4.94 S.E.: 0.2.54; β: -0.45, S.E.: 0.17). Also, expenditure on health as percentage of the overall government expenditure was significantly and positively associated with the outcome variable and 1 percentage point increase in health expenditure was associated with an increase of some 1.3 percentage points in the percentage of commercial sex workers reporting using a condom last time they had sex (β: 1.27, S.E.: 0.62).

Figure 2.4.: Association Between the Percentage of Commercial Sex Workers Reporting Using a Condom at Last Sex and the Democracy Score at Three Different Levels of the Electoral Market Imperfections.



The reminder of the models showed no significant interaction between imperfections in the electoral markets and democracy. In the model where AIDS spending per capita was the outcome (Model 4), even though the multiplicative term for the medium level of IEM and the democracy score was statistically significant, the

marginal association between the democracy and AIDS spending at the medium level of the IEM was not statistically different from 0(β:-0.27, S.E.:0.49). In this model HIV prevalence and health expenditure as percentage of the total government spending were the only variables significantly associated with the outcome variable. Like in the ART model (Model 1), HIV prevalence showed a non-linear relationship with the outcome, with both raw and squared prevalence indicators being significantly associated with AIDS spending (β: -2.08, S.E.: 0.68; β: 0.19, S.E.: 0.033). A 1 percentage point increase in health expenditure as percentage of the total government spending was associated with an increase of about 0.7 percentage points in per capita spending on AIDS (β: 0.71, S.E.: 2.99).

In the model where compliance with the "Three ones" recommendations was the outcome (Model 3), only having proportional representation was significantly associated with the outcome variable. Countries with proportional representation were some 80% less likely to have complied with the recommendation than countries without proportional representation (aOR, 0.22 95%CI: 0.07-0.68).

In the model, where the outcome was the percentage of commercial sex workers accessing prevention services (Model 7), none of the variables included in the model were significantly associated with the outcome variables.

The model where the outcome was the percentage of men who have sex with men accessing prevention services (Model 8) had only 30 observations and 17 degrees of freedom, which was insufficient to conduct a parametric test (Agresti & Finley, 1997; Fox, 1997).

In the model where the knowledge about AIDS in the general population was the outcome (Model 9), only health expenditure as percentage of the total government spending was significantly associated with the outcome variable. An increase on one percentage point in health expenditure as percentage of the total government spending was associated with about 2 percentage point increase in the percent of the population who correctly identified the modes of transmission and methods of prevention of the HIV infection (β: 1.71 (S.E.: 0.49)).

5. Discussion:

Results of the regression analysis presented above support the theoretical propositions outlined in the previous chapter and confirm the research hypotheses presented at the beginning of this chapter, for the provision of ART and PMTC, but not for other outcomes. At the lowest level of the electoral market imperfections, an increase of 1 point on the democracy score was associated with an increase of 5.28 (95% CI: 3.15-7.42) percentage points in the percentage of people in need of ART who were receiving it. However, at the medium and high levels of imperfections, the increases in ART coverage associated with increases in the democracy scores were not statistically different from 0 (β: 0.22, 95% CI: -1.64-2.09 for countries in the 2nd tertile of the IEM and 0.4, 95% CI: -1.26-2.05 for countries in the 3rd tertile of the IEM). Results of the PMTC model were similar. At the lowest level of the imperfections in electoral markets, an increase on one point in the democracy score was associated with an increase of 3.94 percentage points in the percentage of HIV positive pregnant women receiving PMTCT

prophylaxis. However, on the medium and high level of the IEM, increases in PMTCT coverage associated with increases in the democracy score were not statistically different from 0 (β: 1.36, 95%CI: -0.73-3.08 for countries in the 2nd tertile of the IEM and β: 0.96, 95% CI: -0.68-2.6 for countries in the 3rd tertile of the IEM). These results support the theoretical proposition that high levels of imperfections in the electoral markets suppress the positive impact of democracy on HIV policy and service provision.

Seemingly inconsistent with the extant literature, for those two outcome variables, electoral market imperfections were also independently and positively associated with the outcomes of interest. Scholarship on ethnic fragmentation (Easterly & Levine, 1997; Alesina, Devleeschauwer, Easterly, Kurlat, & Wecziarg, 2003) and on the credibility political commitments (North & Weinghast, 1986), has demonstrated that those components of the IEM score hinder governance. It is possible that the findings of extant scholarship are incomplete in that they fail to distinguish the impact of ethnic fragmentation and commitment problems on governance through democratic political institutions from the impact those factors may have through other avenues (e.g. Collier, 2006). In fact, most of the theoretical models of the impact of ethnic fragmentation on governance explicitly (Alesina, Baqir, & Easterly, 1999) or implicitly (Luttmer, 2001, Alesina & La Ferrera) assumes a democratic political regime. As described in the theoretical chapter, the principal mechanism identified by the scholarship on ethnicity and public policy (public goods) is that ethnic heterogeneity hinders the provision of public goods because the citizens/voters prefer private goods, which would only benefit their group, over public goods, that would also benefit other groups. This mechanism clearly assumes that the government is responsive to the preferences of the citizens. Thus,

within this theoretical framework, it is not clear what impact, if any, ethnic fragmentation would have in the absence of electoral institutions.

As far as the impact of the stability of the party system and the age of political parties is concerned, it is possible that, in non-democratic contexts, new governments, who otherwise lack legitimacy, would strive to tackle the AIDS epidemic in order to gain acceptance in the eyes of domestic and international audiences (Kakietek, 2008). Thus, given the high profile of HIV/AIDS in the eyes of the international community, it seems plausible that in non-democratic context the age of the government would be negatively associated with the efforts of combat AIDS.

Statistical analyses conducted above showed that imperfections in the electoral markets mediate the effects of democracy on HIV/AIDS policy as predicted by the theory presented in the previous chapters only in the service provision area. It is possible that outcomes such as the knowledge about the modes of transmission and prevention of HIV and condom use are too far removed from the influence of the national government and thus the quality of governance does not affect those outcomes as much as it does more proximal outcomes such as drug provision. The same could be said about prevention services for most at risk populations (MARPs). In countries where homosexuality, prostitution, and intravenous drug use are illegal, governments cannot get directly involved in service provision to those groups (Pisani, 2008). For example, in both Barbados and Trinidad and Tobago, where laws criminalizing buggery are still in place, prevention and outreach to men who have sex with men is carried out solely through non-governmental organizations. Therefore, difference in the quality of governance associated

with differences in the quality of democracy mediated by the imperfections in the electoral markets should affect those outcomes less.

While AIDS spending is a more proximate policy outcome than AIDS knowledge or percentage of MARPs accessing prevention services, it may be less accurate indicator of the quality of the response to HIV and AIDS. Specifically, while spending figures show how much money has been spent, they do not tell us much on *how* it was spent. More specifically, spending figures may hide governance failures. For example, in 1996 the government of South Africa awarded a 14 million Rand contract to produce and stage an educational play aimed at increasing South African's knowledge about AIDS to the Committed Artist Company, even though a competing bid was placed by Open Africa which offered to produce the play for only 0.6 million Rand (Health System Trust, PHILA Legislative Update, June 1996). Subsequently, an investigation proved the contracting process for the play to be fraudulent and the play - Sarafina II, turned out to be one of the early corruption scandals related to HIV/AIDS in the Mandela administration (only 4 million Rand was eventually recovered by the South African government) (Patterson, 2006; Dispatch November 17, 1998). It is possible that the lack of statistically significant associations is due to missing data and that with more complete data set and larger sample sizes, significant associations would have been found.

A different pattern of association between democracy and the outcomes of interest was found for domestic public spending as the percentage of the overall spending on AIDS, the percentage of the total expenditure on AIDS spent on programming for men who have sex with men, commercial sex workers and their partners, and intravenous drug users, and the percentage of commercial sex workers reporting using a condom the last

time they had sex. The democracy score was significantly and positively associated with those outcomes only at the medium level of the electoral market imperfections. At the low and at the high level of the imperfections, the association between democracy and both outcomes was not significantly different from zero.

With respect spending on programs for MARPs and condom use in commercial sex workers, the theory of social construction of policy targets suggest an explanation of the observed pattern of associations (Ingram & Snyder, 1993). As Ingram and Snyder (1993) have demonstrated, in a democratic context policy measures that benefit social groups that are perceived negatively by the general population are unlikely to be adopted. At the high levels of the imperfections, due to governance failures, national governments do not even consider addressing the needs to the marginalized populations. At the low levels of the imperfections, national governments do consider those needs, but, since they are held highly accountable for their actions by the electorate, addressing the needs of social groups considered undesirable by the general society would have negative electoral consequences. Therefore, such policy measures are not being adopted. In contrast, at the medium level of the imperfections, like at the low level, the government considers addressing the needs of marginalized populations, but, because it is less accountable, it can afford to address those needs as well, because the chances that it will be penalized by the electorate as smaller.

A very cursory look at the pattern of legislation concerning buggery in the Caribbean seems to confirm this intuition. Both Barbados and Trinidad and Tobago have not repealed buggery laws, despite advocacy efforts from international and domestic groups. In Trinidad and Tobago, which has a high level of electoral market imperfections,

a policy review regarding decriminalization of sodomy has not been undertaken. In Barbados, which has a low level of political market imperfections, the government considered repealing sodomy laws, but subsequently rejected a recommendation to do so due to widespread popular opposition. The only country in the Caribbean that has repealed its buggery laws to date are the Bahamas, which also happen to have the medium level of the imperfections in the electoral markets.

On the other hand, since condom use in CSWs is a very distal indicator of a government's policy, it is possible that the association between democracy at the medium level of the IEMs and CSWs' condom use is spurious. The fact that no similar association were found in the model where condom use at last sex in MSM was the outcome suggests that this may indeed be the case[9]. The issue of the differential impact of democracy on policy areas which are considered to benefit the general population or the "deserving" groups and on policy areas that are considered to benefit marginalized or "undeserving" groups will be discussed more in depth in the following chapters.

Quantitative analysis supports theoretical arguments that health policy is path dependent. Health spending as percentage of the overall government expenditure was significantly and positively associated with the outcome variable in Model 1 (β: 1.83 (S.E.: 0.035)), Model 4 (β: 0.71 (S.E.:0.3)), Model 5 (β: 1.6(S.E.:0.8)), Model 9 (β: 1.17 S.E.: (0.49)), Model 10 (β: 1.27 (S.E.:0.57)), and Model 11(β: 1.54 (S.E.:0.684)). This suggests that countries, where governments have prioritized health, at least in terms of

[9] The models where access to prevention services among MSM and CSW potentially could help determine whether the pattern of association found in the CSW condom use model held for more proximal indicators of policy response aimed at marginalized groups. However, both models had very small sample sizes (less than 30 degrees of freedom) which precluded reliable parametric testing.

spending, also have responded better to HIV/AIDS than countries which have not prioritized health.

Interestingly, wealth was significantly associated with the outcome variable only in two models (Model 2, PMTCT, and Model 4, percentage of total AIDS spending from domestic public sources). In wealthier countries on average some 16% of HIV positive pregnant women were receiving PMTMC prophylaxis and about 3% more of the total AIDS spending came from domestic public sources. One possible reason why wealth was not associated with ART provision was that in several developing countries ART programs have been funded through foreign assistance schemes, such as the World Bank Multi-country AIDS Programme (Cit). Thus, even in poorer countries, access to ART can be high due to foreign aid. The same can be said about the overall spending on AIDS. With the increasing amount of funding for national AIDS programs coming from international sources such as the World Bank, the Global Fund, USAID, CIDA, DFID and others, even relatively poor countries have been able to spend on AIDS much more than their meager domestic budgets would have allowed them otherwise. For example, in 2006, Haiti, one of the poorest countries in the world, spent about 8 US dollars per capita on AIDS-related programs. In the same year, per capita AIDS spending in Brazil, one of the largest emerging economies, was only 3 dollars (UNAIDS, 2008).

In contrast to the scholarship on the impact of electoral institutions on social policy, the analyses presented above show very limited association between the type of electoral institutions and HIV/AIDS policy. Having a presidential vs. parliamentary system was not associated with any of the outcomes in the analysis. Proportional representation was associated with a lower likelihood of compliance with the "Three

ones" recommendations, but with a higher percentage of men who have sex with men reporting the use of condom at last sex.

5.1. Limitations:

One general limitation of the analyses and models presented above are scarcity of data and generally small sample sizes, which varied from 347 to as few as 30 observations. In fact, in Model 8 - the percentage of men who have sex with men accessing prevention services - the sample size was so small (30 observations, 17 degrees of freedom) that it precluded parametric testing. It needs to be noted that it was the models with the largest number of observations (ART and PMTMC coverage, Models 1 and 2) that provided the strongest empirical support for the research hypotheses.

Another limitation of this analysis is that, while it has established associations between the indicators of democracy, imperfections in the electoral markets, and HIV/AIDS policy measures, it cannot show whether those associations are driven by causation. This is a general limitation of non-experimental, observational cross-sectional studies, which is, unfortunately, rarely acknowledged in political-scientific empirical analyses. Nevertheless, observational, cross-sectional time series design is a standard mode of analysis in the discipline and, thus, the research design of this study is not inferior to other studies analyzing the impact of democracy on human development and social policy. Furthermore, the issues of internal validity and establishing patterns of causation are explicitly addressed in the following chapters in the analysis of the historical evolution of HIV/AIDS policy in Barbados and Trinidad and Tobago.

6. Conclusions:

Quantitative analyses provided strong support for the research hypotheses in the context of ART and PMTCT provision. Democracy score was positively associated with both outcomes at the lowest level of the electoral market imperfections. At the medium and high level of the imperfections, the association between democracy and the outcome variables was not statistically significant from zero. On the other hand, for domestic public spending, spending on programs for MARPs, and the percentage of commercial sex workers who reported using a condom the last time they had sex, democracy score was significantly and positively associated with the outcome variables only at the medium level of the imperfections in the electoral markets.

These findings were not significant for the remainder of the outcomes included in the analyses. One reason for the absence of significant associations is substantive. Since outcomes such as AIDS knowledge, provision of services to MARPs are more distal, that is, farther removed from the influence of the government, improvements in governance associated with a better quality of democracy (higher democracy score) would have less impact on those outcomes. Another reason is related to the scarcity of data and small sample sizes. It is possible that with a more complete data set and less missing data points, statistical analyses would have shown more significant associations.

One major limitation of the statistical analyses presented above is that they cannot establish whether the patterns of associations they show are causal or not. Subsequent chapters analyzing the historical evolution of HIV/AIDS policy in Barbados and Trinidad and Tobago will serve to capture causal mechanisms more directly.

Table 2. 3.: Descriptive Statistics

	N				
Dependent variables					
Three ones	130				
Yes		71	54.62%		
No		59	45.38%		
		Mean	SD	Min	Max
Per capita AIDS spending	144	5.96	16.35	0.03	119.92
Domestic public spending as proportion of the overall spending on AIDS	136	0.49	0.34	0	1
Spending on MAPRS as proportion of the overall spending on AIDS	144	2.18	6.27	0	57
% of persons receiving ART	440	28.79	25.78	0	96
% of HIV positive pregnant women receiving AZT	379	29.41	28.73	0	96
% of CSW accessing prevention programs	49	55.06	25.14	0.9	96
% of MSM accessing prevention programs	36	46.722	28.17	10	100
AIDS knowledge	120	29.99	18.17	0.9	86
% of CSW reporting to have used a condom with the last sex partner	99	78.25	19.98	4	100
% of MSM reporting to have used a condom with the last sex partner	82	57.25	20.06	8	91
Independent Variables					
Democracy (Freedom House/Imputed Polity Score)	1150	6.62	3.26	0	10
Internet	1071	17.59	20.4	0	95.26
Ethnic fragmentation	1128	0.44	0.26	0	0.93
Age of the largest government party	735	35.46	36.76	1	191
Imperfections in electoral markets composite score	715	2.07	0.49	0.62	2.87
Low (1st tertile)		281	39%		
Medium (2nd tertile)		213	30.00%		
High (3rd tertile)		221	31.00%		
Control Variables					
HIV prevalence	270				
Interpolated	680	2.26	4.72	0.01	26.23

GDP per capita continuous	920	11569	12361	327.25	88335
Wealth categorical					
Wealthy countries (GDP per capita>mean)		316	34.35%		
Poor countries		604	65.65%		
Health expenditures as % of GDP	915	11.04	4.4	77	29.94
Proportional representation	736				
Yes		442	60.50%		
No		294	39.50%		
Institutional regime	864				
Presidential with president elected in direct elections		494	57.18%		
Presidential with president elected in indirect elections		79	9.14%		
Parliamentary		291	33.68%		

* 1 year lag

Table 2.5.: Multivariate Regression of AIDS Policy Indicators on the Interaction of Democracy Score and the Electoral Market Imperfections.

	Model 1		***Model 2***		***Model 3***	***Model 4***		***Model 5***		***Model 6***	
Variable	**ART** β (SE)		**PMTCT** β (SE)		**Three 1s†** β (SE)	**AIDS spending per capita** β (SE)		**Domestic public spending as % of total spending on AIDS** β (SE)		**Spending on program for MSM, CSWs, and IDUs as proportion of total spending on AIDS** β (SE)	
Imperfections in electoral markets composite score											
2nd tertile	33.67	***	23.45	***	0.72	1.45		-46.02		-0.005	
	(11.710)		(8.010)		(1.640)	(5.904)		(27.820)		(0.018)	
3rd tertile	23.31	**	14.29	*	-0.49	10.17	**	-22.889		-0.01	
	(9.070)		(7.780)		(1.660)	(4.328)		(27.360)		(0.015)	
Democracy	5.28	***	3.95	***	0.11	1.14		-2.32		0.002	
	(1.090)		(1.120)		(0.180)	(0.697)		(3.130)		(0.002)	
Democracy*2nd tertile of Imperfections	-5.06	***	-2.59	**	-0.008	0.25		6.72	**	0.004	
	(1.470)		(1.310)		(0.210)	(0.071)		(3.190)		(0.002)	
Democracy*3rd tertile of Imperfections	-4.88	***	-2.99	**	0.19	-1.41	**	0.71		0.0038	
	(1.300)		(1.290)		(0.240)	(0.062)		(3.330)		(0.003)	
HIV prevalence	-2.28	***	-0.2		0.04	-2.08	***	-3.29	**	0.001	*
	(0.850)		(1.020)		(0.200)	(1.285)		(1.360)		(0.002)	
HIV prevalence squared	0.09	**	0.03		0.0003	0.19	***	0.13	*	0.00004	
	(0.040)		(0.050)		(0.010)	(0.072)		(0.070)		(0.000)	

Health expenditures as % of total expenditure on health	1.83	***	0.36		0.068		0.71	*	1.59	*	-0.005	
	(0.035)		(0.440)		(0.063)		(0.372)		(0.830)		(0.001)	
Wealthier countries	2.96		16.18	**	0.18		-4.41		30.24	***	-0.003	
	(3.820)		(5.640)		(0.640)		(3.180)		7.31		(0.011)	
Institutional regime												
Presidential with president elected in direct elections	-6.19		-3.65		0.66		-7.69		-7.15		0.014	
	(3.770)		(4.620)		(0.560)		(2.790)		(9.750)		(0.012)	
Presidential with president elected in indirect elections	11.06	*	0.32		1.81	*	0.81		-14.95		0.0014	
	(5.780)		(5.570)		(0.980)		(6.130)		(11.140)		(0.009)	
Proportional representation	-0.7		-0.02		-1.53	***	-6.77	*	-2.93		-0.017	*
	(3.110)		(3.470)		(0.580)		(3.820)		(7.530)		(0.012)	
Constant	-16.08	*	-1.76		-1.33		-7.01		64.83	***	0.01	
	(8.900)		(7.810)		(1.420)		(7.429)		(29.460)		(0.019)	
N	347		294		102		111		111		111	
Adj R1	0.37		0.25		0.11		0.66					

*p<0.1; **p<0.05; ***p<0.001
† Logistic regression model

Table 2.5. (continued): Multivariate Regression of AIDS Policy Indicators on the Interaction of Democracy Score and the Electoral Market Imperfections.

	Model 7	***Model 8***	***Model 9***	***Model 10***		***Model 11***
	% of commercial sex workers accessing prevention services	**% of men who have sex with men accessing prevention services**	**AIDS knowldege**	**Condom use at last sex (CSW)**		**Condom use at last sex (MSM)**
	B	β	β	β		β
Variable	(SE)	(SE)	(SE)	(SE)		(SE)
Imperfections in electoral markets composite score						
2nd tertile	5.17	36.71	-8.45	-35.4	**	-15.26
	(34.470)		(13.020)	(13.570)		(15.810)
3rd tertile	11.77	70.489	-4.89	-23.68		-5.96
	(30.540)		(11.530)	(14.970)		(20.020)
Democracy	0.822	4.13	0.16	-1.45		-1.27
	(3.160)		(1.440)	(1.530)		(1.760)
Democracy*2nd tertile of Imperfections	0.34	-2.59	1.08	4.96	**	2.2
	(4.689)		(1.850)	(1.880)		(2.050)

Democracy*3rd tertile of Imperfections	-0.05	-7.18	-1.13		3.64	*	0.048	
	(4.600)		(1.840)		(2.110)		(2.569)	
							(2.690)	
HIV prevalence	1.09	-3.64	0.89		4.94	*	4.73	
	(6.160)		(1.190)		(2.830)		(4.330)	
HIV prevalence squared	-0.03	2.57	-0.05		-0.45	**	-0.09	
	(0.440)		(0.060)		(0.200)		(0.484)	
Health expenditures as % of total expenditure on health	0.69	-0.18	1.71	***	1.27	**	1.54	**
	(1.709)		(0.490)		(0.529)		(0.619)	
Wealthier countries	1.5	-6.37	1.26		0.169		-8.43	
	(13.980)		(5.770)		(6.024)		(6.840)	
Institutional regime								
Presidential with president elected in direct elections	-11.06	1.64	-3.2		9.77		-6.55	
	(16.500)		(5.190)		(6.686)		(6.310)	
Presidential with president elected in indirect elections	9.86	17.53	6.28		14.56	*	-9.04	
	(19.910)		(6.440)		(8.268)		(8.150)	

Proportional representation	2.25	-0.36	1.96	-1.93		13.34	**
	(13.890)		(4.468)	(5.233)		(6.350)	
Constant	39.5	7.49	14.79	67.31	***	47.52	***
	(28.900)		(9.820)	(12.454)		(16.230)	
N	38	30	87	79		70	
Adj R1	-0.28	-0.23	0.16	0.25		0.14	

*p<0.1; **p<0.05; ***p<0.001
† Logistic regression model

Table 2.6.: Marginal Association Between Democracy Score and AIDS Policy Indicators at Different Levels of the Electoral Market Imperfections.

	Model 1		***Model 2***		***Model 3***	***Model 4***		***Model 5***		***Model 6***	
	ART B (SE)		**PMTCT** β (SE)		**Three 1s†** β (SE)	**AIDS spending per capita** β (SE)		**Domestic public spending as % of total spending on AIDS** β (SE)		**Spending on program for MSM, CSWs, and IDUs as proportion of total spending on AIDS** β (SE)	
Association between democracy and the outcome variable at the											
Low level of IEM	5.28	***	3.95	***	1.11	1.14		-2.32		0.002	
	(1.09)		(0.88)		(0.19)	(0.70)		(3.14)		(0.002)	
Medium level of IEM	0.22		1.35		1.11	1.4	*	4.4	***	0.006	***
	(0.94)		(0.88)		(0.16)	(0.80)		(1.56)		(0.002)	
High level of IEM	0.4		0.96		1.35	-0.27		-1.61		0.003	
	(0.84)		(0.83)		(0.26)	(0.49)		(1.64)		(0.002)	
N	347		294		102	111		111		111	

*p<0.1; **p<0.05; ***p<0.001

† Logistic regression model

Table 2.6. (continued): Marginal Association Between Democracy Score and AIDS Policy Indicators at Different Levels of the Electoral Market Imperfections.

	Model 7	***Model 8***	***Model 9***	***Model 10***		***Model 11***
	% of commercial sex workers accessing prevention services	**% of men who have sex with men accessing prevention services**	**AIDS knowledge**	**Condom use at last sex (CSW)**		**Condom use at last sex (MSM)**
	B	β	β	β		β
	(SE)	(SE)	(SE)	(SE)		(SE)
Association between democracy and the outcome variable at the						
Low level of IEM	0.82	Not estimated	0.16	-1.46		-1.27
	(3.16)		(1.44)	(1.53)		(1.76)
Medium level of IEM	1.17		1.25	3.51	***	0.93
	(3.52)		(1.22)	(1.10)		(1.52)
High level of IEM	0.77		-0.97	2.19		-1.22
	(3.97)		(1.29)	(1.62)		(2.20)
N	38	30	87	79		70

*p<0.1; **p<0.05; ***p<0.001
† Logistic regression model

CHAPTER 3: BARBADOS CASE STUDY

1. Introduction:

At the beginning of this chapter, let me first re-iterate the theoretical background of the dissertation. The "marketplace" model of democracy assumes that health policy is a normal good. Therefore, the public always demand more and better health policy, that is, there exist a constant political demand for policy improvements. Incumbents respond to this demand by offering a certain course of policy. If the policy course adopted by the incumbents satisfies the demand better than policy alternatives offered by the challengers/political opposition, the incumbents are re-elected. If it does not - the challengers are elected and their policy is adopted. This demand and supply chain may be disrupted when the electoral marketplace is imperfect. Specifically, when the electorate does not have access to information about the policies adopted by the incumbents and the policy alternative proposed by the challengers, they cannot effectively distinguish between the available policy options. Also, if electoral politics are centered around issues such as race/ethnicity or other ascriptive characteristics that are not policy-related, the electoral process will not results in the improvement in policy outputs. Finally, when the voters do not trust electoral promises they have no incentives to vote for candidates who promise to adopt policies that are aligned with the voters' preferences.

Statistical analyses presented in the previous chapter showed that the indicators of democracy were associated with better HIV/AIDS policy outcomes in countries where the level of electoral market imperfections was low, but not in countries, where the level of the imperfections was moderate or high. More specifically, the level of electoral

market imperfections mediated the association between democracy and the provision of ART and PMTCT. At the low level of electoral market imperfections, democratic countries showed higher ART and PMTCT coverage than non-democratic ones. At moderate or high level of the imperfections, the association between democracy and those outcomes was not statistically significant. On the other hand, the level of imperfections was not a mediating variable for other policy indicators: institutional and policy infrastructure, spending, and behavioral outcomes and AIDS-related knowledge in the general population. There were no statistically significant associations between democracy and these outcomes at any level of the imperfections.

The quantitative analysis provided what George and Bennett (2005) call a variable-based, or association-based evidence that electoral market imperfections indeed mediate the relationship between democracy and some areas of AIDS policy. In the following three chapters I will examine whether this research hypothesis can be supported beyond establishing co-variation among the key variables.

In order to accomplish this goal, I employ the "most similar with different outcome" design (George & Bennett, 2005) between two cases from the Eastern Caribbean: Barbados and Trinidad and Tobago. The comparison allows for assessment of the causal impact of the imperfections of the electoral markets on AIDS policy, while controlling for a number of independent variables, the most important of which are democratic regime and the makeup of electoral institutions, as well as HIV prevalence[10], and wealth. Both countries differ sharply with respect to their citizens' access to information, the level of ethnic polarization and mobilization, and politicians' ability to

[10] The estimated HIV prevalence is 1.2% in Barbados and 1.5% in Trinidad and Tobago. In both countries, heterosexual sex is the predominant mode of HIV transmission (UNAIDS 2008).

credibly commit. As newspapers become increasingly displaced by electronic media, Internet use is an appropriate measure of the degree to which the citizens are informed about governmental policies and politicians' actions. The number of Internet users per capita in Barbados is more than triple that of Trinidad and Tobago (CIA World Fact Book). Barbados, where Africans constitute 90% of the population, is also much more ethnically homogeneous than Trinidad and Tobago, which is comprised of 40% Indians (South Asians), 37.5% Africans, and 20.5% people of other ethnic origins. Indeed, ethnicity has been a major polarizing factor shaping the politics of the country, including its party system and social movements (Edie, 1994; Ryan, 1972), while it has been all but absent from Barbadian politics (Beckles 2004, 2006). Also, the age and, presumably, the credibility, of political parties is higher in Barbados, where the largest government party - the Barbados Labour Party - has been in existence since 1938: The equivalent in Trinidad and Tobago - the People's National Movement – is more than two decades younger (Meighoo, 2003; Reddock, 1994).

This configuration of independent variables corresponds closely with the responses to AIDS in both countries. Barbados, has provided a much better coverage of antiretroviral therapy and spent more on fighting AIDS than Trinidad and Tobago. Also, in Barbados, the policy and the institutional framework to fight AIDS was established earlier, and the process of policy development was much more inclusive of key stake holders: people living with HIV/AIDS, and even groups representing gay men[11] (Government of Barbados, 2008). In Trinidad and Tobago, no review of the national AIDS policy inclusive of people living with HIV has been undertaken to date (Government of Trinidad and Tobago, 2008). Finally, prevention efforts among the most

[11] Anal sex and, de facto, homosexuality, are illegal in Barbados.

at risk groups seem to have a greater impact in Barbados, where 64.5% of men who have sex with men report using a condom during the last sexual intercourse, compared to only 45% in Trinidad and Tobago (ibid.)

To generate credible causal conclusions, I will reconstruct the sequence of events leading to policy changes, as well as the motivations and perceptions of the policy makers in both countries. The data presented in this and the subsequent two chapters comes from primary sources and in-depth interviews with key informants who were either directly involved in or witnessed the policy process. These informants include ministers and other government officials, parliamentarians, people living with HIV/AIDS, members of "high risk groups", community and religious leaders, and healthcare professionals in both countries. The data was collected during a nine-month long fieldwork conducted in Barbados and Trinidad and Tobago in 2009-2010.

2. Barbados context:

This chapter re-constructs the process of HIV/AIDS policy making in Barbados. I use the analytic technique of process tracing to assess whether the absence of electoral market imperfections made scaling up response to AIDS easier and more appealing for the political elites on the island. First, I describe the level of electoral market imperfections. Second, I outline the historical evolution of the response to AIDS on the island and show how the imperfections affected the political calculus and ultimately, the policy response.

Figure 3.1.: Map of Barbados

Source: Maps Worldwide (http://www.mapsworldwide.com/online_map.asp?country=41)

Barbados is located in the Eastern Caribbean and it is the eastern most island of the Lesser Antilles. The total area of the island is about 430 square km - about 2.5 time the size of Washington, D.C. (CIA Factbook). The country has a population of about 280,000. Barbados was a British colony since 1625, when it was claimed by Captain John Powell on behalf of King James I; the British settlement was the first permanent European settlement program on the on the island. Barbados was a colony until 1966, when the county gained independence (Beckles, 2006). Today, Barbados is a parliamentary democracy based on the Westminster model. While the Queen of England is the nominal head of state, the Prime Minister appoints the ministers and leads the government.

The Barbadian society is ethnically homogenous. Black account for 93% of the population, whites - for 3.2% and East Indians, people of mixed race and members of other ethnic groups - for the remaining 3.8% (Barbados Census, 2000).

Up until mid 20th century, agriculture, and specifically sugar cane production constituted the largest part of the economy. However, it has now been replaced by commerce and services, in particular tourism, that account for 78% of the gross domestic product (CIA World Factbook, 2000 estimates). Industrial production constitutes some 16% of the GDP and agriculture - 6% (ibid). Similarly, 75% of the labor force is employed in the service sector, 15% in the industry sector, and 10% in agriculture (ibid).

3 Political Market Imperfections and HIV/AIDS policy in Barbados

3.1. Racial/ethnic polarization:

In his seminal work on the history of Barbados, Beckles called the colonization of the island "probably the least problematic of all the Caribbean settlements made by the English" (Beckles, 2006, p. 9). The island was claimed by the British on May 14th 1625. By that time, it had no indigenous Amerindian population; the last permanent Kalinago settlement ended in mid 16th century, most likely due to migration caused by the Spanish slave-raiding missions (Beckles, 2006).

The first group of African slaves was brought to Barbados in 1627; throughout the 1620s and 30s, blacks constituted a small minority of the population and their number did not exceed 800. Beckles notes that "white servant labour was more readily available and

cheaper; most planters did not or could not purchase enslaved blacks" (Beckles, 2006, pp: 20-21).

The distribution of the Barbadian population began changing dramatically in the 1640s and 1650s. In 1655 whites still constituted a majority of the population on the island, albeit, a small one (23,000 whites and 20,000 blacks) (see Table 1). Some sixty years later, in 1712, however, the blacks accounted for more than 70% of the population (12,528 whites and 41,970 blacks) (Dun, R. (1972). Sugar and Slaves: The Rise of the Planter Class in the English West Indies, 1624-1713, p. 87). Those demographic changes were a result of a number of factors including the rapidly developing Barbadian sugar economy, which peaked in the late 17th century, and created a demand for cheap labor. It also coincided with the increasing unavailability and high cost of white indentured laborers, the rapid development of the trans-Atlantic slave trade and the resulting decreases in the costs of black slaves (Beckles, 2004; see also Williams, 1944). By the end of the 18th century, blacks accounted for over 80% of the population of Barbados (see Table 1).

Table 3.1.: Population of Barbados 1655-1780.

Year	Whites Number (thousands)	%	Blacks Number (thousands)	%	Total population	Source
1655	23	53.5%	20	46.5%	43	[1]
1673	21.3	39.2%	33	60.8%	54.3	[1]
1676	19.6	37.7%	32.4	62.3%	52	[1]
1684	12.5	21.2%	46.6	78.8%	59.1	[1]
1700	15.4	26.9%	41.9	73.1%	57.3	[2]
1710	13	19.9%	52.3	80.1%	65.3	[2]
1720	17.7	23.1%	58.8	76.9%	76.5	[2]
1730	18.2	21.8%	65.3	78.2%	83.5	[2]
1740	17.8	19.8%	72.1	80.2%	89.9	[2]
1750	17.2	17.9%	78.8	82.1%	96	[2]
1760	17.8	17.0%	86.6	83.0%	104.4	[2]
1770	17.2	15.8%	92	84.2%	109.2	[2]
1780	16.9	17.0%	82.4	83.0%	99.3	[2]

Sources: 1) Dun, 1972; 2) McCusker & Menard, 1985

Today, the population of Barbados is ethnically homogenous. According to the 2000 census, black Barbadians constitute about 93% of the population (2000 census). Whites account for about 3.2% of the populations, East Indians - for about 1% and other ethnic groups for some 0.2% (2000 census). The Ethnic Fractionalization Index - measure of ethnic diversity developed by Alesina and colleagues (2003) shows that a chance that two randomly selected people will be from different ethnic groups is about 7% (the global mean of this indicator is about 35%).

3.1.1. Race and electoral politics in Barbados:

In 1807 trans-Atlantic slave trade was banned, in 1834 slavery was abolished in the British Empire, and the law introducing full emancipation of former slaves was

passed in Barbados in 1838. However, the abolition of slavery had very little impact on race relations. Whites continued to hold the vast majority of the land and other economic assets, the island's economy was dominated by sugar cane production and the employment opportunities for blacks outside of agriculture were very limited. Thus, as Beckles (2004, 2006) points out, emancipated blacks continued working as domestic servants or field workers often on the very same plantations they lived on as slaves.

Free colored men could vote in Barbados since 1831. However, for most black Barbadians opportunities for political mobilization were very limited. Voting rights were subject to income qualifications, which, even after the emancipation, effectively excluded the vast majority of the blacks on the island form political participation (Beckles, 2006). Labor unions and mass-base political parties were legalized only in the 1930s, following workers riots which took place all over the British Caribbean in 1937 and 1938 (Duncan, 1994; Barrow-Gilles, 2002). However, even then only about 3.5 of the population could vote (Beckles, 2006).

In the 1930s and 1940, race was at the center of electoral politics in Barbados with

the white planter-merchant elite trying to protect their privileged position and preserve their political dominance. However, with the graduate extension of suffrage and the increasing percentage of the blacks in the electorate, the political party supporting white interests declined and, following Barbados' independence, disappeared completely.

In 1943, the income qualification required for voting was reduced from £50 to £25. Also, for the first time in the history of the colony, women were given the right to vote. This resulted in an increase of over 500% in the number of eligible voters (Beckles,

2006). It also corresponded with a marked decline in the number of the seats in the House of Assembly controlled by the planter-merchant party, the Electors' Association (from 18 in 1940 to 8 in 1944) (see Table 2). At the same time, the number of seats controlled by parties representing black professionals and the working class tripled form (from 5 in 1940 to 15 in 1944). Income and property requirements for passive and active electoral rights were completely abolished in 1950, which resulted in the expansion of the electorate from 30,000 to 100,000 and another marked decline in the number of seats controlled by the planter-merchant party (Beckles, 2006). Following the country's independence in 1966, the Electors' Association, which by then had been renamed twice to Progressive Conservative Party and Barbados National Party, disappeared completely form the political scene (see Figure 2.2. and Table 3.2).

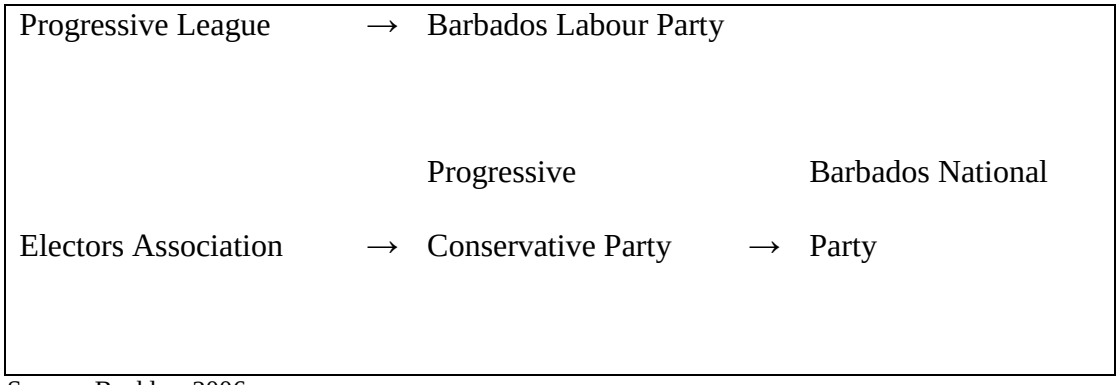
Table 3.2: Political Parties and the Number of Seats in Barbadian Elections, 1940-1971.

Year	Electors' Association/Progressive Conservative Party/Barbados National Party	Progressive League/ Barbados Labour Party	Congress Party	Democratic Labour Party	Source
1940	17	5	0	-	[1]
1944	8	7	8	-	[1]
1946	8	8	7	-	[1]
Universal suffrage					
1951	4	16	2		[1]
1956	4	15	-	4	[1]
1961	4	15	-	5	[1]
Independence					
1966	2	4	-	14	[2]
1971	0	8	-	14	[2]

Sources: 1) Beckles, 2006; 2) Caribbean education online:

http://www.caribbeanedu.com/elections/bb07.asp

Figure 3.2.: Name Changes in Major Political Parties in Barbados



Source: Beckles, 2006.

Historically, after the ultimate defeat the Electors' Association, the white voters did not favor either of the two dominant parties: Barbados Labour Party (BLP) or the Democratic Labour Party (DLP). Both parties, as Beckles (2006) points out, "had cultivated traditions of criticism of the oligarchical political attitudes and practices and the planter-merchant class, but both had sought to court its economic power and managerial expertise." (p. 85). Even though the BLP is considered to be more supportive of the big business, and possibly, of white economic interest, a recent poll conducted by the newspaper the Nation and the Caribbean Development Research Services (CADRES) showed a similar percentage of white supporters in both parties: whites constituted 1.5% of the supporters of the BLP and 2.2% of the DLP[12] (CADRES, 2007). Thus, despite persistent social and economic inequality between blacks and whites, the politics of race in Barbados are characterized by accommodation and disengagement rather than confrontation. As Beckles puts it: "a conciliatory arrangement between white corporate

[12] The poll does not provide standard errors and it is impossible to discern whether the difference in the percentage of white supporters for both parties is statistically significant.

power and black political administration emerged as the dominant political equation of the post-independence period (Beckles, 2004; p. 85-86).”

3.2. Trust in electoral promises:

Career politicians and academicians I have interviewed in Barbados agreed that the level of trust in the political system and electoral promises on the island is high. One informant at the University of the West Indies noted: "I don't think we have an image of corrupt politics the same way they have in Trinidad for example. We also don't have an image of irresponsible politicians, that people go into politics for five years to mess around and take what they can out of the country. We have endless complaints about politicians, but that's more about individuals than about the political system" (personal interview, B17).

There is no survey data available that would capture directly the level of trust of voters in electoral promises. In the absence of survey data, electoral turnouts may be a good proxy measure of the voters' trust. The turnouts in the elections in Barbados have been high (see Table 3.3). The average percentage of registered voters casting a ballot in the parliamentary elections since independence through 2003 was 69.7%.

Table 3.3: Turnouts in the Parliamentary Elections in Barbados, 1971-2002.

Year	Percentage of registered voters voting in elections
1971	81.6%
1976	74.1%
1981	71.6%
1986	76.7%
1991	63.7%
1994	60.2%
1999	63.1%
2003	56.8%

Source: International Institute for Democracy and Electoral Assistance (in the Quality of Government data set)

This trust was attributed by the key informants to the stability of the political and the party system. "Among the older population there is a general trust of government and this is helped by the fact that Barbados has had a very stable political system and that changes in the government happen seamlessly" (B12; also B17, B4).

The party system in Barbados has shown remarkable stability throughout the 20th century. Both of the main political parties, the Democratic Labour Party (DLP) and the Barbados Labour Party (BLP), were contesting the elections for decades before the country's independence. The BLP grew out of the Progressive League established in October 1938 and competed in the general election for the first time in 1941 (Beckles, 2006; Duncan, 1994). In 1954 it was renamed Barbados Labour Party (Beckles, 2006). The Democratic Labour Party (DLP) contested its first election in 1956 - a decade before Barbados became independent. This historical heritage gave voters a sense of trust in the political system and strengthened the credibility of electoral promises.

Conducting interviews with key informants I was very often reminded how seriously both politicians and voters take the electoral platforms and manifestos. When in

1994 David Thompson (leader of the DLP and the current Prime Minister) remarked that an electoral manifesto does not constitute a binding social contract, the statement caused a public outcry: "We had public debates, whether the electoral manifesto constitutes a social contract and whether parties can be hold accountable for implementing it. Some prime minister said that it was not and he got lambasted for it. I think generally people expect it to be. You are morally bound to institute your electoral promises" (personal interview, B4) This view is also often expressed in the media:

"Further, if we adhere to the popular affirmation that a manifesto is a social contract, the DLP was duty bound to create these constituency councils as promised, having obtained the mandate to do so" (Barbados Advocate, "Constituency governance" 12 January 2009). http://www.barbadosadvocate.com/newsitem.asp?more=editorial&NewsID=1939

Career politicians I have spoken to shared the perception that electoral manifestos are important because voters pay attention to them and evaluate parties performance based on those documents:

"The manifesto is a very important document here. Very important. People go through it with a fine-toothed comb and it's referred to constantly" (personal interview; B27).

"In our party, we produce a Promises and Performance document: this is what we promised and what we did. So there are two documents in the election process: the manifest and the Promises and Performance document" (personal interview; B27).

Promises and performance documents are published on the parties' websites (see e.g. "Barbados - Better than Ever" at: http://blp.org.bb/pdf/Promises_web.pdf).

Historical evidence was also confirmed by focus group interviews, during which Barbadians expressed trust in their elected officials and faith that promises in party manifestos are generally implemented if the party wins the election. This contrasts sharply with the attitudes expressed by Trinidadians and Jamaicans who participated in the focus groups I conducted in Barbados: their faith in the credibility of political commitments, and the political process in general, was significantly lower.

Historical evidence, in-depth interviews with the key informants, and focus group discussions showed that the level of trust in electoral promises in Barbados is high. They also showed that it increased the sense of accountability in the elected officials. The voters expect that the electoral promises will be fulfilled and the politicians expect that they will be held accountable for whether they deliver on their promises or not.

"...people are aware and make their decision partially based on performance (personal interview; B31)."

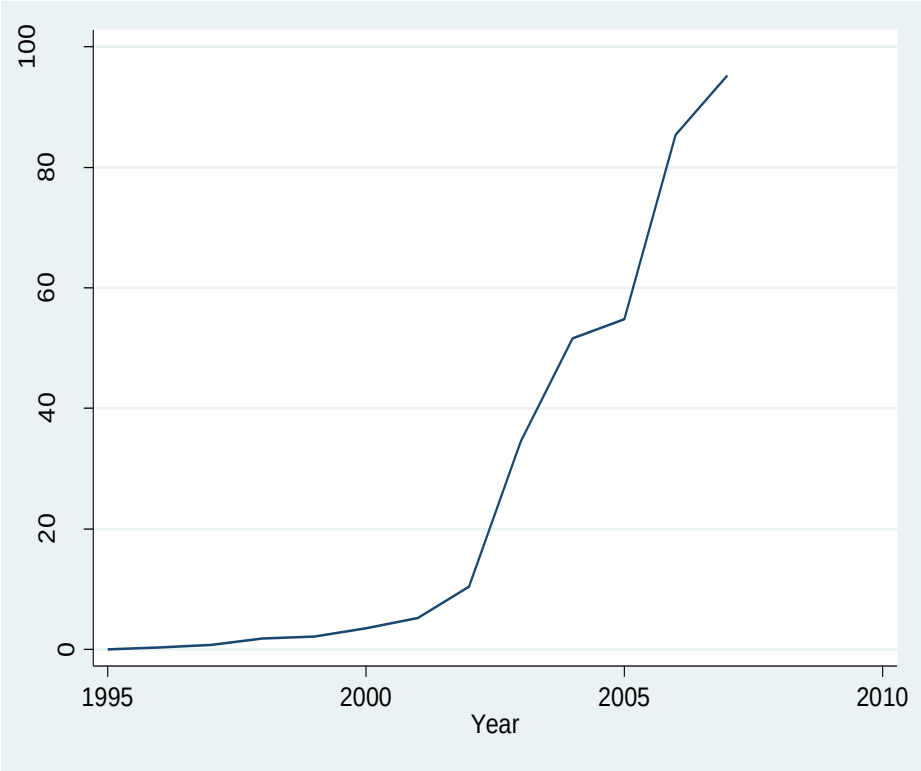
"This is especially true now. If you got elected based on promises that the cost of living will decrease and the cost of living increases you have failed (personal interview; B12)."

3.3. Access to information:

This sense of accountability was reinforced by the high availability of information about the performance of the government. Empirical studies have shown that a low level of newspaper circulation – a measure of the level of information among the citizens is associated with more corruption (Andrea, Boix, & Payne, 2003), poor rule of law, low bureaucratic quality, and low secondary school enrollment (Keefer 2003b).Newspapers in Barbados enjoy high circulation and readership rates. The Barbados Advocate weekend edition has a circulation of 25000 copies and an estimated 75000 readers – approximately 25% of the entire population of the island[13]. The use of the Internet on the island has increased dramatically in the last decade and in 2007 about 95 out of a 100 people were estimated to be using it (see Figure 3). For comparison, the global average was 28 people and the estimate for Trinidad and Tobago was 16 people (World Development Indicators).

[13] The weekend edition. Source: The Barbados Advocate www.barbadosadvocate.com

Figure 3.3.: Internet Users per 100 People in Barbados, 1995-2007.



Source: World Bank, World Development Indicators

The key informants also pointed to the high level of education as an important factors affecting the degree to which the citizens were informed about the governmental policies: "The population is educated. Virtually everybody here has secondary education. This makes Barbados manageable. It makes implementation easier..." (personal interview). Key informant interviews I conducted in Barbados suggested that Barbadians not only have access to information but also follow politics closely.

"I think Barbados has a political culture where the level of engagement in politics is much higher than what I have seen in many other countries. The level of knowledge of

government's agenda and policy in an average person is quite high" (personal interview; B12).

"I would say that an average Barbadian on the street is much more aware that the average American. Politics is much closer to home" (personal interview;B27).

" I think that people do follow politics, mostly economic and salacious things like who slept with whom. But I think they are interested. We are right in between elections, two years into the new government and two years before new elections, but when you read newspapers, it looks like the elections are tomorrow"(personal interview;B4).

The career politicians I interviewed shared this perception of high level of information among the electorate. They also believed that the voters read the manifestos and were well informed about what each party proposed policy-wise if elected.

"The manifesto is a very important document here. Very important. People go through it with a fine-toothed comb and it's referred to constantly"(personal interview;B12 see also B6; B4; B37)

I have argued that easy access to information facilitates political accountability as citizens can follow closely the performance of the elected officials. Focus group participants confirmed that they followed politics in the media and read party manifestos and platforms published before the elections.

Both the key informants and the focus group participants also pointed to the popularity of radio and television call-in shows which focus on political issues of the day.

"The fact that the nation has circulation of 20-30,000 copies suggests that the public is well informed and has a high level engagement. And the call-in programs are very popular and they focus on government program and policies" (personal interview;B12).

Key informant interviews as well as focus groups suggested that Barbadian are particularly interested in the issues concerning the economy.

"I also think that on the intellectual level, people are not really interested in the more "meaty" policy issues. They tend to focus on economic issues" (personal interview;B12, see also B31, B18; B37).

This is particularly important given that, as I argue below, AIDS in Barbados, and in the Caribbean as a whole, was framed as an economic issues affecting the region's human resources and threatening to reverse the developmental gains of the previous four decades.

3.4. Theoretical expectations:

Above, I have argued that the level of electoral market imperfections in Barbados is low: high-quality information about politics and policy is available through traditional and electronic media and Barbadians follow politics closely. Barbados is an ethnically

homogenous society and the ethnic conflict that characterized electoral politics in the early 20th century all but disappeared with the introduction of universal suffrage. Finally, the party system in Barbados is remarkably stable and the two main parties have been contesting elections since the 1950s, well before the country's independence. In-depth interviews with key informants and focus group discussion with UWI students have confirmed that the level of trust in the government and the political system as a whole is high. Therefore, we should expect that the demand-supply mechanism of the electoral marketplace occurred in Barbados without disruptions.

In the analysis of AIDS policy in Barbados in this chapter and the policy in Trinidad and Tobago in the following one, I will focus primarily on the shifts that occurred in the early 2000s. In this period, the national response was expanded from the health sector and included other governmental agencies, civil society, international organizations, and even the private sector. The funding available for AIDS-related programs increased dramatically. Finally, free and universal access to antiretroviral therapy was introduced. The policy changes in that period were the most radical and most closely resemble a true "critical policy juncture". Thus, focusing on this policy juncture should make the causal factors behind policy changes easier to discern.

As I suggested in the first section of this chapter, the reforms which constituted the "policy juncture" were adopted and implemented to a greater extent and more successfully in Barbados than in Trinidad and Tobago. In the following section of this chapter I will use process tracing to outline whether and to what extent the political process described in the theoretical chapter was operative in the shaping the Barbadian HIV/AIDS policy. Specifically, I will examine whether politicians were responding to

policy demand and that that they met those policy demand because the democratic process was unhindered by the imperfections in electoral markets.

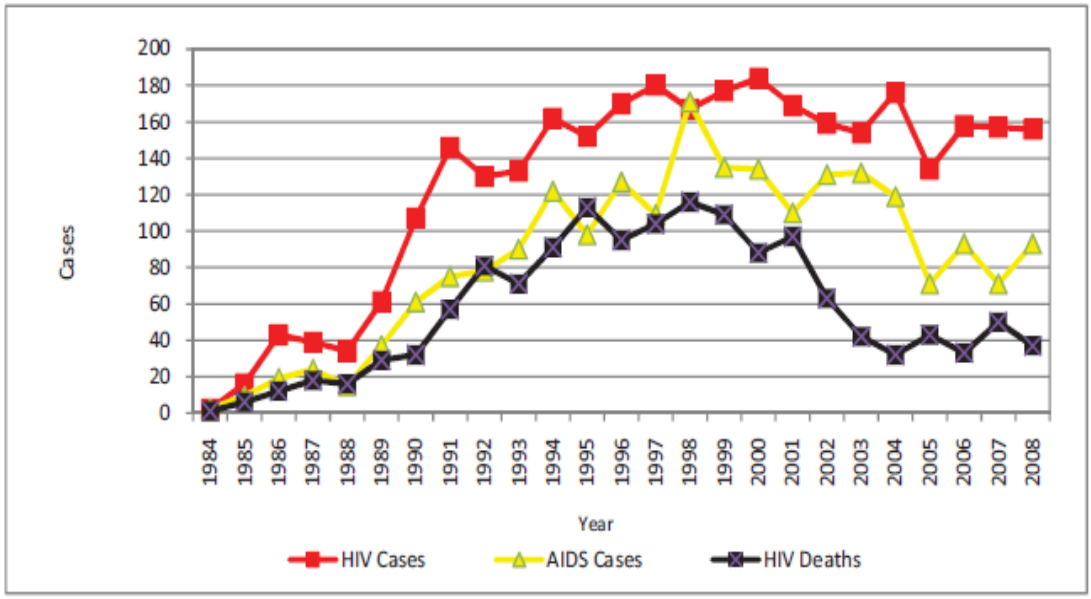
4. AIDS policy in Barbados:

In 1984, a surgical resident at the Queen Elizabeth Hospital (QEH) admitted to the emergency room a man who was diagnosed with a brain hemorrhage reportedly resulting from a fall. The man was taken to the operating theater for craniotomy but when his skull was drilled, no blood was found. The puzzling case was presented the next morning to the professor of surgery and the dean of the Medical School at the University of the West Indies, Professor E.R. "Mickey" Walrond. Reviewing the man's medical history, Walrond noticed that he had been admitted do the emergency room several times before, complaining of several different medical problems. The day before the man came to the emergency room at the QEH complaining of severe headache, but was sent back home. Walrond recalled: "In his history I noticed that the doctors asserted that he was a homosexual and that was one of the reasons why he was ignored and sent home quite often" (personal interview). Based on the man's medical history, Walrond diagnosed the patient with encephalitis and suggested that it was a complication resulting from the newly-discovered immunodeficiency syndrome. The man died shortly afterwards. It was the first diagnosed AIDS death on the island.

Even though AIDS in Barbados was first discovered in men who had sex with men, very soon the percentage of new HIV cases attributed to heterosexual contact exceed that attributed to same sex sex, and in the early 1990s, AIDS became the leading cause of death in the age group of 15-49 years old. By the end of 2008, 1436 people had

died of AIDS and the cumulative total of HIV cases was 3166. The HIV prevalence in the general population was estimated at 1.9% (Government of Barbados, 2010) (See Figure 3.4.).

Figure 3.4.: Summary Profile of Reported AIDS and HIV cases, 1984-2008.



Source: Government of Barbados, 2010. Country Progress Report 2010

Since 1984, the way AIDS in Barbados was dealt with clinically, and, more importantly, for the purposes of this project, policy-wise has undergone several major changes. The history of the response to AIDS on the island can be divided into three stages. The first stage was rooted in the "medical model" driven primarily by the health sector. It focused on the public education, setting up the basic clinical care infrastructure for dealing with the disease and on providing care for AIDS patients. The second stage, roughly between 1995 and 2001 was an extended transition between the "medical model" and a "multi-sectoral approach". The focus of the response remained the same as in the previous period, with one important exception - in 1996 the prevention of mother-to-child

transmission program was launched in Barbados. At the same time, however, the policy-making process became more inclusive of stakeholders from outside of the health sector. The third stage constituted a critical juncture in the HIV/AIDS policy trajectory on the island This stage, which began roughly in 2000-2001 was truly multi-sectoral, with formal linkages established between the National HIV/AIDS Commission, located in the office of the Prime Minster and other line ministries. The funding available increased dramatically and so did the scope of the response. In 2001 Barbados was the first country ever to receive a loan from the World Bank to finance its anti-retroviral therapy program and in early 2002 anti-retroviral drugs became available free of charge to all HIV positive Barbadians. Table 4 illustrates the three policy stages.

Table 3.4.: Historical Evolution of the Barbadian HIV/AIDS Policy: 1984-2009.

	"Before"			"After"
Policy period	***Medical model***	***Transitional period***		***Multisectoral response***
Dates	1984-1993	1993-2000		2001-present
Institutions				
Coordinating body	1985 - AIDS Control Program within the Ministry of Health 1987 -National Advisory Committee on AIDS (NACA) within the Ministry of Health	1993- expanded National Advisory Committee on AIDS (NACA) within the Ministry of Health		2001 - National HIV/AIDS Commission (NHAC) in the Prime Minister's office
Sectors involved	Health	Health , Education, Media, FBOs		Health, Education, Tourism, Labor, Housing, Social Development, private sector, civil society (NGOs, FBOs), media, international partners.
Types of inter-sector linkages	None	semi-formal	**Critical policy juncture**	formalized; line item dedicated to AIDS in every line ministry, full time HIV/AIDS coordinators in 5 ministries; line ministries, civil society (NGOs, FBOs) the private sector, international partners are included in the NHAC.
Policy documents	Medium-term Plan			National HIV/AIDS Policy; National Strategic Plan; National M&E Framework; Public Sector Code of Practice; Social Partners' Code of Practice.
Spending				
	No data	USD 175,000 (1998 NACA budget).		Government financial commitment: USD 3.41 million (2001); USD 11.08 million (2008) World Bank loan USD 15 million (2001); World Bank loan USD 31 million (2008);
Services				
ART	Not available	Available only privately		Universal and free access introduced in 2001; LRU opened in 2002
PMTCT	Not available	Introduced in 1996		Continued

The goal of the following section is to capture the causal process underlying the shift from the medical- and the mixed, transitional model (the "before" in the chronology of the policy evolution) to the truly multi-sectoral approach (the "after in the chronology). Specifically, I will establish whether democracy, low level of electoral market imperfections, and improvements of AIDS policy are causally connected or not. In what follows, I outline the evolution of AIDS policy in Barbados until 2000-2001, describe the shift toward multisectorality, and examine how electoral market imperfections affected policy-making at that policy juncture.

4.1. 1984-1996 - the Medical model:

The initial official response to AIDS in Barbados was characterized by two features. First, it was based solely within the health sector, most notably the Ministry of Health and the Queen Elizabeth Hospital. Second, it focused on public education, care and support for AIDS patients, and clinical management of the opportunistic infections.

In this initial period patients were typically diagnosed based on clinical manifestations of AIDS and died within the first 2 or 3 years after the diagnosis. Walrond recalled the way the medical staff reacted to his suggestion that the patient with encephalitis that was admitted to the QEH might have AIDS: "It was an interesting reaction; you have to see the color when a black person blanches..." Medical staff I interviewed who worked at the QEH in the 1980s noted that stigma against AIDS patients was wide-spread. Like in other countries in the region, medical staff were afraid to treat patients who were or were suspected to be HIV- positive. According to one respondent: "You had a situation when nurses would refuse to the care for patients, orderlies refusing

to transport the patients" (personal interview). One physician remembered having to conduct lengthy negotiations with the OBGYN at the hospital to convince him and his staff to help deliver the baby of a woman who was suspected of having HIV. Thus, in addition to public education aimed at the general population, the initial response to HIV/AIDS in Barbados also focused on educating the medical professions.

In 1985, the AIDS Control Program was set up with the Ministry of Health under Minster Bradford Tatt. Roughly at the same time (1985-6) the Barbados Association of Medical Practitioners set up an AIDS task force whose goal was to educate the medical profession and the general public about the disease.

In 1987, the National Advisory Committee on AIDS was created within the Ministry of Health to advise the ministry and the government of Barbados on policy and management of AIDS on the island. NACA chartered the first comprehensive AIDS policy in Barbados and developed the first medium-term plan for combating the disease (Sun, 1995, "Jacobs will take fight to the people. New NACA head planning big education drive"). The priorities outlined in the plan included rolling out testing, public education, and improving patient care at the QEH.

NACA also developed an AIDS education curriculum for schools which was submitted to the Ministry of Education but was never fully implemented due, in large part, to the opposition from teachers who objected to talking to children about sex (*personal interview;B10*). In addition, surveys of knowledge, attitudes, believes and practices (KABP) we carried out among Barbadian youth. In 1990, the AIDS hotline opened.

There were also improvements in clinical care of AIDS patients. Based on a situation assessment report prepared by the NACA, in 1989 the AIDS Management Team

was set up at the Queen Elizabeth Hospital. The Team was multi-disciplinary and consisted of two physicians, a number of nurses, a psychologist, a dietitian, and a health education officer. The primary task of the team was to provide care to AIDS patients at the QEH. The team also established a counseling clinic - an outpatient facility for clinical management of HIV/AIDS. The secondary goal of the team was to educate the QEH staff, increase their awareness of AIDS and provide information about clinical manifestations and modes of transmission of HIV. One of the team members noted that thanks to the team's outreach to the hospital staff Barbados avoided situations like that in Guyana, where nurses reportedly walked out of the hospital or in Antigua, where crowds were throwing stones at the hospital building were AIDS patients were located (personal interview). In the same year, the Respiratory Unit opened at the QEH which housed the AIDS patients (pneumocystis carinii penumonia (PCP) was the most common opportunistic infection associated with AIDS).

4.2. Transitional period: 1995-2000

In 1993 professor Walrond stepped down as the chairman of NACA and the Committee went on a three year long hiatus until 1995 when it reconstituted itself under a new leadership.

In some respects, this period was a continuation of the policy trajectory established in the 1980s, which focused on public education and support and care for HIV patients.

The new NACA carried out several education and information campaigns (EIC) targeting youth and elementary school children (e.g. Barbados Advocate 5 April 1997 "AIDS Education Initiative"). For example, in November 1995 the NACA together with

Barbados Advocate launched a campaign "You, Me, and HIV" and distributed some 15,000 pamphlets throughout the island (Barbados Advocate, 22 November 1995 "Pamphlet on AIDS for students"). It also carried out EICs targeting the general public and several HIV testing drives (e.g. Nation, 8 April 1997, "Testing time at health fair").

In 1995 a full time position of a medical social worker responsible for AIDS was created. In the same year, the Elroy Phillips Center opened (Sun, 12 February 1995 "AIDS hospice by March"). The center was established as a place for AIDS patients who did not require hospitalization, but were rejected by their families and had nowhere else to go.

NACA's initial budget was very small (BDS 100,000) and only covered the salaries of the Committee's permanent staff. By 1998 it had tripled (BDS 350,000). However, some BDS 250,000 was still spent on salaries of the expanding staff and only BDS 100,000 on programmatic activities.

While there were no significant change in the mandate of the Committee, which focused on public education, care and support for people living with HIV/AIDS, and HIV surveillance, its membership and thus he scope of the national response to AIDS was extended beyond the health sector. The newly-reconstituted NACA included representatives from sectors outside of heath. In addition to Dr. Carol Jacobs, who chaired the Committee, the director of the AIDS Management Team, Dr. Timothy Roach, and the Chief Medical Officer Dr. Beverly Miller, the Committee also included Alies Jordan - representative of the Ministry of Education, Karin Dear - a journalist and the representative of the media, Rev. James Grear - , G.H. Andrew Brewster - ; and at large member and community representative Diane Edghill (Ministry of Health, 7 March

1995). In this respect, NACA's membership signaled a departure from the early "medical model" towards a more comprehensive response. However, the Committee remained located within the Ministry of Health.

This more inclusionary approach to HIV/AIDS policy making and management reflected a global shift in the understanding of what a successful response to the epidemic should look like. In 1996, the WHO Global Program on AIDS we replaced by the UN Joint Program on AIDS (UNAIDS), an independent agency which no longer was part of the WHO. This was a clear signal that the "medical model" was no longer considered adequate in handling the epidemic and that a more comprehensive approach was necessary.

Another change in the response to AIDS in that period was the introduction of AZT for the prevention of mother-to-child transmission of HIV. It was the first time that anti-retroviral drugs were being provided free of charge on the island, albeit for prevention rather than for treatment purposes. A number of factors influenced the Ministry of Health's decision to provide AZT to HIV positive pregnant women. First, in 1995 clinical studies demonstrated the effectiveness of a long-course [check this] Zidovoudine (AZT) in reducing the incidence of infection in infants born to HIV positive mothers. Based on this medical breakthrough, clinicians involved in AIDS care, in particular the AIDS Management Team pressured the Ministry of Health to launch a PMTCT program in Barbados. In-depth interviews I conducted in Barbados also suggested that PMTCT was considered economically necessary. One respondent suggested that not having a PMTCT program was considered to be too much of a financial burden in the future. "[In the absence of a PMTCT program] AIDS would have

been economically unmanageable." Some of the key informants suggested that, in addition to the economic rationale, the provision of PMTCT was also politically motivated: "the government had changed and the Ministry of Health wanted to show they were doing something different."

4.3. 2000 and after: Multisectoral response.

In the early 2000s a number of important changes took place that re-defined the way Barbados responded to HIV/AIDS. First, the response was extended beyond the health sector, and the semi-formal linkages between health and other sectors established in the 1990s were formalized. Second, the institutional and policy environment was brought in line with the recommendations of the international organizations, in particular the UNAIDS (and the World Bank) with the establishment of one multi-sectoral coordinating agency reporting directly to the Prime Minister, and the adoption of a National Strategic Plan and a National Monitoring and Evaluation Framework. Third, the funding for the fight against AIDS increased exponentially. Finally, the introduction of free and universal access to anti-retroviral therapy (ART) for all Barbadians in need of treatment was a fundamental breakthrough in the clinical management of HIV on the island.

This policy change was caused by an increasing demand and pressures on the Barbadian government to expand its response to the epidemic. However, the source of this demand is somewhat inconsistent with the theoretical framework outlined in the preceding chapters. The "democratic marketplace" theory assumes that social policy is a normal good and that there is always a demand for more services and better policy.

However, the general public was generally apathetic about AIDS and the majority of the key informants, including professional pollsters, said that it had never been part of electoral platforms or electoral considerations. Similarly, there were no bottom up pressures for policy change coming from civil society organizations and groups representing those infected and affected by HIV.

In general, key informants agreed that Barbados does not have a strong tradition of community-level mobilization and that "Barbadian political culture in terms of advocacy is very weak" (personal interview). One respondent noted that "Bajans are not culturally into NGOs". To date, there are only three civil society organizations (CSOs) who focus specifically on HIV/AIDS: CARE Barbados - support group for people living with HIV/AIDS, United Gays and Lesbians Against AIDS Barbados (UGLAAB), and AIDS Society of Barbados - a support organizations targeting mostly orphans and vulnerable children. The civil society groups formed around HIV/AIDS were described to me on several occasions as "fledgling" even though CARE Barbados and ASOB had been in existence for over a decade. In particular, key informants noted that both CARE Barbados and UGLAAB had very limited human capital, financial resources and membership base. AIDS-related stigma, wide-spread homophobia, and the chronic issues related to confidentiality resulting from the small size of the country, made joining those organizations very difficult for middle class Barbadians. Thus, the membership of both organizations consists reportedly from people coming from lower socio-economic strata of the society with limited experience in political mobilization.

In addition, the engagement between the CSOs and the government is based on accommodation rather than confrontation. In fact, CARE and UGLAAB are dependent

on the government: both are housed in the building of the National AIDS Program and both receive a subsidy from the NHAC. As one responded put it "we created dependency rather than empowerment [of CSOs]". All three organizations have focused on service provision rather than political advocacy. One government official noted "I don't think they [CSOs] champion the cause and put AIDS at the front burner. Not because of the lack of commitment, but because this is not how CSO operate in our island."

Instead, the demand for policy change came from two other sources: the technocrats and medical professionals engaged in HIV/AIDS work and from international institutions, most notably UNAIDS and the World Bank.

In 2000 the World Bank produced a report entitled "HIV/AIDS in the Caribbean: Issues and Options" (World Bank, June 2000, "red cover" published in March 2001). It was presented to Prime Ministers, Ministers of Finance, and "other key decision-makers" from the members of the Caribbean Group on Cooperation in Economic Development (Marquez, 2004 p. 2). The report outlined the challenges in responding to AIDS in the regional and compared national policies and strategies of dealing with the epidemic. More importantly, it also included the Bank's proposal to finance AIDS programs in individual countries. In the same year the government of Japan offered grants to developing countries to support the preparation of strategic plans to respond to AIDS (personal interviews; B41, B27; Marquez, 2004).

It needs to be emphasized that the pressures from the World Bank and UNAIDS were not uniquely targeting Barbados. Rather, all countries in the region, and worldwide were exposed to the same incentives and pressures to reform the way they responded to AIDS. The World Bank aid for Barbados was part of the Multi-Country HIV/AIDS

Prevention Adaptable Program Loan (APL) for the Caribbean and the program was open to all countries in the region (Marquez, 2004). The Dominican Republic received its first loan in 2001 - the same year Barbados did. Loans for Jamaica and Grenada were approved the following year (Marques, 2004). What distinguished Barbados from other countries in the Caribbean, and, in the context of this analysis, from Trinidad and Tobago, was that the Barbadian government was particularly willing to responded to those pressures and incentives. Barbados very quickly seized this new opportunity to the extent that its Prime Minister Owen Arthur was considered by the World Bank to be "a "champion" of the regional initiative" (Marquez, 2004 p. 2). Thus, the central question of the qualitative portion of this project remains: why was Barbados the first country in the Caribbean to partake in the World Bank program while Trinidad and Tobago, the regional powerhouse, was one of the last countries to join the bandwagon?

The growing international pressures and increasing incentives to expand and improve the responses to HIV/AIDS in the developing countries was grounded in the re-framing of the global discourse on AIDS. In particular, since mid 1990s, AIDS started being considered in the context economic growth and development (see e.g. Pisani, 2008). Experts were describing the disease as the single largest threat to growth and development, particularly in the poor countries in the global South. This discourse was also adopted by the media in Barbados, where AIDS was linked in the public discourse to the issues of economic performance and development.

Given the disease's social context, HIV/AIDS has been covered in surprising detail in Barbadian press. A 2001 national survey of youth showed that over 60% of the respondents obtained information about AIDS from printed media (Ministry of

Education, Youth Affairs, and Sport, 2001). The early discourse on AIDS in Barbados presented it as the disease of sexual perverts, homosexuals, and prostitutes (Howe, 2000). However, already in the early 1990s the public discourse, and presumably, the public perceptions of AIDS have changed. The disease was framed as "heterosexual" and thus able to affect anyone on the island. The media paid a particular attention to new infections in women and babies and presented the epidemic as "feminized" and "affecting predominantly women" often despite contrary epidemiological evidence (Kakietek, 2010). Consequently, responding to AIDS was framed by the media as an economic and developmental necessity. Epidemiological data suggested that AIDS was concentrated in the 15-49 years old age group. Therefore, it was argued that it affected the most productive segment of the population.

"Fifty per cent of the people who are dying from AIDS are form among the working population and these are between 20 and 44. It is having a significant impact on our ability to meet our objectives as individual business and as a country."; Bushel told business executives that drastic action had to be taken as HIV/AIDS will have a direct affect [sic] *on business (Nation, 21 August 2001 "BEC head calls for HIV/AIDS policy").*

The media often pointed to the havoc AIDS wreaked in sub-Saharan Africa and argued that similar situation could develop in Barbados.

"We have systematically underestimated the impact of AIDS on the economy." said Moatti, a professor of economics at the University of Marseille in France. "It doesn't just

kill workers, it kills young adults and young adults make children and raise children - human capital."; Moatti reported that and upcoming World Bank study found that by that calculation, there will be an economic collapse in South Africa within four generations if nothing is done to treat HIV. "South Africa will be taken back to the level of development of Kenya. It's GDP (gross domestic product) will be divided by two" (Barbados Advocate, 14 July 2003 " Experts: HIV treatment makes economic sense").

The press pointed that the spread of AIDS would result in the depletion of human resources on the island and lead to an economic decline.

"AIDS epidemic, if left unbridled, would affect the productivity of all businesses. "Quite apart from the human angle, it has developmental and economic consequences for the entire country" Jacobs stressed" (Nation, 9 May 1996 "Money needed for the fight").

"HIV/AIDS is not merely a growing health problem. It is also a social and labour issue, which impacts on workers and their families, enterprises and national economies" (Nation, 10 February 2003 "Thumbs up for Prot Authority HIV/AIDS project").

This perception was shared by virtually all of the key informants I have interviewed.

In the mid 1990s, those arguments found support in a series of economic impact studies that were carried out by the Health Economic Unit at the University of the West Indies, St. Augustine, in Trinidad and Tobago and modeled the effects of the epidemic on the West Indian economies. The Barbados study was carried out by Sara Adamakoh and

distributed across the island in 2001. The HEU studies projected significant decreases in the rate of growth and GDP if AIDS was not dealt with.

While the assumptions of the economic models and internal logic of the media discourse can be questioned, their ubiquity cannot. AIDS in Barbados and in the Caribbean in general has been framed not as a diseases affecting only a limited segment of the society but as "everybody's problem". This understanding of AIDS was internalized at the highest levels of political leadership. Averting an economic and developmental disaster was mentioned as the key rationale behind the expanded national response to AIDS by the prime minister and several cabinet members:

"Our problem was particularly severe because it [AIDS] was concentrated among the most productive part of our society, our young people. It showed that it wasn't a matter of high-risk sections of the society or of homosexuals but it had become a problem, which had infiltrated the entire general population" (Prime Minster Owen Arthur in an interview for the Sun; "All out fight against AIDS" Sun, 1 July 2001).

"We see this [AIDS] as the greatest threat to human security of the ordinary Barbadian man and Barbadian woman" (Prime Minster Owen Arthur in an interview for the Sun; "All out fight against AIDS" Sun, 1 July 2001).

"If Barbados starts to fall in the Human Development Index it will be because of that factor [the prevalence of HIV/AIDS]*" (Minister of Commerce, Consumer Affairs and Business Development Lynette Eastmond at the Caribbean Business to Business*

Conference; "Eastmond throws out question: Matter of personal choice", Nation, 14 November 2005).

"Health Minister Senator Phillip Goddard addressed the HIV/AIDS pandemic and the private-sector response and cautioned that a failure by business leaders to deal with the ADIS crisis, which now affects 360 000 throughout the Caribbean could impact severely on the livelihood of business in Barbados" (Barbados Advocate, 31 March 2001 "AIDS group coming").

Thus, I argue, the disease was included under the umbrella of economic policy, which was very much at the forefront of the political and electoral agenda. While the disease has not been an explicit part of electoral manifestos, development and economic growth have.

Politicians with whom I have spoken were very much aware of the fact that the public was well informed about their performance with respect to the economy and social policy. I have argued that the high degree of information available to the citizens created incentives for politicians to produce policies fostering growth. Responding to HIV/AIDS was part of this policy agenda. They had also internalized and believed in the argument that, if not addressed properly, the epidemic will have disastrous consequences for the nation's economy.

It is possible to imagine that the framing of the disease in economic terms was done post hoc by the political elites to justify a policy reform that was undertaken for some other reasons. That is, that the politicians decided they wanted to do something about AIDS and its consequences - whether the population wanted it or not, and the

framing of the issue as one of economic development was just a way of "justifying" their effort to the population.

However, there are three reasons why such a scenario seems unlikely. First, the discourse linking AIDS and development was global, and not constructed locally in Barbados (see e.g. Pisani, 2008). Second, the arguments that the epidemic would have a negative impact on the economy were being raised in Barbadian press already in the mid 1990s, well before the government's decision to expand the response to ADIS. Those arguments reached a critical mass when they were embraced by the international financial organizations, most notably the World Bank. This is also when and how they gained political currency. Last but not least, the key decision makers I have interviewed never indicated that they made a conscious effort to promote the perception of AIDS as an economic problem to rationalize in the eyes of the domestic audiences the decision to scale up the policy response they had made for other reasons.

To sum up, even though there was no explicit demand from the population and bottom up pressures to scale up the response to AIDS, politicians perceived it as an economic necessity. Not responding to AIDS would amount to economic mismanagement which would have very clear negative electoral consequences.

Consistent with the theoretical expectations, one important implication of the high level of information and the faith in electoral promises and the expectation that they will be fulfilled was an increased sense of accountability in both the voters and the politicians. As one respondent noted: "There is also very strong pride in the Barbadian population that things work here. The quality of life is as high as it is because of the high level of

public engagement and I think people would not allow the government to provide lower standards."

Institutions and policy environment:

The new institutional and policy environment was created to reflect the recommendations of the UNAIDS and the requirements of the World Banka and other international funding agencies. In 2001, in accordance with the "three ones" principle. Barbados set up the National HIV/AIDS Commission - a multi-sectoral coordinating body that would manage the national response to AIDS. In turn, NHAC developed the National Strategic Plan, the National AIDS Policy, and the National Monitoring and Evaluation Plan. NHAC has organized national consultations to secure support and for the new national AIDS policy. The consultations brought together a wide array of stakeholder from the public sector, civil society, labor unions, employers and the private sectors, and international partners (Marques, 2004). The Commission has also provided technical assistance to HIV/AIDS coordinating bodies in other Caribbean countries (Marques, 2004).

The mandate of the Commission was to set the national policy on HIV and AIDS and to coordinate the implementation of AIDS-related programs across different ministries, civil society organization, international partners, and the private sector. Unlike its predecessor, the NACA, which was located within the Ministry of Health, the Commission was placed in the Office of the Prime Minster[14].

[14] Recently, following the change in the government, it was moved to the Ministry of Family, Youth Affairs, and Sports.

The initial composition of the NHAC reflected its multisectoral character. In addition to the chairman, Dr. Carol Jacobs, the board of directors included the director of the AIDS Management Team, a representative of PLWHA, representative of the Congress of Trade Unions, representative of the Barbados Registered Nurses Association, private sector representative, representatives of the Barbados Christian Council and the Barbados Evangelical Association, youth representative, and representatives of non-governmental organizations, "as well as two members, Diana Edghill and Richard Carter, who were appointed in their own right (Barbados Advocate 17 June 2001 "Body to implement AIDS programme").

The links between the NHAC and the line ministries were strengthened and formalized. The Owen Arthur administration required that all ministries had in their budgets a line item specifically dedicated to AIDS (line item no. 415). At present, five ministries (Ministry of Labor, Ministry of Tourism, Ministry of Social Care, Ministry of Education, Ministry of Family, Youth Affairs, and Sports, Ministry of Housing) have full time HIV/AIDS coordinators.

The line ministries became much more involved in programmatic activities. For example, the Ministry of Labor, where the HIV/AIDS program was established early in 2001, has implemented a number of programs aimed at reducing stigma and discrimination in the workplace and at educating the workforce about the disease. In addition, the ministry staff worked on developing two important policy documents pertaining to HIV/AIDS in the workplace: Social Partners' Code of Practice (SPCoP) and the Public Sector Code of Practice (PSCoP) on HIV/AIDS. The Social Partners' CoP, adopted in 2002, is a set of guidelines for the employers in the private sector addressing a

broad range of issues of AIDS in the workplace (Nation, 24 October 2003 "Code on rights of workers with HIV/AIDS"). The Public Sector CoP, launched in 2009, is a policy for dealing with HIV and AIDS in the public sector specifically. Unlike the Social Partners' CoP it is also binding for all the governmental agencies (*personal interview;B4; B23)*.

The Ministry of Tourism was another ministry where an AIDS program was established early on. Activities of the Ministry have targeted both tourists and the tourist industry. One of the early programs carried out by the Ministry was the distribution of "intimacy kits", which included condoms, lubricants, and towelettes and were placed in rooms in different hotels in Barbados. The Ministry also put up billboards, particularly during the 2006 cricket World Cup, and sponsored AIDS education and awareness messages on the Visitor's Channel. Programs targeting the tourist industry (hotels, restaurants, tourist attractions) included informal education of staff on-site, and training of peer educators in formal settings, such as workshop and seminars. In terms of prevention, massive education and information campaigns (EICs) directed at the general population have produced significant increases in knowledge about the disease and its modes of transmission (Ministry of Education, Youth Affairs, and Sports, 2001; 2004, 2006). The percentage of youth knowing that abstaining from sex can prevent HIV transmission increased from 17.7% in 2001 to 92.7% in 2006; the percentage of youth who were aware that being faithful to one partner and using a condom prevents HIV infection rose from 30.6% and 46.8% in 2001 to 93.2% and 93.7% in 2006, respectively (see Table 5).

Table 3.5.: Percentage of Youth Correctly Identifying HIV/AIDS Prevention Methods, 2001-2006.

	2001 (15-29yos)	2003/2004 (10-18yos)	2005/2006 (15-24yos)
Abstinence	17.1%	82.1%	92.7%
Being faithful to one partner	30.6%	77.8%	93.2%
Condom use	46.8%	87.3%	93.7%

Source: Ministry of Education, Youth Affairs, and Sports, 2001; 2004, 2006

In addition, HIV/AIDS research and education curriculum were established on the Barbadian Cave Hill Campus of the University of the West Indies. The University of the West Indies HIV/AIDS Response Program (UWIHARP) offers courses on peer education in response to HIV and AIDS, peer education training and activities for students and faculty members.

Spending:

In 2001 Barbados received a UDS 15 million loan from the World Bank to help cover the expenses related to the expanded response to HIV/AIDS. The loan had no global precedent for two reasons. Firstly, Barbados graduated from the World Bank program in 1993, which technically made it ineligible for any future assistance from the Bank. Secondly, it was understood that most of the loan would cover the cost of providing fee and universal access to ART on the island. In the past, the World Bank had been providing funding to strengthen health infrastructure, but never to finance specific health programs or services (Marquez, 2004).

In the interviews I conducted with the World Bank staff, they acknowledged the unprecedented character of the loan. In fact, Barbados was the first country to receive World Bank funds to cover its ART program. In addition to a very well developed health infrastructure, the Bank staff pointed to the dedication and leadership in the fight against AIDS at the highest levels of the government, including Prime Minister Owen Arthur as the motivating factors behind the loan.

In 2001, the Arthur administration committed to providing BDS 50 million (USD 25 million) to fights against AIDS over the next five years. This included both the World Bank loan (BDS 30 million; USD 15 million) and domestic resources (BDS 20 million; US 10 million). This constituted a twenty-fold increase compared to the funds the National AIDS Program had at its disposal in the 1990s ("Money needed for the fight. Appeal to businesses to help battle AIDS", Nation 9 May 1996). In 2003, Barbados spend some USD 4.2 million from domestic public sources on fighting AIDS. In 2004 and 2005 it spent USD4.6 million and USD3.3 million, respectively (UNAIDS, 2006. 2006 Report on the Global State of the Epidemic). In 2008 Barbados secured a second loan from the World Bank for USD 31 million to help cover the expenses related to the implementation of the new National Strategic Plan adopted in 2009.

Table 3.6.: Domestic Spending on AIDS, 2001-2009 (USD millions).

	Financial year (April-March)							
	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
Government financial commitment for HIV								
Total	3.41	3.44	3.83	4.75	6.36	6.51	5.24	11.08
Prevention	0.06	0.32	0.44	0.45	0.75	0.56	1.91	4.16
Treatment	1.73	1.35	1.48	2.10	2.95	3.26	2.06	4.51

Source: Government of Barbados, 2010

Access to treatment - ART and PMTCT

The results of the quantitative analyses presented in the previous chapter showed that electoral market imperfections mediate the impact of democracy on the provision of PMTCT and ART. Specifically, Barbados, where the level of the imperfections is low, should have higher coverage of ART and PMTCT than Trinidad and Tobago, where the level of the imperfections is high. This is in fact the case. In 2008 in Barbados, more than 85% of people with advanced HIV infection (including 100% of infected children) were receiving ART (Government of Barbados, 2008). In the same year, the ART coverage in Trinidad and Tobago was only 49% (Government of Trinidad and Tobago, 2008).

The Barbadian PMTCT program launched in 1996, is now considered to be state-of-the-art and comparable to programs implemented in industrialized nations in Europe and North America. Results of a study conducted between 2002 and 2006 showed a reduction in HIV transmission rate from mother to child from 27.1% to 2.5% (Policy Document on the Prevention of Mother-to-Child Transmission of HIV in Barbados, 2009; St. John et al. 2006). In 2008, over 91% of pregnant HIV positive women were receiving

PMTCT prophylaxis (see Table 2 above).The two significant changes in the PMTCT program following the expansion of the national response to AIDS in 2000-2001 was the adoption of the National Policy on the Prevention of Mother-to-Child Transmission, which codified the extant medical practice (Policy Document on the Prevention of Mother-to-Child Transmission of HIV in Barbados, 2009), and the introduction in 2008 a new testing protocol, where pregnant women were tested for HIV twice, during the first and the third trimester.

The introduction of anti-retroviral treatment free of charge to all Barbadians (and in some instances to nationals of other islands) was undoubtedly the most significant departure from the earlier policy course and the greatest achievement of the expanded response to HIV/AIDS in the 2000s. In 2001, Minister of Health Jerome Walcott "described the provision of highly-active anti-retroviral therapy as the most important component of the national HIV/AIDS project" (Nation 21 December 2001 "Walcott: AIDS target reachable").

The total cost of the treatment was estimated at about USD 14.3 million for the first seven years. The program was launched early in 2002. The uptake of ART was very good and by 2006, four years after the program was launched, over 80% of people in need of anti-retroviral therapy were receiving it (Government of Barbados, 2010). In 2009, over 87% of patients who met the clinical criteria for treatment were receiving ART in Barbados (see Table 7).

Table 3.7.: Percentage of HIV -Positive People in Need of ART Who Are Receiving ART and Percentage of HIV Positive Pregnant Women Receiving Prevention of Mother-to-child Transmission (PMTCT) Prophylaxis, 2006-2009.

Year	ART coverage	PMTCT coverage
2006	84.4%	84.6%
2007	85.5%	90.9%
2008	87.6%	91.4%
2009	87.3%	-

Source: Government of Barbados, 2010.

Following the introduction of ART, clinical outcomes in HIV patients improved dramatically and AIDS mortality fell from 90 cases in 2001 to 60 in 2002 and 43 in 2003 (Barbados Ministry of Health, Government's Policy on HAART presentation). By 2006, AIDS mortality was reduced by 72% (World Bank, 2008).

ART in Barbados has been provided through the Ladymeade Reference Unit (LRU) - a specialized public HIV clinic, which was opened in April 2002. Initially, there were about 300 HIV patients registered at the LRU. By 2004, the number of registered patients grew to 520 (Marquez, 2004) and by 2009 - to 1400 (personal interviews with LRU staff). 85% of the LRU patients achieved treatment adherence rate greater than 95% (Marquez, 2004). Already in 2003, the number of hospital admissions of HIV positive patients decreased by 58 percent (from 316 to 183), total hospital days declined by 59.4 percent and the average length of hospital stay - by 30 percent (ibid). Finally, due to decreases in instances and the length of hospitalization, the costs of inpatient care in patients receiving ART dropped by 41%. (Marquez, 2004). In addition to treatment, clinical care, counseling, and nursing services, the LRU also provides a range of diagnostic and laboratory services including CD4, and CD8, and viral load counts not

only for Barbados but also for neighboring countries. In 2009 the Unit was preparing to start ART resistance testing (see World Bank, 2008).

In addition to the availability of the World Bank funding, the provision of ART free of charge was also made possible because the ministers of health in the Caribbean were able to negotiate with the pharmaceutical companies significantly reductions in the cost of drugs (e.g. Nation 21 May 2001 "Health ministers after cut in AIDS drugs cost"). Barbados played a major role in this process and the Barbadian Minster of Health Philip Goddard has been credited by several of the individuals I interviewed with leading the negotiations and successfully pressuring the companies to lower the prices (personal interviews).

As mentioned above, the quantitative analysis suggests that the provision of ART and PMTCT are the categories of outcomes where we should observe the difference between countries in which the level of the electoral market imperfections is low (e.g. Barbados) and countries in which it is high (e.g. Trinidad and Tobago).

The pressures to scale up the response to AIDS, including the introduction of treatment programs, came from international organizations and was facilitated by the decline in the drug prices. Importantly for this analysis, those pressures were global and the negotiations with the pharmaceutical companies in the Caribbean took place through the regional mechanisms of the Caribbean Economic Community (CARICOM). Thus, the pressures and incentives to launch treatment programs were the same for Barbados and Trinidad and Tobago.

ART was introduced in both Barbados and Trinidad and Tobago roughly at the same time: the LRU opened in 2002, the same year that the first cohort of patients started

receiving free ART in Trinidad and Tobago. What distinguishes the ART program in both countries was the coverage, that is, the number of people in need of ART they reach. As I mentioned above, in 2008 some 87% of people with advanced HIV infection were receiving ART in Barbados but only 49% in Trinidad and Tobago (Government of Barbados, 2008; Government of Trinidad and Tobago, 2008). The main impediment of the scaling up of ART in Trinidad and Tobago was that the distribution of drugs in that country was effectively privatized and channeled through a private organization - the Medical Research Foundation (MRF). The director of the MRF, who had strong ties to the ruling party - the PNM, has been effective in preventing, at least partially, the decentralization of treatment in Trinidad to other, public sites. In contrast, the ART in Barbados has, since the beginning, been delivered through public channels - the LRU. As I argue in the following chapter, the problems with the uptake of treatment in Trinidad resulted from the lack of accountability of the key decision makers, and a political culture of patronage, which, in turn, were a result from an unstable political and party system based on ethnic divisions, lack of faith in electoral promises, and low levels of interest and information about politics.

Consistent with the expectation derived from the theoretical framework, there is no evidence that consideration based on race/ethnicity affected AIDS policy making in Barbados. As I showed earlier in this chapter, following the introduction of universal suffrage, race no longer constituted an electoral cleavage. Consequently, there is no evidence that overt political pressures based on racial/ethnic considerations affected the development of AIDS policy on the island. One government official told me: "Everybody is equally susceptive to AIDS. This issue never arose" (personal interview).

Following the tradition of disengagement, the white minority did not seek to prevent the government from introducing policies such as universal and free access to ART even though they were benefiting mostly the black community. One of the key informants I interviewed noted: "The white minority is divorced from government. Their involvement in the discussion on the issues of social policy is very low. There is still some tensions but they only tend to play out in very narrow areas of access to property and economic issues" (personal interview).

Virtually all key informants I have interviewed noted that HIV/AIDS in Barbados should be thought of in terms of class rather than race. "Class is more important [than race]. A lot of people think that it's a problem of poor people"; " AIDS is more of a class issue" (personal interviews). They noted that most of the patients of the LRU were coming from lower socio-economic strata of the society and that, due to stigma associated with AIDS, wealthier HIV-positive Barbadians, both white and black, either accessed private health services on the island or sought treatment overseas, in the US, Canada, or the UK.

It needs to be noted that, like elsewhere in the Caribbean, in Barbados class and socio-economic status are closely associated with race. Because of this association, as Beckles and other authors point out (Beckles, 2004, 2006), even though race is not explicitly part of electoral politics, it may affect the electoral calculus indirectly. Thus, it is possible that race could affect AIDS policy making if the economic elites dominated by white Barbadians pressured the government not to scale up the program which was perceived to benefit mostly poor blacks.

This did not happen. It was the BLP, the party which is considered to be more supportive of the business interests than its political rival - the DLP, that became the champion of the AIDS cause in Barbados. The business community on the island never opposed the expansion of the National AIDS Program. In fact, the private sector has been a key partner in the expanded response. In 2001, AIDS Foundation of Barbados was established to improve the response to HIV/AIDS in the private sector and to represent it on the national AIDS fora. The Foundation's 2008 business plan states that "the AIDS Foundation of Barbados (AFBI) is a direct response to the local need for a single mechanism to coordinate the engagement of business and private sector stakeholders in a cohesive strategy for the management of HIV/AIDS in the workplace, both as a matter of corporate self interest and for the positive indirect impact on the society and the economy as a whole" (AIDS Foundation of Barbados, 2008, Business Plan for the AIDS Foundation of Barbados, p. i). The Foundation carries out sensitization training in private companies that target both the employees and the management (personal interview). It focuses its interventions on the private sector with the aim to "enhance the scope of HIV/AIDS activity in the areas of training, advocacy, voluntary counseling and testing, policy development and workplace programming, to actively engage in the reduction of stigma and discrimination among infected persons affected persons, and other members of society as to stymie the further spread of the disease and its effects" (AIDS Foundation of Barbados, 2008).

The involvement of the private sector shows that not only did the economic elites, and presumably, the predominantly white corporate interests on the island, not oppose the

scaling up of the AIDS response in Barbados, but rather it saw themselves as a critical partner in the process.

5. Summary:

The analysis of the Barbadian case confirm the research hypothesis that the low levels of electoral market imperfections lead to improvements in AIDS policy by increasing the sense of accountability in elected officials. As I have shown above, high level of information among the citizens and the faith and expectation that electoral promises will be met, strengthen the perception of accountability among the politicians. Because the Barbadian public was particularly sensitive to the issues pertaining to the economy and because the public discourse in Barbados and world-wide had linked AIDS to economic growth and development, political elites on the island were compelled to expand the national response, improve institutional infrastructure and provide services, including PMTCT and ART free of charge. At the same time, the demographics and the historical evolution of race-relations on the island rendered race, for all intents and purposes, irrelevant in the context of electoral politics. Therefore, loyalties based on race rather than policy performance, could not distort the electoral process and, consequently, did not affect HIV/AIDS policy making.

However, evidence form Barbados also calls for important refinements in the theoretical framework developed in the first chapter. First, I showed that the electorate did not demand changes in the policy. Rather, the impetus and pressures for policy change came from the technocrats and clinicians, as well as from international organizations, most importantly, UNAIDS and the World Bank. This suggests that health

policy is formulated in the absence of bottom-up pressures. Rather, it is based on the advice of domestic and international experts. It is then evaluated by domestic audiences in the elections. That is, in terms of the Policy Stages heuristic, domestic demand seems less relevant for agenda setting, and more relevant for policy adoption and implementation.

Furthermore, the preliminary comparison of the treatment program in Barbados and Trinidad and Tobago and the fact that both countries launched their ART program roughly at the same time but that the take-up of treatment was different suggest that the political market imperfections affect not policy adoption, but rather policy implementation. This is consistent with the results of the quantitative analysis presented in the previous chapter. The analysis showed that, at the low level of electoral market imperfections, democracy was associated with the coverage of ART and PMTCT, where both adoption (whether or not a country has a universal access to treatment) and implementation (how the treatment delivery is organized, the level of corruption and so forth) affect the level of the indicator. At the same time it showed no differences in outcomes that were more closely related to policy adoption (e.g. compliance with the "three ones" recommendations) and required little or no implementation. As I show more in-depth in the following chapter, the analysis of the historical data from Barbados and Trinidad and Tobago strongly suggests that the difference observed in the quantitative analysis in ART measures are be due to differences in implementation rather than in adoption of policies and programs.

This is an important revision both to the theoretical framework of this dissertation as well as to the scholarship on democracy and social policy. As noted in the theoretical

chapter, the extant scholarship focused on policy adoption and either neglected policy adoption completely or made an unrealistic assumption that the governments are always able to implement the policies they enact (Bueno de Mesquita et al., 2005).

6. Post Scriptum: AIDS policy and Most at Risk Populations (MARPS) in Barbados

The area where the expanded Barbadian response to AIDS has been least successful is the monitoring of the epidemic and programmatic work involving most-at-risk population (MARPS): commercial sex workers (CSW), prison inmates, and men who has sex with men (MSM).

In 2003, the Sex Work Project (SWP) was launched to conduct the assessment of the state of the epidemic in commercial sex workers in Barbados and to develop prevention interventions to curb the spread of the diseases among CSWs and their clients. The first activity of the SWP was to conduct a mapping exercise of sex work in Barbados and a baseline study of HIV/AIDS-related knowledge and sex behaviors in that group. Since then, SWP has been involved in other major research projects on the island. Funded by DFID and the Ministry of Tourism, the "Beach Boys" project surveyed men who worked in the informal tourist industry as beach chair renters, water sports operators, lifeguards, or beach peddlers, and collected data on their sex behaviors, sexual health, health service utilization and health seeking behaviors, to developed prevention programs that could be implemented in the informal tourist sector. The "4th S" project consisted of a survey of sex behaviors of tourists coming to Barbados as well in-depth interviews with the key stakeholders in the tourist industry: hotel managers, Barbados Hotel and Tourism Association, and "low-level" tourism workers (e.g. cab drivers). The project was funded

by the Ministry of Health and the Ministry of Tourism. In addition, when I was conducting fieldwork in Barbados, the SPW was in the initial planning stages of a project to produce population estimates of sex workers in Barbados, which was to be conducted in cooperation with the Caribbean HIV/AIDS Alliance and was required as part of the second World Bank loan agreement, a HIV seroprevalence survey among CSW, and a project on single unemployed dependent women, who had been identified as a new high-risk group in the most recent National Strategic Plan.

It is interesting to note the pattern of funding of the SWP's work. While the salaries of the two SWP staff members have been paid by the government of Barbados, only part of its programmatic work has received governmental funding. Specifically, to date the funding from the government (Ministry of Health, Ministry of Tourism) has been directed to projects that are tangentially related to sex work and focus instead on broader target groups, generally in the areas of tourism ("Beach Boys", "4th S"). In contrast, research projects that have engaged sex work directly have been funded from other sources, such as USAID, DFID, the CDC, and the Caribbean HIV/AIDS alliance (see Table 1.).

Table 3.8.: SPW Projects, Target Groups, and Sources of Funding.

Project name	Target group	Source of funding
"Beach Boys" project	Informal tourist sector	Ministry of Tourism, Ministry of Health, DFID
"4th S"	Tourists, tourist sector	Ministry of Health, Ministry of Tourism
Single unemployed dependent women*	Single unemployed dependent women	Not determined[15]
Base-line survey	CSWs	UNIFEM, CIDA, DFID
Population estimates of CSWs*	CSWs	World Bank
Serosurvey of CSWs*	CSWs	World Bank, CDC

*projects in early planning stages in 2009
Source: personal interviews

This pattern of limited government engagement in the area of surveillance and programmatic work with MARPS is similar with respect to men who have sex with men. The bulk of the work targeting MSM has been done by United Gays and Lesbians Against AIDS Barbados (UBLAAB) - a civil society organization founded in 2001 (Advocate 18 September 2002 "UGLAAB Tackles HIV/AIDS"). On the one hand, UGLAAB has been receiving a subsidy from the government, has been housed in the building of the National AIDS Program, and participated on an equal footing with other NHAC partners in policy development. On the other hand, however, the Barbadian government, and the Ministry of Health, have not engaged directly in any activities targeting MSM[16].

[15] When I was collecting data in Barbados the source of funding for the project on single unemployed dependent women had not been determined.
[16] In the Fall of 2009, when I was leaving Barbados, the Ministry of Health was in a very early stage of planning of a behavioral surveillance study of MSM to be contracted to the Caribbean HIV/AIDS Alliance.

Virtually all health care professionals, academics, and government officials I have spoken to emphasized the limited capacity of UGLAAB to address the needs of MSM with respect to HIV/AIDS. This assessment was also shared by the World Bank:

"Some level of social tension has been observed between key populations at higher risk on
one side, and CSOs that represent them and public institutions on the other, as some vulnerable
people do not identify themselves with the CSOs that represent them. This is the case for MSM and the CSO UGLAAB, as well as PLHIV and the CSO CARE. This would be mainly due to underlying prejudices that accompany the HIVIAIDS epidemic in Barbados and the criminalization of sex work and homosexuality. UGLAAB indicates that many male sex workers and gay men (for example beach boys) do not want to be associated with the organization due to stigma and discrimination" (World Bank, 2008b. Project Appraisal on a Proposed Loan in the Amount of US$ 35.0 Million Equivalent to Barbados For a Second HIV/AIDS Project, July 10, 2008; p. 62).

At the same time, however, those assessment were based on the assumption that UGLAAB, not the government, should lead the fight against AIDS in that community. This is striking, given that the government and not the civil society, has been undoubtedly the dominant player in the fight against AIDS in all the other policy areas.

It is clear that the activities in the area of high-risk population have lagged far behind the other areas of AIDS response. The contrast was significant enough to be pointed out in the World Bank appraisal of its first loan to Barbados:

"there was limited involvement of key groups at higher risk of HIV on preventive interventions. In general, with regard to prevention, there was more focus on IEC for the general population than on outreach work with key groups at higher risk of HIV" (World Bank, 2008, Implementation Completion and Results Report, p. 36).

One reason for this limited engagement is that both prostitution and anal sex (and, in the public mind, homosexuality) are criminalized in Barbados . This makes it very difficult of the NHAC, the Ministry of Health, and other governmental agencies to engage directly in activities targeting men who have sex with men or commercial sex workers. Another reason is that, unlike the provision of treatment, PMTCT, or EICs targeting the general population, the issues of transactional and same sex sex have turned out to be politically very problematic and efforts to provide condoms in prison or decriminalize sodomy and prostitution in Barbados have failed for political reasons. Those divergent trajectories of policies aimed at the general population and the marginalized groups is very interesting both substantively and theoretically. I will address them in depth in chapter five.

At this point, I just want to signal that the way AIDS in Barbados was (not) addressed in the context of MRPS suggest that the relationship between democratic accountability and social policy is different for different issues within the same policy area. Specifically, while it increases the likelihood of the adoption of policy measures viewed as providing benefits to the "desirable" social groups, it also makes the adoption of measures perceived as benefiting "undesirable groups" less likely. These findings are consistent with the results of the quantitative analysis in the previous chapter which

showed that democracy is associated with improved outcomes related to MARPS (percentage of the total expenditure on AIDS spent on programming for men who have sex with men, commercial sex workers and their partners, and intravenous drug users, and the percentage of commercial sex workers reporting using a condom the last time they had sex) at the moderate level of the imperfections, but not at the high or the low level.

At the same time, these findings also confirm the research hypothesis that low levels of electoral market imperfections make governments more sensitive to the preferences of the voters. As I show in greater detail in chapter five, it was precisely consideration of negative electoral consequences, which were heightened by the low level of electoral market imperfections, that were caused the Barbadian government not to address the needs to sex workers and men who have sex with men in the context of AIDS. On the other hand, however, it also shows that democratic accountability does not always lead to optimal policy outcomes and does not always further the public interest.

Finally, the findings also suggest that, in the context of democracy, politicians respond to threats rather than to incentives. The traditional understanding of the "democratic marketplace" model suggests that political candidates listen to the demands of the electorate and select those policy options that are the most popular. In this sense, the policy selection process, in particular at the agenda setting stage, is an optimization problem, where politicians chose those policy options that offer the greatest pay-offs in terms of votes. I argue, that politicians select policy options based not on the demands from the electorate, but on the recommendations from policy experts. Generally, they are willing to accepts the advice of the experts, unless it presents political risks. In those

cases, politicians are willing to forgo the expert advice in the interest of minimizing any negative electoral repercussions. Thus, I argue that policy selection is in fact a minimization problem, where the governments adopt not the policies with the greatest support but rather those with the least opposition.

CHAPTER 4: TRINIDAD AND TOBAGO CASE STUDY

Introduction:

In the theoretical chapter I presented an argument that imperfections in the electoral markets, defined as: 1) limited access to information among the citizens, 2) ethnic polarization, and, 3) uncertainty about the commitments made by political elites, suppress the positive influence of democratic accountability, and ultimately result in HIV/AIDS policy failures. In countries where electoral market imperfections are more pronounced, policies and institutions aimed at fighting AIDS take longer to develop and spending on AIDS and the availability of services, both for those already infected and those at risk of infection, is limited. In countries where the level of the electoral market imperfections is low, greater democratic accountability creates incentives for politicians to scale-up efforts aimed at curbing the disease in the general heterosexual population.

This chapter continues a case study-based inquiry into the relationship between electoral market imperfections and HIV/AIDS policy which I began in the previous chapter. In that chapter I argued that because the level of electoral market imperfections was low, Barbados was able to successfully scale up its response to HIV/AIDS in the late 1990s and early 2000s. In particular, the anti-retroviral treatment program turned out the be the most successful part of this expanded response, with some 95% of people in need of ART receiving it in 2009. These conclusions are consistent with the results of the statistical analysis presented in Chapter 2, which showed that level of electoral market imperfections mediated the association between democracy and the provision of ART. At the low level of electoral market imperfections, democratic countries showed higher

ART coverage than non-democratic ones. At moderate or high level of the imperfections, the association between democracy and those outcomes was not statistically significant. Consequently, ceteri paribus, at the same level of democracy, ART coverage was higher in countries with low levels of electoral market imperfections.

In this chapter, I contrast Barbados with another country case from the Eastern Caribbean: Trinidad and Tobago. The comparison allows for assessment of the causal impact of the imperfections of the electoral markets on AIDS policy, while controlling for a number of potentially confounding variables, such as democratic regime and the makeup of electoral institutions, as well as HIV prevalence[17], wealth, and colonial heritage. In the first part of the chapter I show that the level of political market imperfections in Trinidad in Tobago is higher: the number of Internet users per capita - a proxy measure of how well informed is the electorate, is three times smaller than in Barbados (CIA World Fact Book). The country's population, comprised of 40% Indians (South Asians), 37.5% Africans, and 20.5% people of other ethnic origins is much more ethnically heterogeneous. Furthermore, race has been a major polarizing factor shaping the politics of the country, including its party system and social movements (Edie, 1994; Ryan, 1972). Also, the party system is Trinidad and Tobago is much more volatile than in Barbados and available survey data show high level of distrust towards political parties and the government.

In the second part of the chapter I demonstrate that the high level of electoral market imperfections had a negative impact on the response to HIV/AIDS in that country. More specifically, I show that it slowed down the scale up of treatment on the twin-

[17] The estimated HIV prevalence is 1.2% in Barbados and 1.5% in Trinidad and Tobago. In both countries, heterosexual sex is the predominant mode of HIV transmission (UNAIDS 2008).

islands and resulted in large numbers of people living with HIV not having access to anti-retroviral therapy.

In the concluding section I address some issues and alternative hypotheses which emerged as a result of the fieldwork research. Specifically, I discuss the impact Trinidad and Tobago's reliance on petrochemical production had on HIV/AIDS policy making. I argue that it had made the country less responsive to potential dangers of AIDS and contributed to the delays in re-structuring the national response to the epidemic form a health-centered approach to the multi-sectoral one. However, I also show that it played no role in the problems the country experienced in expanding the ART coverage.

Like the previous chapter, this one relays on process tracing as the principal analytic technique. I reconstruct the sequence of events leading to policy changes, as well as the motivations and perceptions of the policy makers and other key actors. At the same time, I use cross-case comparison and contrast both the constellation of the dependent and independent variables, as well as the nature and the sequence of the policy process in Trinidad and Tobago with those from Barbados.

The data presented here comes from primary sources and in-depth interviews with key informants (ministers and other government officials, parliamentarians, people living with HIV/AIDS, members of “high risk groups”, community and religious leaders, and healthcare professionals) who were either directly involved in or witnessed the policy process. It was collected during fieldwork research I conducted in Barbados and Trinidad and Tobago in 2009 and 2010.

1. Trinidad and Tobago Context:

Figure 4.1.: Map of Trinidad and Tobago

Source: US Department of State; http://travel.state.gov/travel/cis_pa_tw/cis/cis_1043.html

Trinidad and Tobago is the southern-most country of the Eastern Caribbean. At its closest point, it is only 11 km away from Venezuela and the South American continent. The total land area of the twin islands is 5,128 square kilometers (CIA World Factbook).

Trinidad was claimed for the Spanish Crown by Columbus in 1498, however the first permanent Spanish settlement was not established on the island till 1592 (Premdas, 2007). In 1797 it was taken over by the British and in 1803 it became a British colony (ibid). Tobago was joined to Trinidad in 1888 and the two islands were fully unified into one colonial entity in 1899 (Meighoo, 2003). Trinidad and Tobago achieved independence from Great Britain in 1962. Even though it became a republic in 1976, the country still remains part of the British Commonwealth.

Initially, like other Caribbean colonies, the economy of Trinidad was dominated by agriculture, with sugar cane, cocoa, and cotton being the main cash crops. However, in 1910 oil was discovered off the coast of Trinidad which rapidly transformed the country's economy. Today, oil and gas account for some 40% of its economy and 80% of its exports (CIA World Factbook). Recently, Trinidad and Tobago emerged as the largest exporter of the liquefied natural gas (LNG) to the United States (ibid).

According to the 2010 estimates, the population of Trinidad and Tobago is about 1,228,000. It consist of 40% East Indians, 37% Blacks, 20.5% people of mixed race. The White, Chinese, and Syro-Lebanese minorities account jointly for some 1.2% of the population (CIA World Factbook). Premdas (2007) notes the economic stratification of the major ethnic groups, where "Afro-Creoles are found mainly in the public bureaucracy, professions, and the petrochemical industries; Indians predominate in sugar and commerce, while the small European, Chinese and Syrian communities are found mainly in trading and business" (p. 26).

The Port and the Plantation: Race and ethnicity in Trinidad and Tobago.

The island of Trinidad was claimed for the Spanish Crown in 1498 by Columbus, during his third voyage to the New World. However, no permanent Spanish settlement was established there until 1592 "and even them it remained but an isolated outpost with a tiny population and minimal commercial activity" (Premdas, p. 27). The island was inhabited by Amerindian tribes (Arawaks and Caribs), most of whom were enslaved as

part of the encomienda (land and people grants) system or sent to work on plantations in other parts of the Caribbean (Premdas, 2007; Brerton 1981). African slaves were first brought to Trinidad in 1517. However, until late 18th century, they remained a small minority and the Amerindians accounted for the bulk of the island's population (ibid).

In 1783, Cedula de Poblation (Population Decree) was adopted by the Spanish Crown which aimed at encouraging the settlement of the island. The incentives offered as part of the decree included 30 acres of land for each white settler and additional 15 acres for each slave they brought with them; 15 acres were also offered to free Africans and mixed-race Mulattos. The Cedula brought a wave of new white settlers, mostly from the French colonies in the Eastern Caribbean, who arrived with their own slaves and established large-scale sugar plantations (Premdas, 2005; Wood, 1968). In 1797 Britain conquered Trinidad "but the entry of the British did not alter the open door policy of immigration"; the white population remained dominated by the French migrants and was mostly French speaking. (Premdas, 2007).

At the end of the 18th century, a typical Caribbean plantation-based economy emerged in Trinidad with sugar cane, coffee, cocoa, and cotton as the main crops and enslaved Africans as the main source of labor. By 1803 the number of Blacks on the island increased over 60-fold compared to 1783, when the Cedula was enacted. By 1803, Blacks accounted for over 70% of the total population of the island (see Table 3).

The Emancipation Act of 1833 abolished slavery in the British Empire. The emancipation created a dire demand for a new source of labor which exacerbated by the fact that freed black slaves were leaving plantations looking for opportunities in the urban center of Port of Spain and San Fernando.

Table 4.1.: Population of Trinidad by Race/ethnicity, 1783-1838.

Year	Total	Whites		Black		Amerindians		Free non-whites	
		N	%	N	%	N	%	N	%
1783	2763	126	4	310	11	2032	73	295	11
1797	17718	2151	12	9922	56	1063	6	4476	25
1803	28000	2261	8	20464	73	No data	-	5275	19
1838	36359	3993	11	20656	57	No data	-	12006	33

Source: Premdas, 2007

Initially, new sources of labor were sought in other West-Indian colonies and in St. Helena and Sierra Leone, where blacks from slaver ships captured by the British were being returned. Also, several groups of black soldiers who escaped the United States arrived on the island. However, just like the emancipated slaves, these new black migrants tended to leave plantations and gravitate towards urban areas.

The metropolitan government sought to address the problem of agricultural labor shortages in its Caribbean colonies by introducing a program of the importation of indentured labor form India. As part of the program, which lasted from 1838 through 1917, about 551,000 Indians came to the Caribbean (Premdas, 2007).

The indentured workers came mostly from the northern part of India: Uttar Pradesh and Bihar. The first group of 225 Indian laborers arrived in Trinidad in 1845. The five year contracts, under which most Indians arrived, could be extended for another five years in exchange for free repatriation (Premdas, 2007). However, the majority of laborers tended to stay on the island after their contract expired. By 1917, when the indenture system ended, some 143,000 Indians had arrived in Trinidad with only about 33,000 returning to India (ibid.).

Unlike Blacks, Indians tended to stay in rural areas and find employment mostly in agriculture on and outside of large plantations. The emergence of independent Indian

agriculture was supported by the land commutation scheme - a system of land grants en lieu of repatriation, which was introduced in 1869 and lasted through 1880. Even though only a small number of Indians received land under the scheme, it served to reinforce the economic stratification of the Trinidadian society into urban Afro-Creoles, and rural Indians. Independent of the land commutation schemes, Indians who decided to stay in Trinidad also bought land from the Crown and on the private market. Premdas notes that: "Indians became entrenched predominantly as rural dwellers so that by 1921 only 1.9 per cent resided in the main urban township, Port of Spain, while only 1.28 per cent lived in San Fernando, the second largest township (Premdas, 2007; p. 32).

With Indian arrival, the ethnic composition of the Trinidadian population started shifting rapidly. By 1871, Indians accounted for 22% of the population (significantly, already by that time some 14% of them were born on the island) and by 1911, the percentage of Indians had risen to 33%, with only a small minority born outside of Trinidad. By the end of the 20th century, East Indians became the largest ethnic group in Trinidad and Tobago accounting for some 40% of the population.

The ethno-cultural divide between East Indians and Afro-Creole communities was strengthened by economic segmentation of the Trinidadian society. As mentioned above, the freed African slaves and free black migrants tended to leave the plantations and seek economic opportunities in the urban centers. When oil was discovered in Trinidad at turn of the twentieth century, the labor force in the petrochemical industry came to be dominated by Afro-Creoles. The establishment of the public education system in Trinidad and Tobago further strengthened the economic stratification and the distinction between "the port" and "the plantation". The system was based on Christian British colonial model

and while Afro-Creoles embraced it, East Indians were reluctant to take advantage to the new educational opportunities out of fear that the public schools would serve as a vehicle for Christian proselytizing (Premdas, 2007). Thus, as Premdas notes, "Indians remained illiterate and unschooled" (Premdas, 2007, p. 37). Skewed enrollment ratios in the public schools, in turn, lead to Afro-Creole dominating the public service, including the Teaching Service, and the professions[18].

The Devil and the Deep Blue Sea: Ethnicity and party politics in Trinidad and Tobago:

Several authors have also pointed to the role of the colonial rule in shaping the politics of ethnicity in contemporary Trinidad and argued that the present conflict is a result, in a large part, of the way the British managed the Afro-Creole and the East Indian populations on the island (CIT). While, without any doubt, the process of the creation of ethnic Afro and Indo-Trinidadian identities as part of the colonial enterprise is very important in understanding the genesis of the ethno-political cleavage in contemporary Trinidad, this analysis is more concerned with the consequences of ethnic politics rather than its sources.

The Westminster model based on simple plurality single-member districts imprinted the socio-economic differences between East-Indians and Afro-Creoles onto party politics. Premdas writes: "The political system provided no incentive to

[18] The French-Creole community constitutes the wealthiest section of the society and big business owners and managerial elites. Significantly, like in many other Caribbean countries, following the independence, the French-Creole elite all but completely withdrew from formal politics. Thus, the East Indian and the Afro-Creole communities became the centers of the bi-polar political and partisan divide in Trinidad and Tobago.

consociation and power sharing across the ethnic divide but reinforce the sectional cleavages breeding alienation within the out-group" (Premdas, 2007, p.47).

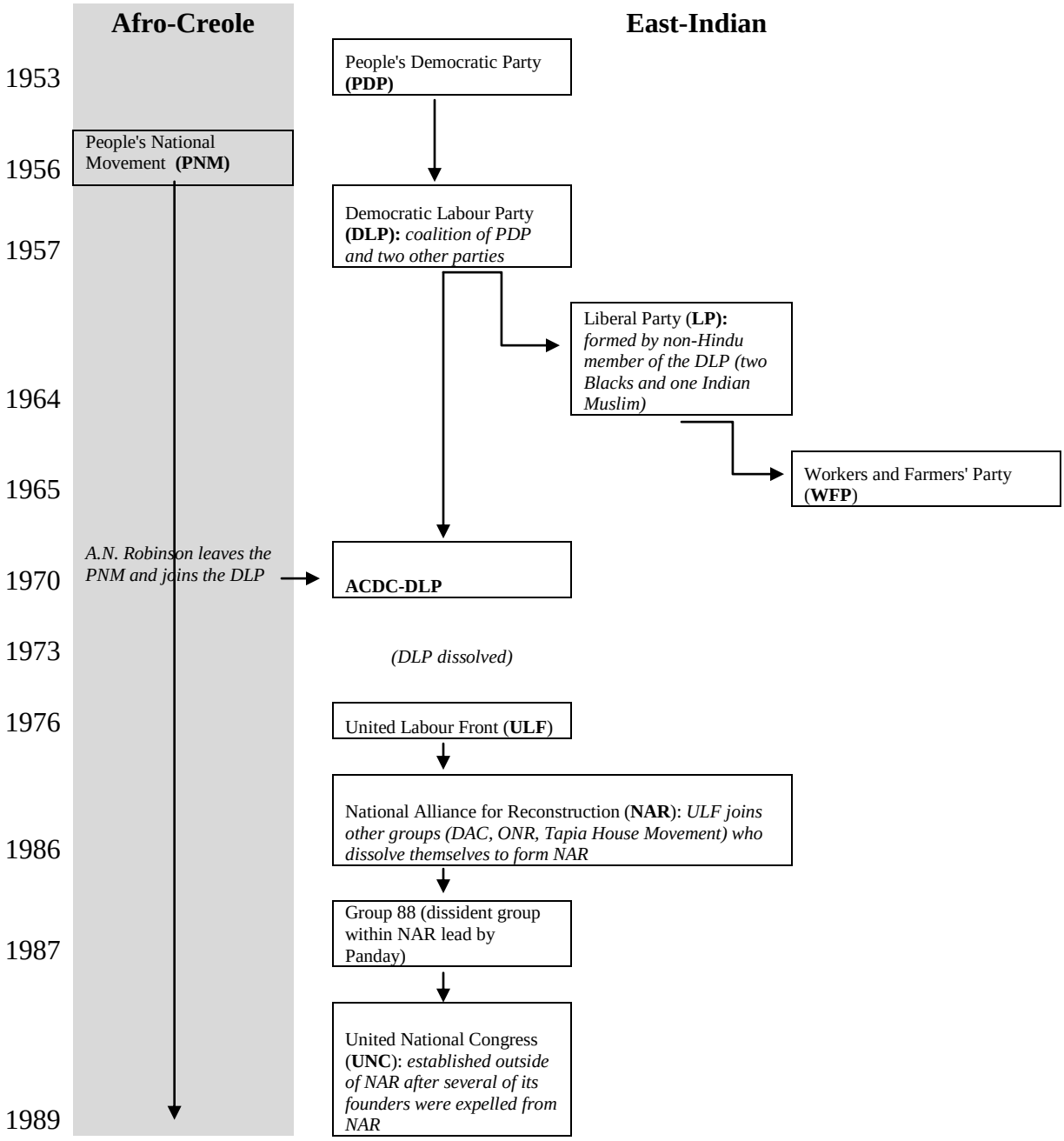
Dr. Eric Williams and the People National Movement - the first truly national party in Trinidad and Tobago were instrumental in securing the political independence for Trinidad and Tobago in 1962 (Ryan, 1978, 2003, CIT). However, despite Williams' supposedly "color-blind" nationalist ideology, the bulk of the leadership of the PNM was formed by black intelligentsia, or what Oxaal (1969) call the "Black bourgeoisie", its political base was firmly grounded in the black working class, and the constituencies in the East-West corridor, inhabited mostly by Afro-Trinidadians, are still considered to be the party's strongholds (Premdas, 2007; Ryan, 2003, Meighoo, 2007). Already in the 1950s, when threatened by the DLP - a party set up by Indian members of the colonial Legislative Council, Williams and the PNM used communal racial rhetoric to mobilize political support. Meighoo writes:

"Addressing a crowd at Woodford square on "The Danger Facing Trinidad and the West Indian Nation" Williams launched into an unrestrained attack against the backward, rural, Indian "wave of illiteracy" swamping the PNM's urban strongholds; he called the Indians a "hostile and recalcitrant minority", prostituting the name of India for selfish and reactionary ends" (Meighoo, 2006, p. 49).

East-Indian community also developed its own ethno-political organizations. In fact the People's Democratic Party - a coalition of all Indian members of the colonial Legislative Council was established in 1953 - three years before the PNM. As I show in

the next section, the East Indians political organizations at least until the late 1980s were much more fluid and fragmented than the PNM (see Figure 3, p. XX). Over the years, 6 parties attempted to mobilize the Indian voters. Only in the last two decades, the United National Congress emerged as the dominant Indian party and was able to win the elections twice, in 1995 and most recently in 2010. However, despite fragmentation, since independence the party system in Trinidad has been bi-polar with two main political organizations representing the two major ethnic groups contesting each election (see Figure 2).

Figure 4.2.: Afro- and Indo-Trinidadian Political Parties, 1953-1989.



Virtually all key informants I interviewed in Trinidad and Tobago emphasized dominant role of race in national politics.

"I think politics in Trinidad and Tobago is overshadowed by the ethnic problem. Afro-Trinidadians are afraid of Indo-Trinidadians that if they come to power they will do this and that. Some of it is justified and some if is not. Some of it is justified because words get thrown that "when we come to power we will do so and so" and people get scared. ... And when I hear about ethnic cleansings in Bosnia and other places, I hope they are listening. But when I hear politicians speak, I know they are not listening. Because the things they say, it's a fuel. " (TT14)

The monopoly the PNM held over political power since 1961 through 1986 reinforced a sentiment of political exclusion in the Indian community (Ryan, 2001). East Indians claimed that they were underrepresented in state institutions and public administration (Premdas, 2007), that the state favored Afro-Creole forms cultural expressions such as Calypso and the steel pan, over Indian ones, and that East Indians got an unequal share of the economic and social benefits provided by the state, such as state scholarships (see Premdas, 2007; Ryan 2001, 2003).

On the other hand, Afro-Trinidadians were afraid of the East Indians taking over the state and its institutions. One respondent poignantly summarized the sentiments that I think are quite wide spread:

"Our society just came out of slavery and the Afro-Trinidadians are afraid that the Indo-Trinidadian will come and enslave them again. They will get better jobs. They have the land, and all the shops, and they are afraid that they will only employ their own. Which is

something that we see, because when you go to a business owned by an East Indian you see East Indians working there. I cannot say that this is the other way around." (TT14)

The ethnic cleavage in Trinidad manifests itself not only on the organizational-level of the party system, but also in the way the voters perceive the parties, and more importantly, evaluate their performance. In the theoretical framework of this dissertation I argue, that ascriptive characteristics of parties and candidate in ethnically polarized societies tend to trump other considerations, most importantly past political performance. Thus, voters support co-ethnic parties and candidates even if those parties and candidates do not put in place policies that benefit their supporters. In this sense, political polarization based on ascriptive characteristics hinders democratic accountability.

Survey data from Trinidad show that ethnicity not only informs what party one supports but also that voters indeed evaluate politicians performance through the lens of race. For example, a survey conducted by St. Augustine Research and Associates (SARA) asked respondents a number of question regarding the performance of the UNC (Indian) government and more specifically, about its alleged corruption. The survey results show marked difference in how Afro-Creoles and East Indians perceived the government's performance (see Table 2). While 94% of the Afro-Trinidadian respondents said that corruption in Trinidad and Tobago was a very serious or a serious problem only 56% of Indo-Trinidadians thought that it was a very serious or a serious problem. Similarly, when presented with a statement that the UNC government headed by Basdeo Panday had not dealt seriously with corruption, 89% of Afro-Trinidadians agreed or strongly agreed, compared to 71% Indo-Trinidadians; 8% of Afro-Trinidadians disagreed

or strongly disagreed with the statement compared to 23% Indo-Trinidadians. Finally, while 69% of Afro-Trinidadians thought that Prime Minster Panday was himself guilty of corruption, but only 29% of Indo-Trinidadian thought so. Conversely, 3% of Afro-Trinidadians thought that Panday was innocent compared to 35% Indo-Trinidadians. On all three issues, Afro-Creoles perceived the Panday government in much more negative terms than East Indians. Those stark differences are a very good illustration that one's ethnicity affects the way one evaluates political performance.

Table 4.2.: Attitudes Towards the UNC Government's Performance by Race/ethnicity, October 2001.

		Afro-Trinidadian (%)	Indo-Trinidadian (%)	National (%)
How serious is the problem of corruption in Trinidad and Tobago?				
	Very serious	79	37	58
	Serious	15	19	17
	Not very serious	3	23	12
	Uncertain	3	16	9
Panday has not Dealt seriously with Corruption				
	Agree strongly	56	49	53
	Agree	33	22	29
	Disagree	5	9	8
	Disagree strongly	3	14	5
	Uncertain	3	6	4
Panday guilty of Innocent of Accusations of Corruption				
	Guilty	69	29	49
	Innocent	3	35	19
	Do not know	22	27	25

Source: St. Augustine Research Associates (SARA) survey, October 2001, in Ryan 2003 pp: 106-8.

Key informants I have interviewed in Trinidad and Tobago confirmed that ascriptive characteristics tend to be more important to voters than policy and performance:

"In the existing landscape, in my opinion, persons are voting along party slash race lines. And the individual performance is not an issue." (TT31)

"In Tobago, when we have elections, those politicians come around and promise that they will fix the road, do this and do that and five years will pass and they will come again. And they will vote for the same party because the other party maybe has some Indians in it. It's not what the party did for you, it's about who's in the party." (TT14)

Thus, even if its performance while in power is unsatisfactory, the co-ethnic party is still better than the alternative:

"That is where we're in a catch 22 in this country because even if you disagree with Patrick Manning [PNM ; Afro-Trinidadian] and his politics and you say "I'm not going to vote", who else are you going to vote for? Basdeo Panday [UNCI - Indo-Trinidadian] and his politics or Minister Dookeran and his politics? So it's the devil and the deep blue sea quite frankly. You weigh all the devils. Put all the devils in a hat, who's the lesser evil?" (TT7, see also TT5)

In the bamboo batch: trust in electoral promises.

Historical evidence, existing survey data, and in-depth interviews with key informants suggest that the level of trust in electoral promises in Trinidad and Tobago is low. In the theoretical chapter I argued that political predictability reinforces voters' trust that electoral promises will be fulfilled (Keefer, 2007). The longer a party has been on the political scene, the more predictable it is and the more trusts the voters can have that it will deliver. In contrast, new political parties are untried and thus an unknown to the electorate. Thus, the stability of the party system is one indicator of the confidence the voters can have in electoral promises (see Keefer, 2003). Consistent with this theoretical argument, key informants in Barbados emphasized the stability of the party system as the key factor explaining the high level of confidence Barbadians have that electoral promises will be fulfilled.

"Among the older population there is a general trust of government and this is helped by the fact that Barbados has had a very stable political system and that changes in the government happen seamlessly" (B12; also B17, B4).

Prior to the 1950s the electoral scene in Trinidad and Tobago, still a British colony, was dominated by independent candidates (Meighoo, 2003). In the period immediately preceding the country's independence, the political landscape in Trinidad and Tobago was in constant flux. For example, out of the 16 candidates who contested the election of the Legislative Council in 1956, only six ran with the same party or independent affiliation as they did in the 1950 elections (Meighoo, p. 40). This contrasts

sharply with Barbados, where as early as the 1930s, political parties rather than independent candidates became the dominant vehicle of political representation (see Chapter 2, Beckles 2004, 2006, Duncan, 1994).

People's National Movement (PNM), established in 1956, was the first truly national party in Trinidad and Tobago - it was the first political organization to ever contest seats in all constituencies (Meighoo, 2003, p. 38). Among the party's founders was Dr. Eric Williams, the architect of Trinidad and Tobago's independence. Kirk Meighoo writes "Williams fervently sought to prevail over the political tradition of independent candidates by introducing the concept of party discipline and programme, to portray himself as a national, as opposed to sectional or racial leader" (p. 27). The PNM has survived as an organization since the 1950s and became the dominant party in the twin islands. It won majorities in 8 out of 13 general elections that took place from 1961 to date and was in control of the government for a total of 9 terms.

However, PNMs organizational continuity is an exception, albeit a very important one, rather than the rule on the Trinibagonian political landscape. Other parties, including the major opposition East Indian parties, have been in constant flux. Since 1953, 6 major parties (not including smaller splinter groups) have represented the East Indian Community (see Figure 2). The United National Congress (UNC), that party which won the most recent election and at present controls the government, was not established till 1989, even though its former leader, Basdeo Panday, and other key party members, were part of the leadership of the ULF - an earlier East Indian party, which was dissolved to form the multi-ethnic catch-all party, the National Alliance for Reconstruction (NAR) in 1986 (Meighoo).

Table 4.3.: Parties Contesting the General Elections in Trinidad and Tobago, 1961-2001.

Year	Number of Parties running	Parties running	Number of Candidates running	Number of parties winning seats	Parties winning seats
2001	5	PNM, UNC, NAR, Team Unity, National Democratic Organization	110	2	PNM, UNC
2000	6	PNM, UNC, NAR, People's Empowerment Party, The Mercy Society, Independents (4)	79	3	PNM, UNC, NAR
1995	7	PNM, UNC, NAR, Natural Law Party, Movement for Unity and Progress, National Transformation Movement, The People's Voice	114	3	PNM, UNC, NAR
1991	5	PNM, UNC, NAR, NJAC, Independents (5)	141	3	PNM, UNC, NAR
1986	5	PNM, NAR, NJAC, People's Popular Movement, Independents (2)	124	2	PNM, NAR
1981	12	PNM, ULF, DAC, ONR, NJAC, Tapia House, National Freedom Party, Fargo House Movement, People's Republican Party, West Indian Political Congress Movement, Independents (1)	156	3	PNM, ULF, DAC
1976	12	PNM, ULF, DAC, Tapia House, Democratic Liberation Party, Social Democratic Labour Party, West Indian National Party, Liberation Action Party, United Freedom Party, National Trinidad and Tobago Party, Young People's Party, Independents (5)	269	3	PNM, ULF, DAC
1971*	4	PNM, Democratic Liberation Party, African National Congress, Independents (2)	66	1	PNM
1966	8	PNM, DLP, Liberal Party, WFP, PDP, Butler Party, Seukeran Independent Party, Independents (4)	154	2	PNM, DLP
1961	5	PNM, DLP, Butler Party, African National Congress, Independents (2)	69	2	PNM, DLP

* Election boycotted by the opposition; 18 seats were uncontested
Source: Adopted form Meighoo, 2003.

The proliferation of political parties and the fluidity of the party system in Trinidad and Tobago is in stark contrast with the party politics in Barbados which have

been characterized by stability and continuity. Between 1976 and 2001, on average, 7 political parties (including independent candidates counted as a separate party), with an average of about 4 candidates contesting each seat. In contrast, in Barbados during the same period, on average 4 parties, including independents run in each general election, and an average 2.4 candidates contesting one seat.

In addition to the proliferation of different political parties, dramatic internal schisms *within* parties distinguish politics in Trinidad and Tobago from that in Barbados and have caused the citizens to lose trust in the elected officials. In 1986, a multi-party and multi-ethnic coalition the National Alliance for Reconstruction (NAR) won the general election and broke, for the first time since independence, the hegemony of the PNM and its continuous control of the government. However, the coalition broke down soon after with the East Indian factions leaving the NAR to re-establish a separate party (Meighoo, 2003). In 2001, a conflict over who should succeed Basdeo Panday as the head of the United National Congress, lead to a split within the party and the effectively toppled the UNC government (Ryan, 2003, Meighoo, 2003). In the subsequent elections, the UNC dissidents ran as a separate party - "Team Unity" (Ryan, 2003).

When I was conducting my fieldwork research in Trinidad and Tobago in 2009 and 2010, UNC was holding an internal election to decide who would be the new leader. The campaign was both very mean-spirited and very public and it left many of the key informants I interviewed disgusted over politicians and politics:

"Those internal elections for the UNC which are coming up...the people keep washing their dirty linens. Now they're washing the whole dirty house in the public domain. For me that does not inspire confidence when everybody's fighting." (TT7)

The instability of the party system in Trinidad and Tobago suggests that voters do not have a great deal of confidence in political candidates and their electoral promises. Available survey data supports this conclusion. It shows that the level of trust in government and political parties, and thus arguably, in the commitments and promises they make, is low. In 2007, survey data was collected in Trinidad and Tobago as part of the World Values Survey (WVS). Two questions asked as part of the WVS in Trinidad and Tobago speak directly to the level of trust in government officials and political candidates. The WVS asked the respondents: "I am going to name a number of organizations. For each one, could you tell me how much confidence you have in them: is it a great deal of confidence, quite a lot of confidence, not very much confidence or none at all?"; among other option listed were the government and political parties (Quality of Government Institute, 2010). The questions were coded using a Likhert scale: 1) A great deal, 2) Quite a lot, 3) Not very much, 4) None at all. Thus, somewhat counter intuitively, higher scores indicate less confidence. The data presented below were takes form the Quality of Government cross-sectional data set (Quality of Government Institute, 2010) which provides numerical averages of the WVS responses for each item in a given country.

The WVS was not carried out in Barbados and a direct comparison of attitudes between the two case studies is impossible. However, using the Survey, we can compare

the attitudes in Trinidad with global averages and averages from other democratic countries. Table 4 below compares the responses from Trinidad and Tobago with the mean of the mean response in each country for which the data were available (global average) and an average from countries scoring above 9 on the interpolated Freedom House/Polity 2 score (democratic average). The data show that respondents in Trinidad and Tobago were less confident in their government than respondents in an average country and respondents in an average democratic country. The (lack of) confidence in government score for Trinidad (2.86) was higher than the global and the democratic average (2.58 and 2.65 respectively). Similarly, Trinidadians had more distrust towards political parties. The (lack of) confidence in political parties score in Trinidad was 3.2 - higher than the global average (2.96) and the average in democratic countries (2.95).

Table 4.4.: Confidence in Government and Political Parties: World Value Survey data.

	Global average	Democratic countries	Trinidad and Tobago
Confidence in:			
Government	2.58	2.65	2.86
Political parties	2.96	2.95	3.2

Source: Quality of Government dataset; Quality of Government Institute, 2010.

Key informant interviews confirmed that Trinibagonians did not have a great deal of trust towards political candidates and the promises they made during electoral campaigns. In Barbados, the key informants emphasized the importance of electoral manifestos and the scrutiny they were receiving form the public. In Barbadian public discourse, manifestos were construed as binding social contacts. In Trinidad and Tobago,

in contrast, the key informants tended to perceive the manifestos as purely rhetorical devices.

"A lot of it we know is propaganda. A lot of the things in those manifestos if you do the research, a lot of those things never happen. They never come to pass. Again I remember in one government, in one budget speech early days, they were very proud to say there was a $10 million budget for HIV and AIDS. At the end of the year, because we paid particular attention to that, at the end of the year out of that budget just $400,000 was allocated to HIV. And the other money was absorbed in other ministries." (TT7; see also TT21, TT32)

"That's politicians: they come, they make speeches....I personally have lost faith in politics After the elections you don't see them for the next five years. And that's another issue in that constitutional reform that people should have the right to recall." (TT18)

"I think they [the party] will say one thing now [before the elections] and then they will always find a reason why they didn't do it when they got elected." (TT5)

Several people whom I have interviewed pointed to the connection between the unsatisfactory policy performance and the lack of trust in electoral promises. On the one hand, some argued that the reason the electorate does not have faith in promises is the fact that the elected officials have failed to address specific policy concerns, in particular, the rising levels and intensity of crime:

" But overwhelming portion of the persons here would say no [they don't trust electoral promises] because the issue of crime is not addressed sufficiently. Because of that most people would say that promises are not being met. Also, another issue is water - the supply is not consistent. The issue of job security. And if those things are still persistent, people are questioning more and more the credibility. " (TT31).

"[laughing] given what has been happening on both sides, on three sides for the past years absolutely no trust. Absolutely no trust...There are murders every day and so many of our friends got high jacked and they don't even report it anymore. And our politicians on both sides seem not to notice what's going on.... There is the linkage between the politicians and the criminals on both sides." (TT9)

On the other hand, key informants also argued that voters keep supporting political parties and candidates even thought they do not have faith in electoral promises and believed that the policies that will be enacted will not further public interest.

"I think now they [politicians] don't [keep their electoral promises]. People know that it ain't gonna happen. But the funny thing is that they will still vote for you. But they don't trust you. " (TT8).

"Because we have a lot of people dependent on the largesse of the state, no matter how they feel , come election they're going to vote for who gives them...I say politicians want to keep us barefoot and pregnant." (TT9)

It also creates a sense that politician are not accountable to the public and a sense of helplessness, especially in the people employed in the public sector, who are responsible for the day-to-day policy implementation.

"In Trinidad and Tobago, people were always afraid they could not do their jobs freely, because if you rub a minister or someone the wrong way, you are going to be, we have a saying in Trinidad, thrown in the bamboo batch. It probably happens in other places, I don't know, but somehow I don't feel it that much when I travel in the rest of the Caribbean." (TT14)

In the theoretical framework of this dissertation I focused on the negative impact of the lack of trust on accountability and argued that low levels of trust lead to policy under-performance. The in-depth interview material, however, suggests a more complex causal linkage between the two. The lack of trust in electoral promises makes voters care less about the outcome of the elections and creates disincentives for supporting parties and candidates even though they may put forth policy proposals that correspond well with the voters' preferences. This leads to public policy failures as politicians, in turn, have no incentives to pursue policies that are benefitting the voters. However, the data also shows that poor policy performance further erodes the voters' trust in the political

system and the electoral promises. This suggests a vicious-circle-like dynamic relationship between public policy and trust in electoral promises.

Information:

In the theoretical chapter I argued that uninformed citizens cannot effectively monitor the policy performance of the government and evaluate the policy alternatives put forth by the opposition. This, in turn, leads to the collapse of the democratic accountability mechanisms and public policy failures. Secondary data suggest that in Trinidad and Tobago, the electorate is less informed about politics that in Barbados. Newspaper circulation in Trinidad in Tobago is lower than in Barbados (see Table 5).

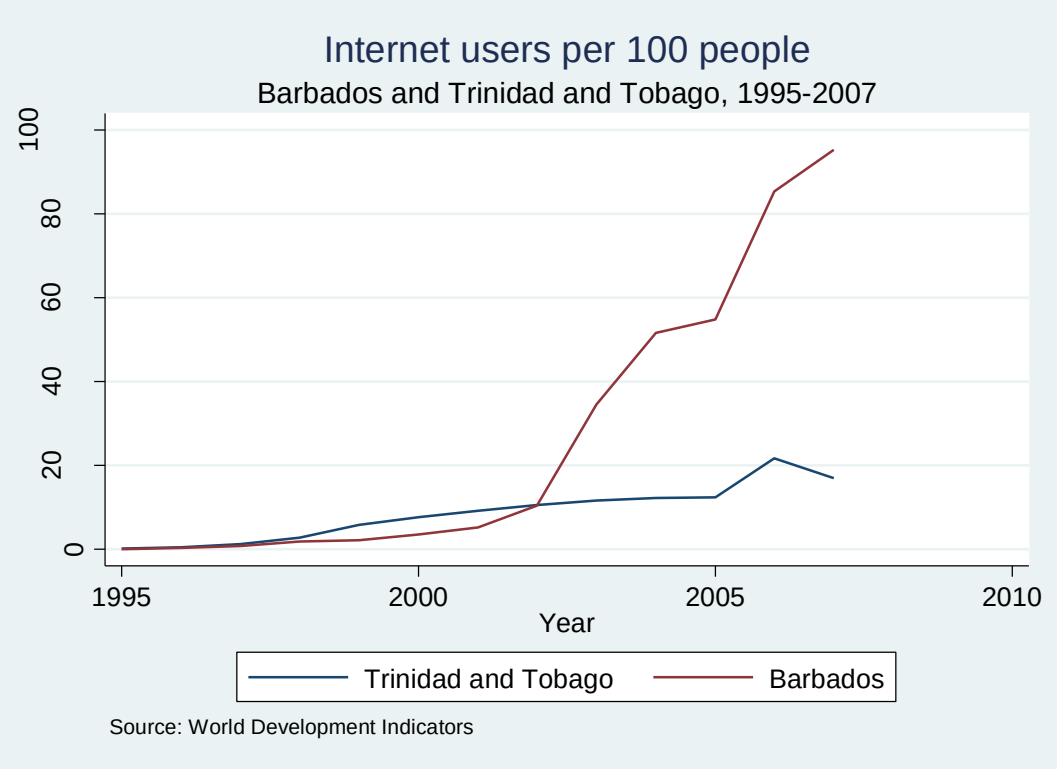
Table 4.5: Newspaper Circulation in Barbados and Trinidad and Tobago, 2002-2004.

	Copies per capita	
Year	Barbados	Trinidad and Tobago
2002	0.13	0.097
2003	0.134	0.098
2004	0.14	0.1

Source:

Similarity, as mentioned in Chapter 3, fewer people used the Internet (see Figure 3). In Barbados in 2007, about 95 out of a 100 people were estimated to be using it. In Trinidad and Tobago, only 16 out of 100 people had access to the Internet, well below the global average (28 people) (World Development Indicators).

Figure 4.3.: Internet Users per 100 People in Barbados and Trinidad and Tobago, 1995-2007.



The World Values Survey data show that not only relatively few Trinibagonians were accessing information outlets such as newspapers and the Internet, but also they were less interested in politics than people in other countries. As one of my key informant put it: *" I'm not [interested in politics]. I don't even read the papers - for me that's very depressing." (SM).* The World Value Survey asked the respondents: "How interested would you say you are in politics?" (Quality of Government Institute, 2010). The questions were coded using a Likhert scale: 1) Very interested, 2) Somewhat interested, 3) Not very interested, 4) None at all interested. Like in the questions regarding confidence in political institutions, counter intuitively, higher values indicate less interest and thus the score may be better interpreted as capturing disinterest in politics .

Table 4.6. below compares the responses from Trinidad and Tobago with the global average (a mean of the mean response in each country for which the data were available) and an average from democratic countries only (countries scoring above 9 on the interpolated Freedom House/Polity 2 score). The data show that respondents in Trinidad and Tobago were less interested in politics than respondents in an average country and respondents in an average democratic country. The (dis)interest in politics score for Trinidad (2.89) was higher than the global and the democratic average (2.62 and 2.58 respectively).

Table 4.6.: Interest in Politics: World Value Survey data.

	Global average	Democratic countries	Trinidad and Tobago
How interested would you say you are in politics?	2.62	2.58	2.89

Source: Quality of Government dataset; Quality of Government Institute, 2010.

In-depth interviews with key informants supported the secondary data and emphasized the link between uninformed electorate and accountability failures:

"I don't know if the level of the education in the population even allows them the understand what is being promised. It's only the opposition that does it. They only say: you promised this and that. The public will never have an assessment and hold the government accountable." (TT14)

The lack of awareness and the disinterest in politics and issues was on several occasions attributed to the fact that party politics were shaped race rather than by substantive policy debates:

" You see the issue of the racial divide is the problem. It is so strong that if you're Indian - you belong to UNC, if you're African, you belong to PNM.. .Unfortunately we're not people who think of issues. " (TT18)

Electoral market imperfections and HIV/AIDS policy:

The "marketplace" model of democracy assumes that health policy is a normal good. Therefore, the public always demand more and better health policy, that is, there exist a constant political demand for policy improvements. Incumbents respond to this demand by offering a certain course of policy. If the policy course adopted by the incumbents satisfies the demand better than policy alternatives offered by the challengers/political opposition, the incumbents are re-elected. If it does not - the challengers are elected and their policy is adopted. This demand and supply chain may be disrupted when the electoral marketplace is imperfect. Specifically, when the electorate does not have access to information about the policies adopted by the incumbents and the policy alternative proposed by the challengers, they cannot effectively distinguish between the available policy options. Also, if electoral politics are centered around issues such as race/ethnicity or other ascriptive characteristics that are not policy-related, the electoral process will not results in the improvement in policy outputs. Finally, when the voters do not trust electoral promises they have no incentives to vote for candidates who promise to adopt policies that are aligned with the voters' preferences.

In the previous sections of this chapter I have shown that the level of political market imperfections in Trinidad has been high. Race, rather than substantive policy

debates, was the main factor shaping party politics, the citizens did not trust electoral promises, in part because of the electoral capture of the ethnic constituents by ethnicity-based parties, and were not well informed and not very interested in the political process in general. Based on this configuration of the independent variable, the theoretical framework of this dissertation suggest that Trinidad and Tobago should have experience AIDS policy failures and that it should lag behind Barbados in terms of its policy environment, outputs, and outcomes. Based on the results of the quantitative analysis, those policy failures should occur mostly in the area of service provision, in particular in the ART coverage. On the other hand, there difference in the institutional and policy infrastructure should be relatively minor.

HIV/AIDS policy chronology in Trinidad and Tobago:

The Medical Model: AIDS in Trinidad in the 1980s and 1990s.

The first AIDS case in Trinidad was diagnosed in 1982. Like elsewhere in the Caribbean, including Barbados, the disease was first found among men who had sex with men. However, just like in Barbados, the number of infections dues to same sex sex was quickly surpassed by the number of infections attributable to heterosexual intercourse. By 1999, AIDS was a leading cause of death in the population among 15-34 year olds (Central Statistical Office, 1999).

Up until 2003 the response to HIV/AIDS in Trinidad and Tobago followed the "medical model" where policy, planning, and programmatic activities were lead by the

Ministry of Health and concentrated primarily within the health sector. The first formal institutions aimed specifically at fighting AIDS: the National AIDS Program (NAP) and the National AIDS Committee (NAC) were established in 1986. The NAC was a body that coordinated policy development, while NAP was responsible for the implementation and programmatic activities Initially, the staff of the NAP consisted of only two people: the NAP coordinator and a secretary (personal interview, TT3). (see also World Bank, 2003, p. 6). The program expanded somewhat in the early 1990 and in 1992, the staff of the NAP included the Program Coordinator, Education and Information Campaign Coordinator, graphic designer, accountant, and a health educator.

Like in Barbados, in the 1980s the response was dominated by the health sector. The NAP was housed within the Ministry of health and the Chief Medical Officer was the chairman of the NAC (personal interview). As one key informants put it:"It was very medically focused. The Ministry of Health took and ran it." (TT8).

The NAC included representatives from outside of the Ministry of Health, including academics form the Faculty of Medicine of the University of the West Indies, staff from the Caribbean Epidemiology Center (CAREC) as well as representatives from other ministries, such as Education and Labor . However, in the absence of formal linkages between the NAP and the line ministries, attendance in meetings and the programmatic involvement of those ministries remained minimal. One former director of the NAP told me:

"We had those people but the people who were not health-related did not see their value on the committee and so their participation was poor. So if somebody came from the

Ministry of Labor and they would sit and listen, the next time they would either send someone down the line or they would not come because they would not see it as important." (TT14)

Another director said that throughout the 1990s the NAP "was mainly a health-based thing. We had a lot of people coming from the health sector." (TT26).

Like its counterpart in Barbados, the NAC/NAP focused on public information campaigns. Those efforts in the 1980s received support from the European Community and a program to reach women in rural areas, supported by UNICEF was launched in collaboration with the Community Development Division. In 1987, the AIDS Hotline was set up with Helena Joseph as its coordinator and Dr. Farley Clughorn as the medical director. In 1995, a youth education and outreach program called "Rapport" was launched. Funded by the EU, and housed within the Health Education department, Rapport was set up as youth information center "operated by young people for young people in school and out of school" (TT8).

The NAP staff engaged in efforts to educate the medical profession about HIV and AIDS. They held lectures and information sessions for the members of the medial associations, the Trinidad and Tobago Registered Nurses Association, and the Dental Association of Trinidad and Tobago.

During that period the NAP also engaged in educating Trinibagonian media about HIV and AIDS. In the 1990s, the Program also carried out capacity building efforts supporting the emerging civil society organizations including HIV Anonymous, which in

1989 was renamed Community Action Resource and remains the largest organization for PLWHA in the country (personal interviews TT15, TT17, TT26).

Since late 1980s HIV testing was available at the Venereal Diseases Clinic (which was renamed the Queen's Park Counseling Center and Clinic) in Port of Spain. Limited treatment, consisting mostly of the management of opportunistic infections and palliative care were being provided in QPCCC as well as at Ward 2 of the Sand Fernando General Hospital (Adoo, 2000):

"We had doctor Adoo in San Fernando. And everybody who was positive tended to go do San Fernando..."(TT14; TT27).

"Dr. Adoo was running Ward 2 treating with whatever was available. And people would live a little longer. Not that the treatment then was effective, but the people [patients] recognized that not everybody was putting them down." (TT4)

One stark difference between the response to AIDS in Barbados and Trinidad and Tobago was the proliferation of clinical research activities in the latter (see e.g. Cleghorn, Jack, Murphy, Edwards, Mahabir, Paul,. et al. 1995, Cleghorn, Jack, Murthy, Edwards, Mahabir, Paul, et al., 1998; Cleghorn, Jack, Carr, Edwards, Mahabir, Sill, et al. 2000). AIDS in Trinidad and Tobago was discovered during the course of a research project on another retrovirus - the Human T-lymphotropic Virus (HTLV). In 1985, a study of HIV seroprevalence in gay men who were attending the STI clinic in Port of Spain was published in the Journal of the American Medical Association (JAMA, 1985). In 1986,

the University of West Indies received a grant from the National Cancer Institute to investigate the distribution of HIV and it sequelae and HTLV in Trinidad and southern Caribbean. After the first 1.5 years, the project was moved to the Caribbean Epidemiology Center (CAREC); in the early 1990s, the Medical Research Foundation (MRF) was set up to house it.

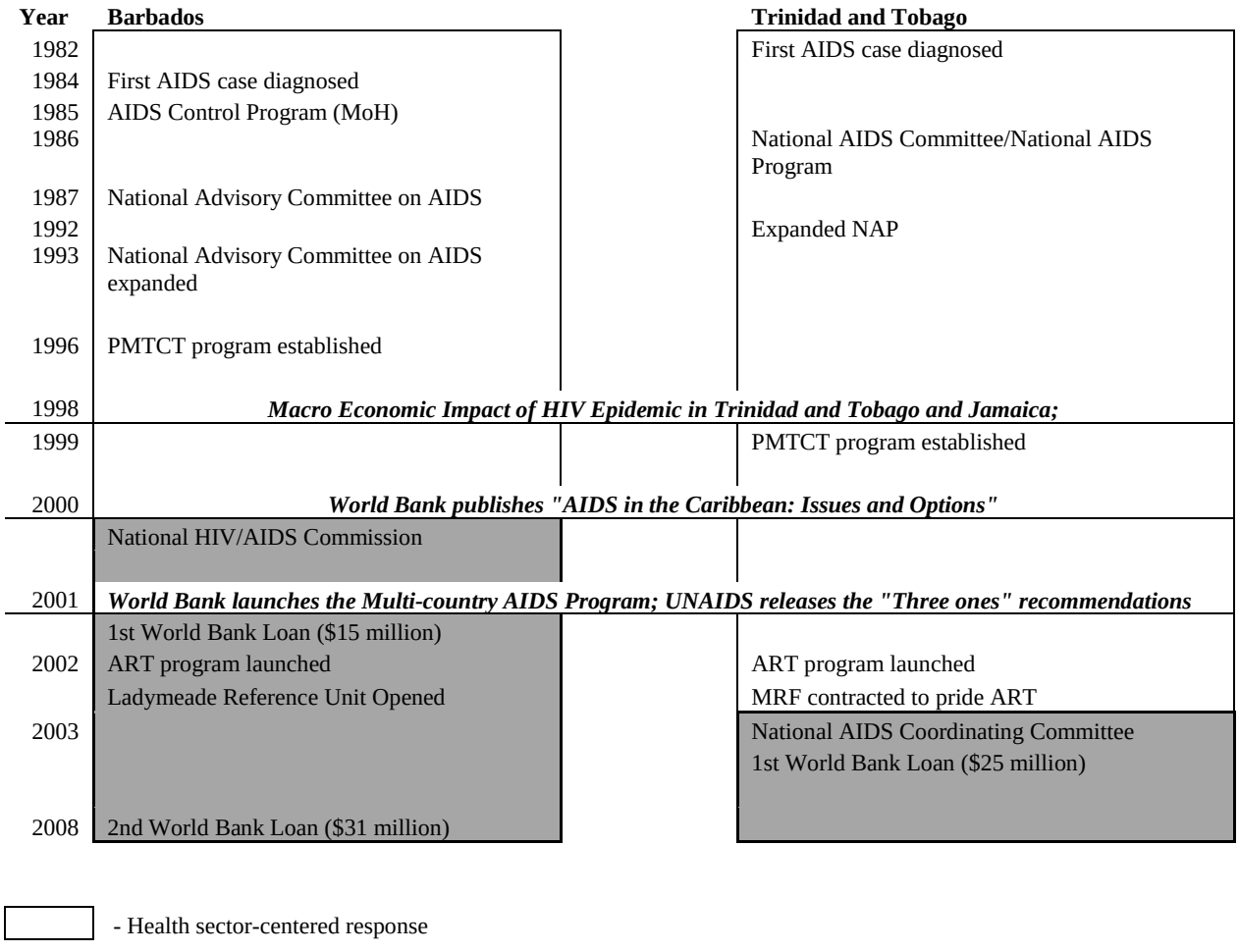
However, there were no formal institutional linkages between research activities and the NAP, even though some member of the NAC were involved in research. More importantly, these exceptionally vibrant research activity did not translate into programmatic work.

Multi-Sectoral Response: 2003 to date

A major shift in the scope of the response to AIDS in Trinidad and Tobago came about in 2002 and 2003. During that period, the "medical model" was replaced with a multi-sectoral approach advocated by the international organizations, including UNAIDS and the World Bank. Trinidad and Tobago developed an institutional and policy infrastructure consistent with the best practice model and the "three ones" recommendations of UNAIDS. In 2003, the NAC was replaced with the National AIDS Coordinating Committee (NACC), located within the Office of the Prime Minster. Like in Barbados, formal linkages between the NACC were established and by 2009 six ministries had full time HIV/AIDS coordinators (Ministry of Health, National Security, Sports and Youth Affairs, Education, Social Development, Labour and Small and Micro Enterprises (Government of Trinidad and Tobago, 2010).

In2003, the country adopted a National Strategic Framework, a document guiding the multi-sectoral response. In the same year, the government secured a USD 21 million loan from the World Bank to finance the expanded response to AIDS. In 2002, in anticipation of the World Bank funding, an ART program was launched which offered free and universal access to anti-retroviral drugs. Figure 4 below shows a summary comparison of the historical evolution of HIV/AIDS policy in Barbados and Trinidad and Tobago

Figure 4.4.: Historical Evolution of HIV/AIDS Policy in Barbados and Trinidad and Tobago.



 - Multi-sectoral response

There are two stark difference between the way AIDS was addressed at the turn of the century in Barbados and Trinidad and Tobago. First, the multi-sectoral approach in addressing AIDS was adopted in Barbados earlier than in Trinidad and Tobago. Significantly, developing its policy and institutional infrastructure Barbados was very pro-active and "ahead of the game", so to speak. It set up its multi-sectoral coordinating body in 2000, before the UNAIDS officially launched its "Three ones" recommendation. Also, it adopted a National Strategic Framework in 2000 before the World Bank launched its Multi-Country AIDS Program, which made having a NSF a conditionality for receiving funding. Trinidad, on the other hand, adopted a NSF and set up the NACC after and because of the Bank's policy and UNAIDS' recommendation.

Second, in Barbados, the scale-up of the ART program was very successful and the treatment program is considered to hallmark of the national response to AIDS (e.g. Marques, 2003; Headley and Siplon, 2006). In contrast, in Trinidad and Tobago, the limited coverage of ART remains one of the main challenges of the response to the epidemic (Government of Trinidad and Tobago, 2008, 2010).

Quantitative analysis presented in Chapter 2 suggests that electoral market imperfections are not associated with improved policy and institutional environment. Consistent with those results, my fieldwork research suggest Trinidad and Tobago's lagging behind Barbados in bringing its policy and institutional environment in compliance with the global "gold standard" promoted by international organizations can be attributed to two factors, one rather idiosyncratic, and one systematic but laying beyond the theoretical framework of this dissertation. First, the constitutional crisis and

the electoral stalemate which developed in 2001-2002 to a large paralyzed the government and halted a great deal of policy activity. Second, its reliance on petrochemicals, rather than on services and tourism, made Trinidad and Tobago less responsive to the need to prioritize AIDS as a health and potential economic crisis. I will address especially the second factor in the last section of this chapter.

On the other hand, my fieldwork demonstrated that the differences in ART coverage can be directly attributed to governance failures resulting from the high levels of electoral market imperfections.

Electoral market imperfections and ART provision in Trinidad and Tobago:

Quantitative analysis presented in Chapter 2 showed that the electoral market imperfections mediate the association between democracy and HIV/AIDS policy in the areas of treatment provision. As I suggested in the previous chapter, there are indeed stark difference in treatment program between Barbados and Trinidad and Tobago. Both programs were launched at about the same time, in 2002. However, by 2006 the percentage of people in need to anti-retroviral therapy who were receiving it in Barbados was 84.4% while in Trinidad and Tobago - only 49% (see Table 7 below) (Government of Barbados, 2008; Government of Trinidad and Tobago, 2008). In the subsequent years, those difference persisted. While the ART coverage in Barbados increased to 87.3% by 2009, in Trinidad and Tobago it has hovered at about 50%.

Table 4.7.: Percentage of People in Need of ART Who Are Receiving It in Barbados and Trinidad and Tobago, 2006-2009.

Year	ART coverage	
	Barbados	Trinidad and Tobago
2006	84.4%	49%
2007	85.5%	54%
2008	87.6%	51.78%
2009	87.3%	50.77%

Source:

One of the main reason why the uptake of ART was so low in Trinidad and Tobago was that treatment provision has been centralized (e.g. County Progress Report 2010, p. 37). More specifically, anti-retroviral therapy has been provided mainly through one organization - the Medical Research Foundation located in Port of Spain. I argue that the centralization of ART provision is a example of a public policy failure resulting from the lack of accountability and a tradition of providing patronage through distribution of government contract. Before I proceeded, however, let me first address an alternative explanation, namely that the larger size of Trinidad and Tobago is the reason why the uptake of treatment has been limited because it made service provision more difficult.

A look at the historical record of public health outcomes in Barbados and Trinidad and Tobago shows that geography is not destiny and that implementation of social and health policy has not always been easier in Barbados due to its smaller size. In the first half of the twentieth century, the state of public health was much better in Trinidad. In the 1920s, both adult and infant mortality rates were much lower there (Table 8). In 1946 Barbados had the highest infant mortality rate in all of the British West Indies (147 per 1,000 live births) while infant mortality rates in Trinidad were the lowest in the colonies (75 per 1,000 live births). Infant mortality rates remained lower in Trinidad and Tobago through the 1950s (78.2 and 136 respectively in 1952)

(Development and Welfare in the West Indies, 1952. Colonial Office Report, 1953; in Beckles, 2006, p. 242-243).

Table 4.8.: Adults and Infant Mortality in Barbados and Trinidad and Tobago, 1925-1929.

	Death rate per 1,000 inhabitants		Death rate under 1 year per 1,000 live births	
Year	Barbados	Trinidad	Barbados	Trinidad
1924	29.5	no data	298	no data
1925	29.5	29.5	312	134
1926	29.6	28.8	314	143
1927	20.2	17.8	201	130
1928	30.1	18.7	331	129
1929	23.7	18.5	239	128

Source: Beckles, 2006

The immediate reason for the dismal state of public health in Barbados was poverty of the working class. The poverty, in turn, had its sources in bad governance. The white elite resisted any efforts toward a significant land reforms. Thus, as Beckles points, in Barbados "the alienation of the workers from ownership of the land was most extreme" (Beckles, 2006, p. 242). Declining sugar prices were compensated by land owners by labor squeezing, which lead to further impoverishment of the working class (Beckles, 2006).

The historical data show that governance has had more decisive impact on difference in public health between Barbados and Trinidad and Tobago than geography. While Barbados' smaller size can perhaps make service delivery easier, it cannot protect it from bad governance. Conversely, I argue, it is bad governance rather than larger size of Trinidad and Tobago that made treatment provision there less successful.

The Medical Research Foundation and the ART provision in Trinidad and Tobago:

The ART treatment program was launched in Trinidad and Tobago in 2002. At the inception of the program, the government contracted the Medical Research Foundation to carry out treatment provision (World Bank, 2003, p. 9). During my fieldwork, I was not able to secure any interviews with the current staff of the MRF. My official request to interview the director of the Foundation, Professor Courtenay Bartholomew was denied:

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Dear Mr. Kakietek

Professor Bartholomew sees no connection between Political
Science and the HIV/AIDS epidemic in the Eastern Caribbean.
He suggests that such information can be obtained elsewhere
and not meeting with him.
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Only two former MRF staff members I have approached agree to be interviewed. Information in this section comes from publically available primary and secondary sources and from interviews with key informants who were not working for the Foundation.

The Medical Research Foundation was established on March 1st, 1997 to provide organizational infrastructure for research on HIV in Trinidad (www.mrftt.org) which began in the early 1980s. In that time, in collaboration with Dr. Robert Gallo from the National Cancer Institute at the US National Institute of Health, Professor Courtenay Bartholomew was conducting research on the Human T-lymphotropic Virus (HTLV) a retrovirus which causes T-cell leukemia. During the course of the research, Bartholomew's team found several cases which resembled the HTLV infection but were in fact AIDS. In the 1980s and early 1990s Professor Bartholomew, together with other researchers, including Gallo, conducted several research projects, including a study on

HTLV - HIV confection, and has received grants from the National Institute of Health, University of Maryland, and elsewhere. The Medical Research Foundation was established when the research program outgrew the infrastructure within the University of the West Indies where it had been housed. In 1998 the MRF became part of the HIV Vaccine Network and received a grant from the NIH to conduct an HIV trial in Trinidad and Tobago. Preliminary results showed that the vaccine was ineffective and the trial was discontinued (Cleghorn, Pape, Schechter, Bartholomew, Sanchez, Jack. et al., 2007).

With the introduction of free and universal access to ART in Trinidad in 2002, the MRF found a new life as it re-imagined itself as a treatment center. As one key informant put it:

"[Bartholomew] needed a new platform. And with all the new funding [coming in]....and having control over those funds through a sympathetic government was the expedient thing to do and that's what he did. (TT3)"

It needs to be noted that while it is true that the Foundation has been the "repository of biomedical knowledge" (personal interview), with connections to leading HIV research institutions and scientists in the world, prior to 2002 it had not engaged in treatment or other programmatic work (personal interviews, TT1, TT33, TT3). Interestingly, HIV patients were being treated at Ward 2 of the (public) San Fernando General Hospital located in central Trinidad (historically, an area dominated by Indians, and a UNC stronghold) by Dr. Adoo and Dr. Mohammed, admittedly, without the biomedical expertise that the MRF had (personal interviews; see also Adoo, 2000).

Nevertheless, it was the MRF that became the principal treatment site on the island. In the 2002 budget speech, the PNM Prime Minster Patrick Manning emphasized the role of the MRF in the scale-up of HIV treatment in Trinidad:

" Access to comprehensive care and treatment will be significantly expanded. The cost of HIV/AIDS drugs will be reduced through appropriate subsidisation. Anti-retroviral drug treatment will be provided to persons living with HIV/AIDS and the Mother to Child Treatment Programme will be expanded. We have also allocated $3.2 million to the Medical Research Foundation of Trinidad and Tobago, headed by the world famous pioneer in HIV/AIDS research and son of the soil Professor Courtenay Bartholomew."(Government of Trinidad and Tobago, 2002; accessed at: http://www.search.co.tt/trinidad/budget/2003.html)

The MRF's work has been guided by a memorandum of understanding between the Foundation and the Ministry of Health. The MoU is a confidential document and I was not able to obtain of a copy. From the key informant interviews I found out that the Ministry of Health pays salaries of the MRF staff, even though the Foundation is able to seek additional outside funding. In addition, the government of Trinidad and Tobago provides the Foundation with equipment necessary for clinical management of HIV patients, including a viral load machine and reagents. Anti-retroviral drugs are also procured by the government.

While the MRF is not the sole provider of ART in Trinidad and Tobago (San Fernando General Hospital, Tobago Health Promotion Clinic, and since 2009, Sangre

Grande Hospital treat HIV positive adults; ART for pediatric patients if offered at the Sir Eric Williams Medical Center, the Cyril Ross Nursery, and the Scarborough Regional Hospital in Tobago) it remains the largest provider of anti-retroviral for adults (Government of Trinidad and Tobago, 2010, p. 30). As mentioned above, the centralization of treatment within the MRF is widely considered the main cause of the low uptake of ART in Trinidad, as patients from other areas of the island are often unable to travel to Port of Spain to receive their medication (see e.g. World Bank, 2003, Government of Trinidad and Tobago, 2008, 2010).

"When you have HIV, and live in Arima you have to come here, and it takes a day. People are afraid. If you work and take a day of every two weeks, people start to talk. " (TT6)

In addition, key informants from other treatment sites pointed to the unwillingness of the Foundation to share its expertise and resources.

"[the MRF] is very close-nit. It's great to be there if you're on the inside. I really like the people there. But they need to spread the information. This is science, it's not anybody's property. And the Prof is very much against decentralizing and rotating different people in his clinic." (TT27).

I have been told that the Foundation refuses to do viral loads on specimens from other sites, which is ironic, given that it is the government that pays the supplier for renting the viral load machine housed at the MRF and buys the reagents. Thus, the MRF not only

hinders the uptake of ART but also makes clinical management of HIV patients in other sited more difficult.

The MRF and Professor Bartholomew have resisted decentralization of ART provision claiming that physicians in Trinidad and Tobago do not have sufficient expertise in managing HIV patients (e.g. Trinidad and Tobago Express, 15 September 2004 "Quacks adding to HIV menace"; Trinidad and Tobago Express, 17 September 2004 "Bartholomew backs "Aids quacks" charge"; Trinidad and Tobago Express, 26 September 2004 "Camara needs to get HIV facts straight") and that MRF is the only facility on the island that can provide adequate standard of treatment.

"One of the issues in the NSF [National Strategic Framework - a document guiding the national response to HIV/AIDS in Trinidad and Tobago] was the decentralization of treatment but some of the doctors who are in charge think that there are not enough doctors who can treat HIV" (TT14)

"[S]o we've been involved in this ongoing dialogue about decentralizing care. But Prof would have none of it because if care is decentralized, it means all the resources will be removed. And of course he doesn't want that..." (TT7)

On the other hand, most of the key informants I have interviewed said that, maintaining monopoly was a way to ensure the control over funds and the institutional survival of the Foundation. As one of the key informants put it: "Bartholomew...was able to convince

the government that he was the only person who should be allowed to treat AIDS officially in the country." (TT3).

"[The MRF] staff is overwhelmed, they're overworked, so what's the problem with decentralizing care? The problem is money and power. That's the problem. It's not about the damn people who need care and treatment, it's about the money and the power." (TT7)

MRF's reputation as the leading research (but not treatment) center , Bartholomew's position within the medical profession, and his service as the Dean of the Medical School undoubtedly help convince the government that the treatment program should be implemented through the Foundation (personal interviews, TT35, TT3). However, I argue that political factors were very important in the emergence of the MRF as the principal provider of ART in Trinidad.

The signing of the Memorandum of Understanding between the MRF and the Ministry of Health occurred in the context of the People's National Movement (PNM) re-taking of the government in 2001, after 6 years of UNC rule, and its retrenchment following the 2002 general election. I argue that Bartholomew's political connections and entrenchment within the PNM were critical in the MRF's being able to seize control over ART. Professor Bartholomew is alleged to be a personal physician of Dr. Eric Williams, the author of Trinibagonian independence and one of the founders of the PNM, as well as Sir Ellis Clark, the penultimate Governor General and the first President of Trinidad and Tobago, who was elected twice by a PNM-controlled House of assembly

(when PNM lost the election in 1986, Clark did not seek a third term under the NAR government) (Meighoo, 2007). In fact, Clark is the official Patron of the Foundation (www.mrf.org). This close rapport between the ruling party and the director of the MRF was corroborated by key informants:

"The Prof as he's fondly called, has been the teacher for most of the doctors in the country currently now. They pass through his hands so he has a lot of influence. Prof continues to be the chief physician for I think both the Prime Minister but certainly the President of this country. So he has reached into the higher echelons of society." (TT7)

"I heard that too [that he was Dr. Williams' personal physician]. So that put him on good terms with the PNM. Exactly."(TT18)

I know he was very close with Dr. Williams. I'm not sure if he's that close with the government now..."(TT25)

"It just happened that the Professor had all the clout, the association with Robert Gallo, and all the political clout so he saw a need early and ran with it. What we are facing right now is that he wants everything for himself which is bad." (TT8)

"He has a lot of power. And that is true. And he's using this power to keep that shop." (TT6)

MRF's becoming the principal provider of AIDS treatment on the island is not a historic idiosyncrasy. Rather, it is consistent with the general practice of patronage and the provision of political "pork" through employment in the public sectors and awarding government contracts. When the PNM returned to power in 2001, during what Ryan calls the "hung parliament" period, the PNM Prime Minister Manning "sought to project the view that he was not a pro-term Prime Minister" (Ryan, 2003, p. 195). Not only did he appoint an extraordinarily large cabinet, consisting of 29 members and including his wife as the Minster of education, but also started replacing public sector officials appointed by UNC with supporters of the PNM. It needs to be noted that the PNM is not the only party guilty of distributing patronage through public service appointments. Ryan observed: "What one was witnessing was not "ethnic cleansing", a terms that had a very specific meaning, but the operation of a spoils system that was a normal feature of the "winner takes all" paradigms that was characteristic of American and Westminster type political systems."(p. 200). In fact, this came to be expected by supporters of both parties. Following the election in 2010, when UNC returned to power, several party activists very publically expressed dissatisfaction that they were not being given public sector jobs:

"Members of a newly-formed association, comprising some 500 People's Partnership activists, are calling on the party to provide them with jobs. Members of the group—Social Ground Troops Association—feel they were sidelined for jobs after the PP came into Government. "The PP has not lived up to the mandate that was given to it," UNC activist Juliet Davy said during a press conference at the Communication Workers' headquarters, Henry Street, Port-of-Spain, yesterday. "Their mandate was not only to fix

crime but to continue the process of removing middle management PNM operatives who would be on state boards and they have not done that," she said.

She said the frontline activists of the party should have been given jobs within those state boards. She added: "It is not that we were promised jobs but I want to look at it as right [sic] *of passage. "We have contributed to what has taken place now…this victory the PP now enjoys is a victory as a result of the hard work people like myself have put in." She said she found it unfair that persons who were screened to be PNM candidates prior to this year's general election now held "high positions" in Government while die-hard PP activists were unable to feed their families. She said the members of the association would be unable to send their children to school when the term started on Monday because they have been without jobs for years, since the tenure of the PNM Government.*

...

"When Government changed hands activists had expected Government would have removed the appointees who were there before, and they would have been able to place our people in those positions," she said".

Trinidad and Tobago Guardian. 2 Sep 2010. "PP activists cry neglect from Govt."

I argue that MRF monopolization of ART is a part and parcel of Trinibagonian politics where the state largess is used to provide benefits to political allies. This in turn, is possible because of low accountability of politicians, resulting from a high level of political market imperfections.

I discussed the situation in Trinidad and Tobago with some of my friends and key informants in Barbados and asked them why they think similar problems did not occur in their country. Why didn't Dr. Jacobs, who was also very well politically entrenched, try to privatize and monopolize ART? I expected to hear explanations about her characters: "she wouldn't want to do that", "she's not that kind of person" or that she lacked political influence. Instead, the response I got was that "she wouldn't get away with it". That is, my informants claimed, such efforts on her or anybody's part would not be possible due to high degree of scrutiny over the health and the public sector in general. This emphasis on high level of accountability rather than personal reasons or lack of opportunity is very telling and pointedly illustrates the central premise of this dissertation, namely, that high levels of electoral market imperfections diminish accountability of public officials and lead to public policy failures. In Trinidad and Tobago, where the level of the imperfections was high, HIV/AIDS treatment, including the lab infrastructure, even though financed from the public purse, was effectively privatized, which in turn lead to slow uptake and low coverage of ART. In Barbados, on the other hand, ART had been distributed through the public health care system, and even though the infrastructure (the LRU) and the distribution channels had to be created from scratch, the coverage of ART has been much higher.

Liquid Gold: Petrochemical and the AIDS in Trinidad and Tobago

In addition to treatment provision, the HIV/AIDS policy trajectory in Trinidad and Tobago and Barbados shows another significant difference. While Barbados was

very pro-active in re-structuring its national response and bringing it to compliance with the recommendations of the international institutions, Trinidad and Tobago lagged behind. As Figure 3 on page 21 shows, Barbados adopted its first National Strategic Plan and set up a single multi-sectoral coordinating body located within the Office of the Prime Minister in 2000. It is important that policy and institutional infrastructure reform happened pro-actively, that is before and in anticipation of the World Bank's funding becoming available. Thus, when the Bank launched its Multi-country AIDS Program and the Adaptable Loan Plan for the Caribbean, Barbados was very well positioned to tap into the funding. In fact, together with the Dominican Republic, it became the first country in the region to receive a loan supporting the national response to AIDS. Furthermore, it became the first country in the world to receive support from the World Bank to finance an ART program (Marquez, 2003; personal interviews WB1, WB2). One of the main reasons Barbados was selected as a pilot country for such a loan was its reputation as the leader in the fights against AIDS, which resulted, among other things, form the country's reforming its policy and institutional infrastructure.

In contrast, Trinidad and Tobago did not adopt a national strategic plan and set up a multi-sectoral coordinating agency until 2003. Unlike Barbados, the country was re-active, rather than pro-active, in responding to the incentives and opportunities offered by the institutional organization, including the World Bank. The Bank staff members I interviewed told me that Trinidad and Tobago did not receive its first loan from the Bank until 2003, because it was "not ready", that is, it had not adopted a national strategic plan to deal with AIDS and had not set up a multi-sectoral coordinating body.

As I mentioned above, there were two reasons for the delays in the full-fledged adoption of the multi-sectoral model in Trinidad and Tobago. The first was the constitutional crisis which lasted from 2000 through 2002, which made the country less able to respond to the incentives offered by the international organizations that the stable government in Barbados was ready to embrace.

In 2000, the UNC won the election, securing 19 out of 36 seats in the House of Assembly. The PNM won 15 seats and the NAR - 1 seat in Tobago. At that time, UNC was torn by an internal crisis caused by a conflict over who should succeed Basdeo Panday as the party's leader (Ryan, 2003). A dissident faction within the UNC lead by Panday's successor-(not) to-be, Lawrence Maharaj, left the party, and formed a separate political organization - Team Unity. Team Unity MPs: Maharaj, Maraj and Sudama formed an alliance with the PNM, allegedly to eradicate corruption from the UNC government (ibid). Thus, shortly after the election, the UNC lost the majority in the Parliament. New general elections took place in 2001 and resulted in a parliamentary stalemate, with UNC and the PNM winning 18 seats each. After weeks of what amounted to a constitutional crisis, the President A.N. Robinson appointed Patrick Manning, the leader of the PNM, as the country's Prime Minister. Without a majority in the parliament, the new PNM government was not able to govern effectively, and a new general election took place in 2002. The PNM won 20 seats and the political stalemate ended (ibid).

Key informants I have interviewed suggested that the constitutional crisis and political instability affected the general policy-making capacity of the government and that that period of time was inconducive to any policy reform (TT33, TT1). When crisis

was resolved and the PNM gained a majority in the Parliament and the policy activity, including the reform the HIV/AIDS policy, resumed.

The second reason for the delays in updating policy and institutional infrastructure of the national response to AIDS, I argue, was the nature of the Trinibagonian economy. I chose Trinidad and Tobago and Barbados as the case studies for this project because, while they vary with respect to the levels of electoral market imperfections, they are very similar regarding a number of other important confounding variables: HIV prevalence, geographic location, size, colonial heritage, level of democracy, electoral system, and political institutions. One important exception from this "all being equal" case selection is the nature of the two countries' economies. More specifically, while Barbados, like the majority of other Caribbean states, relays primarily on services and tourism, which account for some 75% of its GDP and 80% of exports, the economy of Trinidad and Tobago is dominated by petrochemical industry (petroleum and natural gas production and processing) accounting for some 40% of the economy and 80% of exports (CIA World Factbook).

My fieldwork research showed that the nature of the economy affected the degree to which decision makers felt that the national economic "bottom line" was threatened by AIDS. As I mentioned in the previous Chapter, in mid 1990 the global AIDS epidemic and its impact started being framed in economic terms (Pisani, 2007). It was argued that the disease would have a disastrous impact on the economies of the developing countries, decimating the work force, and creating a shortage of qualified labor (e.g. World Bank, 2000, Barnett and Whiteside, 2002, Haacker, 2004, Birdsall and Hamoudi, 2004, Bell,

Devarajan and Gersbach, 2004). This global discourse was embraced in the Caribbean and taken up by the local media (see Chapter 2; Kakietek, 2010).

In 1998, the Health Economic Unit at the University of the West Indies, St. Augustine (Trinidad and Tobago) published a study estimating the impact of the AIDS epidemic on economic growth in Trinidad and Tobago and Jamaica (Shelton, McLean, Theodore, Henry, Bilali, 1998; see also Camara, Shelton, & McLean, 1997; Nicholls, McLean, Theodore, Henry & Camara, 2000). The study was the first in a series of economic impact studies conducted by the Department of Economics/Health Economics Unit in association with various local partners in Suriname, Guyana, Organization of Eastern Caribbean States, and Barbados (personal interview, TT31). The estimated for Barbados were produced in 2001 (Adomakoh, 2001). They served to support and reinforced the perception that responding to AIDS was an economic necessity.

In Chapter 3 I showed that the Barbadian political leadership wholeheartedly adopted this discourse and used it to justify the expansion of the fight against AIDS. The discourse was officially espoused by the political leadership in Trinidad and Tobago as well. For example, at the 26th Special Session of the United Nations' General Assembly to Review and Address the Problem of HIV/AIDS in June 2001, the Minister of Health, Hamza Rafeeq said:

"The disease is a major development problem. With the most economically active and productive population groups being the most affected by this epidemic, severe social and economic repercussions are inevitable.

With 50% of the new infections now occurring in our young people between 15-24 years and 70% of all HIV/AIDS cases falling between the age group 15-44, there is no doubt that if this trend continues, Trinidad and Tobago will be well on the way to an economic and social crisis. It is onerous on the country's resources and the economy is finding it difficult to sustain this heavy burden."

AIDS was even included in the "Vision 20/20" document - a roadmap to transforming Trinidad and Tobago into a developed country by 2020. Vision 20/20 stated that: "prevalence of HIV/AIDS epidemic which threatens to eliminate the working population if left unchecked" (Government of Trinidad and Tobago, 2007, p. 68).

However, I argue that despite the official discourse, political leaders in Trinidad and Tobago felt less threatened by AIDS than the leadership in Barbados. When asked about why the transition from the health model to the multi-sectoral approach occurred, some of the key informants in Trinidad and Tobago did mention the economic bottom line (TT34, TT11, MSTT). *"It was the sense of this development agenda that was put at risk because of HIV"* (TT11). However, most of them pointed to the advocacy and pressures from international organizations such as UNAIDS and the WHO, and the funding available from the World Bank (e.g. TT21, TT8, TT18) In Barbados, in contrast, while some key informant pointed to the international factors (B1, PB16, B12), most said that economic considerations were the primary rational for Owen Arthur's administration's decision to scale up its response to AIDS (B3, B20, B33, B16, B25, B18, B27, B31, B36). As one government official told me:

"The Prime Minster realized that HIV/AIDS could reverse all the development gains we have made post independence." (B9)

This perception of threat was strengthened by the fact that Barbados is a resource-constrained country, with a human capital-intensive economy and that the population is its most important asset:

"We were told that we only had one resource, which is people" (B3)

Because of that, the economic impact of AIDS would be much greater there than in other, more resource-rich countries:

"Barbados is a resource constrained country, We really don't have any natural resources compared to countries like Guyana, Trinidad, Jamaica...Our population is our biggest resource....HIV would wreak havoc in out productive sector if it was left unchecked." (B31; see also B9, B27)

In stark contrast, none of the key informants I interviewed in Trinidad linked AIDS and the depletion of limited human resources of their country to economic decline. This is hardly surprising. While petrochemicals account for 40% of the economy and 80% of total exports, only about 5% of the labor force is employed in that sector (CIA World Factbook). As an official from the Ministry of Finance told me: "Most of [our] economic output was coming from the minerals. You contrast this with our human

resource utilization. Our human resource utilization was limited in the hydrocarbon sector" (personal interview, TT11). Furthermore, the labor force, especially the skilled workers and the management, are dominated by expatriates (Premdas, 2007; personal interviews TT11). Thus, even very high morbidity and mortality due to AIDS, would not have affected the key sector of the economy to a great extent.

This is consistent with the results of quantitative analysis presented in Chapter 2, which showed that the level of imperfections was a mediating variable for the provision of ART but not for policy outputs such as compliance with the "Three Ones" recommendations. This suggests that other factors, including the structure and nature of the economy, may better explain the adoption of such policies.

While the structure of the economy affected the responsiveness of the Trinibagonian government to international pressures and incentives to reform its policy and institutional environment, I found no evidence that it affected service delivery. I have argued that reliance on petrochemicals made politicians less scared of the potential impact of AIDS on the country's economy. This, in turn, resulted in Trinidad and Tobago delaying AIDS policy reform. Consequently, if reliance on petrochemicals, rather than patronage, were responsible for the slow scale-up of ART in Trinidad and Tobago, we should expect that the low coverage would be a result of late introduction of free access to ART. This is not the case. In fact, the treatment program was launched before the overhaul of the Trinibagonian AIDS policy which took place in 2003. The decision to provide free and universal access to ART was adopted at roughly the same time in Barbados and in Trinidad and Tobago. As I discussed in depth above, the problems with

the ART delivery in the latter were caused by the MRF's control of the treatment program and its effective resistance to decentralization.

Conclusions:

The analysis of HIV policy evolution in Trinidad and Tobago confirms the research hypothesis that electoral market imperfections negatively affect the provision of HIV/AIDS related services. In this chapter I showed that the ethnic polarization of the political system, low level of trust in electoral promises, and lack of interest in and information about politics greatly reduced democratic accountability and contributed to the emergence of political culture based on patronage, where the provision of "pork" to supporters and allies is considered the norm and a behavior expected of politicians and government. As a former PNM minster said: "all we thief" (Ryan, 2003).

In the area of HIV/AIDS policy, this culture expressed itself in the Medical Research Foundation, a private organization run by Professor Bartholomew, who was well entrenched within the PNM, being selected as the principal provider of anti-retroviral therapy. Even though the government pays for the anti-retroviral drugs the MRF distributes, rental fees for the diagnostic equipment and reagents the Foundation uses, as well as the salaries of the MRF physicians, the Foundation remains a private entity with very little governmental supervision. The resistance of the MRF and Professor Bartholomew has been the main obstacle to the decentralization of treatment. Consequently, as ART provision remains centralized, the uptake of anti-retroviral

therapy has been unsatisfactory (only about 51% of persons in need to ART were receiving it) and Trinidad and Tobago lags far behind Barbados.

In Barbados, where anti-retrovirals are distributed through public channels, about 87% of the people in need to ART (including 100% children) are receiving it. Key informant argued that "privatization" of ART provision, such as took place in Trinidad and Tobago, would not have been possible in Barbados because of the high level of accountability of public officials in that country.

These findings are consistent with the results of the quantitative analyses presented in Chapter 2, which showed that electoral market imperfections mediated the impact of democracy on service provision, including ART coverage. It also showed that, all things being equal, democratic countries with lower levels of electoral market imperfections (e.g. Barbados) had better ART coverage that similarly democratic countries with high levels of the imperfections (e.g. Trinidad and Tobago).

As I suggested in the previous chapter, the evidence from the case studies calls for an important refinement in the theoretical framework of this dissertation. The analysis of the historical data from Barbados and Trinidad and Tobago strongly suggests that democratic accountability affects policy implementation, rather than policy adoption. This is an important revision both to this dissertation as well as to the scholarship on democracy and social policy. As noted in the theoretical chapter, the extant scholarship on democracy and public goods has under-theorized the connection between public policy and public goods provision. By not addressing explicitly the former and focusing on the latter instead, it either made an unrealistic assumption that the governments are always able to implement the policies they enact (Bueno de Mesquita et al., 2005) or

ignored the distinction between policy adoption and implementation altogether (e.g. Baum and Lake, 2000; Lake and Baum, 2003, Zwifel and Navia, 1999).

In the context of this research the distinction between policy adoption and implementation is important for two reasons. First, quantitative analysis presented in chapter 2 showed that electoral market imperfections are associated with service provision, but not necessarily with indicators capturing outcomes more closely related to adoption (e.g. compliance with the "Three Ones" recommendation). Second, consistent with quantitative analyses, the analysis of the case studies demonstrates that factors other than the imperfections, particularly dependence on oil production in Trinidad and Tobago and dependence on services and tourism in Barbados, might have affected policy HIV/AIDS adoption, but not implementation.

Based solely on a variable-based comparison of the two country cases, we could not tell whether the structure of the economy mattered in addition to or instead of the electoral market imperfections. With only two cases and two (economy and imperfections), rather than one key independent variable co-varying, such cross-case comparison would be over-determined. However, using process tracing, I can address the issue of over-determination. Based on the interviews with the key informants I it is quite clear that while the reliance on petrochemicals versus services and tourism likely affected the degree to which the governments in Barbados and Trinidad and Tobago prioritized responding to AIDS, it did not impact the way ART were distributed in both countries.

CHAPTER 5: ELECTORAL MARKET IMPERFECTIONS AND SOCIALLY MARGINALIZED GROUPS - THE CASE OF THE WALROND REPORT

1. Introduction:

In Chapters 4 and 5 I showed that, consistent with my theoretical argument, low levels of electoral marker imperfections created an environment of accountability wherein policy makers felt compelled to respond decisively to HIV. The difference between the two county cases is particularly stark in the area of treatment provision.

In both countries free and universal access to ART was introduced in 2002. However, the implementation of the ART program was much more successful in Barbados than in Trinidad and Tobago. By 2006 the percentage of people in need to anti-retroviral therapy who were receiving it in Barbados was 84.4% while in Trinidad and Tobago - only 49% (see Table 7 below) (Government of Barbados, 2008; Government of Trinidad and Tobago, 2008). In the subsequent years, those difference persisted. While the ART coverage in Barbados increased to 87.3% by 2009, in Trinidad and Tobago it has hovered at about 50%.

In Barbados, the ART program has been centralized and the drugs have been provided through Ladymeade Reference Unit (LRU) - a specialized public HIV clinic, which in addition to clinical care, counseling, and nursing services, also provides diagnostic and laboratory services not only for Barbados but also for neighboring countries. In Trinidad and Tobago, in contrast, due to accountability problems resulting

from the high level of electoral market imperfections, the ART treatment was taken over by a private organization, the MRF. Furthermore, the lack of transparency and accountability, enabled the MRF to resist the efforts to decentralize treatment provision. Consequently, ART coverage in Trinidad and Tobago is limited and only about half of the people who need anti-retroviral treatment are receiving it. Furthermore, Barbados was able not only successfully develop diagnostic and laboratory infrastructure within the public health system but also become and exporter of diagnostic services to other countries in the region. In Trinidad and Tobago, the MRF has been reluctant to let other treatment sites use the diagnostic equipment it houses but which has been leased by the government from public funds.

In this chapter, I return to the issue the differential impact of democracy and the imperfections in the electoral markets on policy measures aimed at the general population and the measures targeting socially marginalized groups. Statistical analysis in Chapter 2 has shown that democracies with low levels of electoral market imperfections were providing more completed coverage of treatment services than democracies with medium or low levels of the imperfections. In contrast, however, those countries were also spending less on programs targeting men who have sex with men, commercial sex workers, and intravenous drug users than democracies with medium level of imperfections.

In this chapter I argue that a high level of democratic accountability may be an obstacle, rather than a facilitating factor in introducing policies and programs benefiting socially marginalized groups. I describe the efforts to decriminalize commercial and same sex sex in Barbados, introduce as a measure to fight AIDS among MSM and CSWs, and

show that they were unsuccessful because they created electoral risks for the Owen Arthur administration. The "curious case of the Warlond Report" is consistent with the theoretical framework of this chapter: in countries with low levels of electoral market imperfections, politicians feel more accountable to the electorate and thus are more constrained in adopting policies seen as beneficial for social groups perceived in the negative light by the majority of the population.

2. The Curious Case of the Walrond Report:

Following the successful implementation of the ART program in the early 2000s, the creation of the Ladymeade Reference Unit as the center for AIDS treatment, and the dramatic improvements in clinical outcomes in HIV infected persons recorded at the LRU, the emphasis within the National AIDS Program was shifting from treatment and care towards prevention, and the human rights-based approach advocated by UNAIDS (UN Special Session, June 2001 on Human Rights). The 2001 Declaration of Commitment on HIV/AIDS called on the governments to ensure that national legislation promoted and protected the rights of people living with the virus and those most at risk of infection (ibid.). In February 2004 Attorney General, Mia Mottley (who also served as the deputy Prime Minister) commissioned a report to evaluate the existing legal framework and identify laws and regulations that presented obstacles to the implementation of a successful response to HIV/AIDS in Barbados. The terms of reference stated that the goal of the report was to provide a “comprehensive review of legislation relevant to HIV and AIDS and its attendant socio-economic impact…The recommendations that are made in this report are primarily intended to remove the social

barriers to the spread of HIV by: 1) removing the legislative props that encourage the marginalization of groups at high risk for transmission of the disease among themselves and into the wider community; 2) strengthening the legislative framework for an effective public health response to controlling the spread of HIV; 3) suggesting changes that will remove ambiguities in relation to the sexual conduct of minors and their exploitation by adults" (Walrond, 2004, p.1).

Attorney General handed the preparation of the report over to the National HIV/AIDS Commission which, in turn, delegated it to an independent consultant, Professor E.R. "Mickey" Walrond. Walrond was a professor of surgery and a former dean of the School of Clinical Medicine and Research at the University of the West Indies (Cave Hill Campus) and the Queen Elizabeth Hospital who was involved in treatment of the first AIDS case in Barbados. Walrond was also the head of the AIDS working party at the Barbados Association of Medical Practitioners and served as the chairman of the National Advisory Committee on AIDS at the Ministry of Health from 1987 through 1993[19].

The Report on the Legal, Ethical, and Socio-Economic Issues Relevant to HIV/AIDS in Barbados, which came to be known as the Walrond Report, was completed in June 2004. It examined a number of issues and areas that should be reformed in order to remove obstacles in the fight against AIDS which included: lack comprehensive anti-discrimination legislation, issues related to recklessness and deliberate transmission of HIV, buggery (anal intercourse) laws, sexual offences with children, prostitution, mandatory HIV testing, subpoenaing medical records, counseling and professional

[19] Walrond was also a member of the NHAC but during the writing of the report he suspended his membership on the Commission.

conduct, issues related to confidentiality such as sexual contact tracing of HIV infected individuals, general breaches in confidentiality, insurance application and medical record forms, and research. The Report also addressed issues pertaining to immigration, HIV and employment, as well as HIV transmission in criminal settings including condom distribution to inmates and needle exchange programs in prisons (Walrond, 2004).

As expected, among other suggestions, the report recommended liberalization of existing laws and regulations pertaining to controversial issues such as buggery (and, de facto, homosexuality), prostitutions, distribution of condoms in prisons, and access to healthcare and HIV testing without parental notification for minors who have reach the age of sexual consent[20]. It stated that "there is a need to begin the process of destigmatizing of marginalized groups such as homosexuals, prostitutes, and sexually active adolescents, who are at high risk of for HIV transmission in order to diagnose them earlier and reduce the prevalence of HIV among them" (ibid., p. 2).

With respect to buggery, the report recommended that "anal intercourse like other sexual acts practiced between consenting adults in privacy should no longer carry the threat of imprisonment for life but would remain a serious offence in the commission of sexual offences" (ibid., p. 2). With respect to prostitution, the report recommended bringing commercial sex work "into a regulated public health framework" which could include amending the extant Sexual Offences Act so that it required registering brothels and "other businesses supplying services with may involve sexual acts" and their compliance with public health laws (ibid., p. 4). With respect to HIV transmission in criminal settings, the Report recommended that "condoms should be designated in the

[20] The age of consent in Barbados is 16 for both men and women.

correction facilities as toilet articles, and made available through correction's health care/counseling facilities." (ibid., p. 12).

Professor Walrond claims that the Report was intended only for circulation within the Attorney General's Office and the National HIV/AIDS Commission. Indeed, the copy I obtained from the Ministry of Health has a heading which reads: "Confidential." However, shortly after the report was commissioned, a cabinet meeting with different stake holders in the area of HIV took place, where the Attorney General presented the idea behind the Report and said that it was expected to address the issues of buggery, prostitution, and condoms in prisons. The presentation met with a very strong opposition from the stake holders and the member of the cabinet. The cabinet members insisted that that the Report be presented to the public in a process of national consultation in order to gauge the feelings of the citizens with respect to the recommendations and, implicitly, to assess political risks stemming from the recommendations.

Thus, the Walrond Report, was sent out to a number of stakeholders and a series of meetings took place with several groups including health care professionals, faith-based organizations, NGOs, businesses, labor unions, youth and student groups, the media, and political parties. Those stakeholder meetings were generally poorly attended and interview data I collected suggest that the interest in the Report was generally low.

In addition, two town hall meetings took place in order to give ordinary citizens an opportunity to express their views. An invitation to participate in the meetings was published in both of the major newspapers on the island, and, unlike the stakeholder meetings, the town hall meetings were very well attended. However, observers agree that the public was not representative of the general population and that it was dominated by

Evangelical and Pentecostal Christians (personal interviews; Synthesis of the National Assessment Exercise on the Legal, Ethical and Socio-Economic Issues Relevant to HIV/AIDS in Barbados). During the meetings, the discussion focused almost exclusively on controversial issues of buggery, prostitution, and condoms in prisons and the recommendations of the Report pertaining to those areas were strongly condemned. Below is an excerpt from the summary report presented to the NHAC by the moderator of the town hall meetings describing public reaction to the recommendation to decriminalize anal sex:

> "The opposition to this recommendation was vigorous and widespread. It was clear during the national consultation that some elements of the religious community in particular actively mobilised their membership in opposition to this recommendation. As a result many commentators opposed the recommendation on Biblical or religious grounds. Others expressed the view that the recommendation would only serve to sanction deviant behaviour and would open the floodgates to the decriminalisation of other deviant practices in the society. There were also frequent references to a homosexual agenda which commentators felt was being actively promoted in the region and this particular recommendation was either unwittingly or perhaps even deliberately in support of this agenda which sought to promote and support homosexual lifestyles…
>
> ***In general the weight of public opinion in the national consultation was against the recommendation for the decriminalisation of anal sex. Based on the consultation it seems clear that any attempt to pursue this recommendation could polarise Barbadian society on an issue to which the majority appears to be in opposition.*** [emphasis original]***"***

(Synthesis of the National Assessment Exercise on the Legal, Ethical and Socio-Economic Issues Relevant to HIV/AIDS in Barbados, NHAC, pp. 4-5)

Similar reactions were recorded with respect to decriminalization of prostitution and distribution of condoms in prisons. Both recommendations were opposed mainly on religious and moral grounds. Participants argued that legalization of prostitution would "weaken the moral fabric of the society without achieving a reduction in the spread of HIV/AIDS " (ibid., p. 7). With respect to condom distribution in prisons, opponents suggested that alternative strategies, such as dealing with overcrowding and preventing rape should be pursued instead. Some also argued that inmates will "resent the implication raised by the issue of condom distribution" (ibid., p. 12). The Synthesis suggested that implementing those recommendations would arouse "intense objection" and, in fact, "could alienate substantial proportion of the national population" (ibid., p. 7).

The Walrond Report received a very thorough, albeit selective, coverage in the local press, with the issues concerning buggery, sex work, and condoms in prisons, dominating the discussion. Some of the coverage was overwhelmingly negative and condemned the recommendations as undermining the core values of the Barbadian society (e.g. Barbados Advocate, January 24, 2005; Barbados Advocate, January 31, 2005; the Nation, June 19 2006). Supporters of the Report argued that the recommendations were misunderstood by the general public (the Nation, June 11 2006; the Nation, January 26 2006).

Following the consultation process, government officials, including the Prime Minister made public announcements that the recommendations would not be implemented. Shortly after the town hall meetings took place, Owen Arthur held a meeting with representatives of churches and faith-based organizations concerning a

proposed referendum whether Barbados should become a republic. Even though this was not part of the meeting's agenda, Prime Minister went to a great length to assure the representatives of the churches that the government had heard their voice regarding the recommendations put forth in the Walrond report and that he had no intention of implementing those recommendations (personal interview). Thus, as one respondent put it, following the process of national consultation the Report "died a peaceful death".

Interestingly, while some of recommendations made by the report have been taken up by the DLP government following the 2008 election, the issues of sex work, anal sex, and condoms in prisons remain a political taboo. At a debate before the Lower House on the update of the Barbados National HIV Policy in May 2008, Minister of Family, Youth Affairs, and Sports said that "[Providing condoms] is not the thrust of our action in dealing with the inmates." She said further that making condoms available to inmates "would not make sense, since condoms are not 100% effective in preventing the HIV transmission" (Nation, May 28, 2008).

3. Electoral market imperfections and the Walrond Report:

The case of the Walrond Report, shows how political pressures, electoral considerations, and the (lack of) imperfections of the electoral market very directly influenced the way the recommendations were dealt with.

First, it is clear that easy access to information primarily through the pre-existing organizational structures helped mobilize opposition against the Report which came primarily from the Evangelical and Pentecostal churches in Barbados[21]. Barbados

[21] The largest Christian denomination in Barbados, the Church of England, did not oppose the recommendations. My interviews with the Anglican Bishop and Archdeacon of the Anglican diocese

Evangelical Association (BEA), in its official response to the Walrond Report said that it had "strong reservations in relation to some of the recommendations". I particular, recommendations for "same sex acts to be brought in line with normal heterosexual relations and for legalization of prostitutions" were unacceptable to the BEA which argued that "the problems, which will be created by the recommended amendments [to the existing legislation] will be far greater and more inimical to the society's interest than those the recommendations are meant to solve" (p. 2)[22]. The BEA also opposed distribution of condoms in prisons arguing that it "facilitates same sex activity [which] runs counter to its strongly held views and values, concerning standards of human behaviour." (ibid.). The BEA also objected to the recommendation for allowing minors who have reached the age of consent to seek HIV testing without parental notification and permission.

Information about the Report was disseminated across Barbados through two types of pre-existing organizational channels: 1) the umbrella organization of Evangelical and Pentecostal Churches – the BEA, which focused on lobbying key decision makers and, and 2) individual congregations, which focused on mobilizing grass root opposition.

The Walrond Report was discussed by the leadership of the BEA, which issued an official response mentioned above. In addition, the BEA produced a document entitled "Faith, Hope, and Human Sexuality" which presented a Christian alternative to the recommendations of the Report (BEA, 2005). As one respondent put it, the document

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showed that the church saw decriminalization of buggery and prostitution, as well as allowing teenagers who have reached the age of sexual consent to seek medical help without parental permission, as secular issues which were within the purview of the government. In fact, as early as 1996, the Anglican Bishop of Barbados said publicly that his church would not oppose decriminalization of buggery on the island (the Nation, July 11, 1996).

[22] The BEA statement was issues after the town hall meetings took place. However, the statements quoted are representative of the position of the majority of Evangelical and Pentecostal congregations in Barbados.

was distributed to "every parliamentarian, every member of the Senate, [and] other social partners in the community" (personal interview). In addition, the BEA published several editorial pieces condemning the Report in the national newspapers. The Association also used the Internet to publicize its opposition to the repot and to promote its own alternative "Faith, Hope, and Human Sexuality" document.

In addition, the BEA and individual ministers disseminated information about the Report across their congregations and encouraged congregants to participate in the town hall meeting held by the NHAC. As the vice President of the BEA told me: "We challenged them to get out there and let their voices be heard" (personal interview).

Such channels for information dissemination did not exist for groups who were to benefit from policy changes advocated in the Walrond Report: gay men, sex workers and prisoners. No organizations exist that represent commercial sex workers or prisoners in Barbados. The only existing organization working with men who have sex with men – United Gays and Lesbians Against AIDS Barbados (UGLAAB) is relatively young (was established in 2001) and has a limited membership of about 50 people. It grew out of a small group of friends and has no organizational ancestors. In addition, UGLAAB is perceived as not very representative of the gay community in Barbados by both professionals working in the area of HIV/AIDS prevention, as well as the local gay men. Its membership is thought to consist mainly of people coming from lower socio-economic strata of the society and its members are considered to be too flamboyant and radical by middle class educated and professional gay men. Unlike the BEA, financial and human resources of UGLAAB are very limited. The organization does not even have

a website. Consequently, UGLAAB was all but invisible in the national debate considering the Report.

Barbadian media covered the report extensively. “The print and electronic media presented the recommendations of the Report to the public and facilitated considerable public debate through a range of fora including letters to the editor, regular columns in the print media, the call-in programmes and public discussion programmes in the electronic media (Synthesis of the National Assessment Exercise on the Legal, Ethical and Socio-Economic Issues Relevant to HIV/AIDS in Barbados, NHAC, p. 2)”

Easy access to information was a key factor behind the demise of the Walrond Report. First, high readership of newspapers and online news outlets was instrumental in encouraging participation in the town hall meetings, which in turn, proved to be a critical venue in which those opposed to the Report could voice their opinions. As noted above, both the Nation and the Advocate printed invitation to the town hall meetings, including times and locations where the meeting were to take place. Had this information been less available, it is possible that participation in the meetings and, consequently the opposition to the Report, would have been less significant.

Second, extensive, albeit selective, press coverage provided Barbadians with a very detailed account of the policy changes the government and the NHAC were considering. In fact, portions of the Report were re-printed in both the Nation and the Advocate. Interview data makes it very clear that the elected officials felt that the public was very well informed about the developments concerning the report. All of the respondents I have interviewed believed that the recommendations could not be

implemented without the public knowing about it. It is clear that the availability of information increased the sense of accountability of the elected officials.

Given the theoretical framework of this project, it is striking that the opposition to the Report was framed by some media as the democratic majority protecting its interest threatened by a special interest group: "What is the size of the population that would benefit from the proposed decriminalization? … We live in a democratic society. There was due consultation with the people. Why is then the professor [Walrond] do indignant? Why would he be minded to discredit the consultative process, dismiss popular opinion and accuse the Government of pandering to the "ignorant" masses? If the people desire the law to remain as it is, then so let it be." (Evelyn, the Nation, June 19, 2006).

Again, it needs to be emphasized that the definition of information in this project focuses on the actions of political actors. By high level of information I mean that the citizens had: 1) accurate knowledge of the policy changes the government suggested, or, in this instance, about the contents of the Report, and 2) knowledge of what the government was doing with respect the Report. My definition of information does not refer to whether the public perception of the value of the recommendations for public health and HIV prevention was accurate or not.

Public health and health care professionals I have interviewed universally believed that the opponents of the reports either did not understand the recommendations or willingly distorted their meaning. However, this inaccuracy in the public perception is separate from the type of information my theory focuses on. As I argued in the theoretical chapter, the perceptions of the validity of policy options conceptually belong with the issues of demand for policy. The extant political economic literature assumes that social

services are normal goods, that is, that citizens always know what is best for their interest and always want more and better services. I will address the validity of this assumption in the context of HIV in Barbados in the following section of this chapter.

Lack of social polarization can also be linked to the failure of the Report. Race and ethnicity in Barbados does not constitute a major partisan cleavage and the efforts to mobilize against the report did not have to overcome racial and ethnic divisions. Even though the theoretical argument of this dissertation project focuses on racial and ethnic polarization it builds upon literature that examines social polarization based on ascriptive characteristics in general. Therefore, I also examined the religious dimension of polarization in Barbados and the impact it had on the fate of the Walrond Report.

Despite theological difference, different churches in Barbados work together on social issues and the clergy is very well interconnected through professional and personal networks. While there exist an organizational division between the older "historical" churches (e.g. Anglican Church, Catholic Church, Methodist Church, Moravian Church) and the Evangelical and Pentecostal ones, the former being associated under the umbrella of the Barbados Christian Council (BCC) [23], and the latter - under the BEA, all the respondents from faith based organizations agreed that as far as social issues are concerned, there exists "a good working relationship" among different Christian denominations on the island. Since the 1930s, most of Evangelical and Pentecostal ministers have undergone at least part of their training at the Cordington College, an Anglican theological seminary. This facilitated establishing friendships and interpersonal networks across denominational lines.

[23] Such as the. For a full list see:
http://www.oikoumene.org/en/member-churches/regions/caribbean/barbados/bcc.html

In fact, it can be said that it is precisely the efforts to overcome sectarian differences in the field of HIV/AIDS that contributed to the failure of the Report. National HIV/AIDS Commission wanted to be as inclusive in its engagement of faith-based organizations as possible. Since its establishment in 2001, the Commission actively sought to encourage Evangelical and Pentecostal community to engage in its work, and since its inception, representatives of the BEA have sat on several of the Commission's sub-committees. This connection between the Commission and the Evangelical and Pentecostal churches made quick and wide dissemination of the Report in the community possible. In fact, the Walrond Report was distributed by the Commission even to congregations which did not belong to the BEA and were considered radical and very socially conservative even by the BEA leaders (personal interviews). As one religious leader told me:

"They [the government] always ask faith-based organizations for opinion. I have responded for so many things. Barbados is a Christian society, not a melting pot like Trinidad or Guyana. It is a wise government that asks churches for an opinion."

Finally, high degree of credibility of political commitments also played a role in the failure of the Walrond Report. The report was commissioned when the BLP was preparing to run for government for a fourth consecutive term and the party's leadership knew that the campaign would be very difficult. The party did want to be associated with the recommendations fearing that the Report would become and electoral issue. I have been told by several respondents including senators, members of parliament, and former

Ministers of health, that if the government did not disassociate itself from the Report, they expected a large block of voters who opposed the recommendations not to support them in the election because those voters feared that once re-elected, the BLP would implement the recommendations. In other words, it is precisely because the voters perceived political commitments as credible, that they would see government's lack of a public condemnation as a *credible threat* that the recommendations would be implemented.

In fact, it is striking that nobody within them Arthur administration wanted to own the Report and be seen as its advocate. First, the report was pushed form the Attorney General's office to the National HIV/AIDS Commission. When I spoke to the Attorney General over the phone I was told that she was not personally involved with the report at all and that it was her office's staff who dealt with it. This was not corroborated by others involved, including the Chairperson of the National HIV/AIDS Commission, and Professor Warlond himself, who told me that the Attorney General commissioned the report personally. National HIV/AIDS Commission, in turn, outsourced the report to a consultant - Professor Walrond. It was agreed that during the town hall meetings, the Commission would not defend the recommendations but only collect opinions expressed by the public. The methodology section of the Synthesis report summarizing the consultation process emphasizes that "the Commission interpreted its role in the national consultation as a *facilitator* [emphasis original], [because] it was felt that adopting a formal position might have had the impact of influencing public response or of *forcing the Commission to defend a particular position in public* [emphasis added]. (Synthesis of the National Assessment Exercise on the Legal, Ethical and Socio-Economic Issues

Relevant to HIV/AIDS in Barbados, NHAC, p. 2)". In fact, once the feedback from the stakeholders and town hall meetings was reviewed, the Commission publicly recommended to the government that Walrond's recommendation NOT be implemented.

The curious case of the Walrond Report confirms my theoretical propositions by showing that low levels of electoral market imperfections make it easier for the majority to further their demands and the government – more accountable and more receptive to those demands. Pre-existing organizational structures allowed for a rapid and effective dissemination of information condemning the Report. The citizens were well informed about the process and able to closely monitor the government's actions with respect to the Report. Low levels of social polarization made mobilization against the recommendations easier. High degree of political credibility made it very difficult for the Arthur's government to support the report. If BLP politicians were perceived as supporting the Report, the voters would also believed that, if re-elected, the BLP would follow through and implemented its recommendations. The party was not willing to take that risk.

Several key informants pointed to the electoral consideration as the key factors behind the report's "peaceful death":

"The elections were coming up and the government didn't push the report farther and shelved it because they didn't want to lose any seats."

"A very courageous government could have just pushed it thought the parliament but at the time they were coming up for an election so there was no way they were going to do it."

"No political administration is going to want to be the one associated with this whole change of homosexuality and prostitution. Guaranteed loss of votes, especially form the large Christian community."

The case of the Walrond Report shows that low levels of electoral imperfections make it easier for the majority to effectively pursue its interests. However, somewhat contrary to my theoretical framework, it also shows that this needs NOT to translate automatically into good public policy, that is, a policy that furthers public interest. Studies from the Caribbean and elsewhere have shown that men who have sex with men also have sex with women and that HIV travels easily from the perceived high-risk to non-high risk groups (Padilla, 2007; Murray, 2002, 2009; Kulick, 1998; Wekker, 1999). Therefore, increasing numbers of MSM who have HIV will likely be mirrored in increased number of infections in the general population. Increasing number of infections in sex workers and in prison inmates will have the same effects, as the clients of sex workers continue to have sex with their wives and girlfriends (and boyfriends) and so do the inmates when they are released.

Even if HIV stays primarily within the high-risk groups, the growing burden of the disease will impose increasing costs on the society. Higher numbers of HIV positive people will mean higher expenditures on ART and drugs used to treat opportunistic infections. Also, with a growing number of individuals receiving anti-retrovirals, there will be an increasing risk of the emergence of drug-resistant strains of the virus and an increased need to provide second and third line drugs, which are not included in the agreements between the government of Barbados and pharmaceutical companies and

remain very expensive. In a country with a socialized healthcare system, this growing financial burden will be ultimately born by every citizen.

To sum up, the ostensibly democratic character of the political process and low level of electoral marker imperfection created a situation where the majority of the citizens was able to pressure the government to pursue its preferred policy option (in this case, not to implement the recommendations of the Walrond Report). At the same time, the policy course preferred by the majority is likely to have negative public health and economic consequences not only for the minority groups perceived to be the beneficiaries of suggested policy changes, but also for the very same majority who resisted them.

4. Implications:

Results of the analysis of qualitative data from Barbados confirm my theoretical propositions, namely that low levels of electoral market imperfections affected policy making and compelled politicians to respond to HIV/AIDS in a decisive and, in most cases effective, manner. The data also call for a number of very interesting refinements in the theoretical framework of this dissertation.

First, it highlights the importance of disaggregating "AIDS policy" into different policy areas and episodes. As outlined in the theoretical chapter, the general tendency in political science literature is to conceptualize policy on a very aggregate level and use measures such as general spending on health or even infant mortality rates as indicators of policy performance. Analysis of qualitative data from Barbados shows that the same configuration of independent variables may have dramatically different effects on different aspects of the same policy area. While low levels of political market

imperfections were conducive to the introduction of policy measures which were seen as serving the general population and as necessary for sustained economic growth, they were also crucial in the toppling of policy measures perceived as serving undesirable minority groups such as gay men and commercial sex workers.

Another point which the analysis of the data from Barbados makes abundantly clear is the importance of policy framing. The political-economic scholarship within the rational choice tradition assumes that voters always know what is best for them, which makes the issue framing theoretically irrelevant. Social services such as public health and education have been conceptualized as public, or more accurate as normal goods. By definition then, it was assumed that those services are always in demand. A priori, it is not unreasonable to think of AIDS prevention and treatment as public and normal goods. Provision of anti-retroviral therapy (ART) reduces infectiousness of HIV-positive individuals and thus lowers the risk of infection for all their future sexual partners. In this sense it is non-rival and non-excludable. Prevention measures such as information and education campaigns are also a good example of a public-good-like character of HIV/AIDS policy outputs. In addition, as I have argued above, failing to prevent the spread of HIV even in minority groups such as MSM and CSWs will have negative health and economic consequences for the entire society. Nevertheless, the empirical data from Barbados shows that those consequences were in fact inconsequential in the national debate concerning the Walrond Report. Instead, the recommendations were perceived as furthering a minority political agenda, and as harmful to the general society by their undermining of its core moral values.

The case of Barbados shows that policy frames in a very visible way influence what did and what did not get done. Reflecting a global trend, AIDS in Barbados has been framed as "everybody's problem" despite the lack of convincing epidemiological evidence. Consequently, as noted earlier in this chapter, policy measures aimed at the general population have been implemented with a great success. The PMTCT program, launched in the 1996 is considered to be state-of-the-art and comparable to the best standards in industrialized countries. Introduction of the universal and free access to ART produced very significant improvements in clinical outcomes in HIV patients, including reduction in AIDS morbidity and mortality, as well as increased patient satisfaction with the quality of care. Massive education and information campaigns have produced visible improvements in youth's knowledge about HIV transmission and prevention methods. In contrast, when policy was framed as benefiting undesirable minority groups, no improvements in policy have been made. No specific interventions which would go beyond very rudimentary peer education efforts targeting MSM, CSWs or prisoners have been implemented in Barbados to date.

What highlights the importance of issue framing is the fact that the characterization of the AIDS epidemic in Barbados as generalized and, often, feminized is problematic (see Kakietek, 2010). Indeed, such characterization is unfounded because to date no serosurveillance data has been collected among commercial sex workers or men who have sex with men and it is impossible to assess the HIV prevalence in those groups and determine whether it is indeed not much higher than in the general population. International consultants and staff members of the Centers for Disease Control and Prevention Global AIDS Program I have spoken to believe that the epidemic

in Barbados is not generalized but rather that it is localized precisely in those high risk groups. Again, however, those claims could not be substantiated due to the lack of data. In the absence of scientific data, policy is made based on beliefs regarding the nature of the epidemic. Therefore, as I argue, the way AIDS has been framed in Barbados had a crucial impact and shaped policy responses to the epidemic.

CHAPTER 6: CONCLUSIONS

In this dissertation I argued that the relationship between democracy and social policy is conditional. That is, it is mediated by a set of conditions I called jointly "imperfections in the electoral markets". Following Keefer (2005) I defined electoral market imperfections as: 1) lack of access to information among the citizens, 2) ethnic polarization, and, 3) low level of trust in electoral promises. I argued that high level so of the imperfections *suppress the positive impact of democratic accountability and lead to HIV/AIDS policy failures in democratic countries.* I argued that when the level of the electoral market imperfections is low, democratic accountability creates incentives for policy improvement. However, when the level of electoral market imperfections is high, the positive impact of democratic political institutions on social policy is suppressed because politicians have fewer incentives to pursue policies that further the welfare of the citizens.

This chapter summarized the empirical findings of the from chapters 2 through 5. It also addresses some of the implications, new hypotheses, and areas for further research.

The impact of democracy on AIDS policy is conditional

The primary research hypothesis this dissertation sought to evaluate was:

In countries with ill informed citizenry, high degree of ethnic polarization, and the voters do not trust in electoral promises the beneficial effects of democracy will be suppressed; the response to the epidemic will be slow, policies and institutions aimed at fighting AIDS

will take longer to develop, the availability of services for those infected and at risk will be low, and the effects of the efforts to fight AIDS, such as behavioral change - limited.

Figure 6.1.: Government Accountability in Democracies and Autocracies at Different Levels of Electoral Market Imperfections.

		Institutions	
		Autocracy	Democracy
Electoral market imperfections	Low	low	low
	High	low	high

Empirical analysis showed that the level of electoral market imperfections indeed mediated the association between democracy and AIDS policy. Increases in the level of democracy were associated with improvements in AIDS policy at low, but not at medium and high levels of electoral market imperfections. Simply put, in the presence of a high level of electoral market imperfections, democracies did not differ from non-democracies in terms of policy performance.

These findings held for the indicators associated with service provision: ART and PMCTC. Quantitative analysis in chapter 2 has demonstrated that increases in the democracy score were associated with higher coverage of treatment services (ART, PMTCT) in countries with the low level of imperfections, but not in countries with medium or high level of the imperfections. Comparative case study in chapter 3 and 4 showed that ART coverage in Barbados, where the level of the electoral market imperfections was low, was higher than in Trinidad and Tobago, where the level of the

imperfections was high. Interestingly, the model used in the quantitative analysis very accurately predicts the observed ART coverage rates in both countries. The linear prediction of ART coverage in Barbados for 2007 is 84.4%. The actual observed coverage in that year was 85.5%. In Trinidad and Tobago, the predicted coverage rate was 52.72% while the observed coverage rate was 54%. In Chapters 3 and 4 I have also showed, that the electoral market imperfections had a critical impact on the provision of ART in both countries.

Thus, this dissertation offers an important refinement to the existing literature on the impact of democracy on social policy and human development. It shows that democratic institutions by themselves are not a sufficient condition to ensure that elected politicians are accountable to the public and to create incentives for governments to pursue policies that increase the health and welfare of their citizens. I show that, in order for the democratic accountability to be effective, a set of conditions needs to be fulfilled. Specifically, the voters need to be interested and informed about politics and policy, have to have faith that electoral promises will be fulfilled, and must based their electoral decisions on policy proposals rather than astrictive characteristics, such as race or ethnicity of the candidates and parties.

Democratic accountability affects implementation rather than adoption

Empirical analysis showed a positive association between democracy at the low level of electoral market imperfections, and the provision of HIV/AIDS related treatment services. On the other hand, I found no evidence of an association between democracy score and the indicators of compliance with the "Three ones" recommendation, total

spending on AIDS, and health and behavioral outcomes among countries with low, medium, and high levels of electoral market imperfections. Democracy score was not associated with those outcomes at any level of the imperfections.

As I argued in Chapter 2, the lack of association between democracy and health and behavioral outcomes is not surprising. Those areas of the response to AIDS are far removed from the influence of governments and the differences in governmental accountability should have only minimal, if any, effects.

The lack of association between democracy (at any level of the imperfections) and the measures capturing policy reform and spending is interesting and has important implication for this dissertation and the scholarship on democracy and social policy. Specifically, it suggests that democracy is associated with policy implementation rather than adoption.

The extant research on the impact of democracy on human welfare has relied on the concepts of public goods and public good provision (Lake & Baum, 2003, Bueno de Mesquita et al., 2003). This dissertation suggests that this is not a very useful way of conceptualizing social policy and its impacts. First, "public good provision" fails to distinguish between policy adoption and policy implementation. Because the models used in the literature focus on prospective voting behaviors (voters supporting candidates based on their electoral promises) they suggest that democracies adopt better policies than non-democracies. However, the distinction between adoption and implementation is never explicitly addressed. While some authors explicitly assume implementation out of their models (e.g. Bueno de Mesquita et al, 2003), others simply relegate the complex processes of policy design, adoption, implementation and revision into the black box of

"public goods provision". My research shows that democracies, especially those with low levels of electoral market imperfections, are better implementers, but not necessarily better adopters. Democracy was not associated with outcomes most closely related to policy adoption: the establishment of a national coordinating body to lead the fight against AIDS or compliance with the "Three Ones" recommendation of the UNAIDS.

My research strongly suggests, that accountability resulting from democratic processes operating in a context of low levels of electoral market imperfections, prevents government officials from distributing patronage (e.g. though awarding of government contracts to political allies) and increases the *efficacy* of public policy. When the levels of accountability are low due to high levels of the imperfections, like it was the case in Trinidad and Tobago, public policy, in particular service delivery, can be captured by special interests, which, in turn, limits its efficacy and impact. To evaluate the validity of this proposition, he following set of hypotheses should be tested in further empirical research:

There will be no differences in likelihood of policy adoptions between democracies with low and high levels of electoral market imperfections. Countries with low levels of imperfections will be better able to implement adopted policies (e.g. have a better service coverage) than countries with high levels of imperfections.

The comparative case study also suggests that the impact of democratic accountability on social policy may depend on how "capturable" policy (delivery) is. For example a policy banning discrimination based on HIV status provides very few

opportunities for capture. It is difficult to imagine what benefits it could provide for special interests or groups of potential supporters. On the other hand, policy areas that involve channeling of public funds through grants of contacts are much more capturable, in that it can offer very tangible benefits to those who are able to tap into the money flows. In Trinidad and Tobago, MRF's capture of the ART program provision ensured Foundation's salaries, supplies, prestige, and organizational survival. This is another reasons why the impact of democracy and the difference in this impact among countries at different levels of electoral market imperfections are most visible in the area of service provision.

This suggests another set of empirically testable hypothesis.

The impact of democracy on social policy will depend on the degree to which policy delivery can be captured. For non-capturable policies, there will be no difference between countries with low levels of accountability (high levels of electoral market imperfections) and high levels of accountability (low levels of electoral market imperfections). For capturable policies, countries with low levels of imperfections will implement policies more effectively (e.g. have better service coverage) than countries with high level of imperfections.

Figure 6.2.: Impact of Democratic Accountability on Policy Adoption and Implementation.

	Adoption	Implementation	
		Non-capturable	Capturable
Impact of democratic accountability	Low	Low-Medium	High

Electoral Market Imperfections Are Linked to Clientelism.

By showing that the impact of democracy on social policy is conditional, but also, that the degree of accountability affects policy implementation rather than policy adoption my dissertation problematizes the "accountable government" literature. As I noted above, when the level of electoral market imperfections is high, countries suffer from public policy failures not because governments adopt bad policies, but because the process of policy implementation is derailed. This brings this dissertation project into close proximity to the scholarship of clientelism (e.g. Stokes, 2010, Kitschelt & Wilkinson, 2007, Stokes, 2005; Auyero, 2000, Scott, 1969).

This literature, like my dissertation project, questions the assumption of what Kitschelt and Wilkinson (2007, p. 3) call the "responsible party government" and what I called in the theoretical chapters the "accountable government" model, which suggests that the democratic process reliably creates incentives for politicians to deliver collective goods, such as public health or economic growth. The principal premise of the clientelism scholarship is that, as Kitschelt and Wilkinson put it, "in many political systems citizen-politician linkages are based on direct material inducements targeted to

individuals and small groups of citizens whom politicians know to be highly responsive to such side-payments and willing to surrender their vote for the right price (Kitschelt & Wilkinson, 2007, p. 3).

This scholarship has identified a number of "varieties of clientelism" or modes of exchanging selective incentives for political support. Different scholars used terms like "pork-barrel" "patronage", "neopatrimonialism", "clientelism" "prebendism", at times interchangeably (Muno, 2010). My empirical analysis of the case study material emphasized the importance of patronage, that is, offering access to the largesse of the state by awarding governmental contracts or job in the public service or state-controlled enterprises, in exchange for political support. In Trinidad and Tobago, the contract for ART provision was awarded by the PNM government to the MRF, an organization run by a staunch PNM supporter.

This dissertation can add to the literature on clientelism in three ways. First, I identify a set of conditions - electoral market imperfections, which creates an environment conducive to the emergence and proliferation of patron-client relations. Traditionally, the clientelism literature emphasized macro-economic conditions, the intensity of electoral competition, the extent to which the economy was controlled by the state, and to a lesser extent, ethnic heterogeneity, as the principal causes of the emergence of patronage (e.g. Kitschelt and Wilkinson, 2007). By comparing two cases with similar levels of development, competitiveness of the electoral system, and engagement of the government in the economy, it highlights the importance of political polarization based on ascriptive characteristics as a factor that facilitates the emergence of patron-client relations.

Second, I show that lack of information and lack of trust in electoral promises may increase the degree to which public policy is vulnerable to capture by patron-client networks. This is quite contrary to the arguments put forward in the clientelism literature (e.g. Kitschelt & Wilkinson, 2007a, 2007b, Median & Stokes, 2007, Stokes, 2010) which is based on a principal-agent framework and which suggests that the transparency of patron-client exchanges is important for the perpetuation of patronage.

Furthermore, while the bulk of the literature emphasizes quid pro quod as the central feature of clientelism (Kitschelt & Wilkinson, 2007a; Medina & Stokes, 2007) my findings support arguments that patronage is not always based on exchanges of tangible benefits for political support (e.g. van de Wall, 2007). Interview material from Trinidad and Tobago showed that considerations other than a direct exchange of votes for benefits affected voters' support for co-ethnic parties. Specifically, party support was engendered by a sense of within-group loyalty, and, more importantly, by a sense of threat from the rival group. Thus, my project also points to the cultural and affective dynamics and sources of patronage.

Electoral Market Imperfections Tend to Cluster:

I have not developed a theory regarding the relationship among the three components of the electoral market imperfections. The measure I used in the statistical

chapter is a simple additive index and does not presume that one of the elements is a necessary or sufficient condition for other elements. However, factor analysis conducted in Chapter 2 showed that the indicators of the electoral market imperfections load up to only one factor, which suggests that, in the global sample of all countries, ethnic polarization, access to the internet/access to information, and age of political parties/trust in electoral promises, are clustered together. In other words, political parties in countries with a high degree of ethnic fragmentation tend to be younger and fewer people tend to have access to the Internet than in countries that are less ethnically fragmented.

One potential explanation for the clustering of the three dimensions of the imperfections is that in the 1940d, 50s and 60s, decolonization created a host of newly independent countries with ethnically fragmented population, virtually no tradition of mass political organizations, and population with low average educational attainment and information infrastructure.

It is possible that information scarcity and lack of trust in electoral promises create incentives for the voters to support candidates who share with them the same ascriptive characteristics. Chandra (2007) argued that "situations in which observers have to distinguish between individuals under sever information constrains...bias them towards schemes of ethnic categorization" and leads them to support ethnic parties and candidates (Chandra, 2007, pp: 84-85; see also, Chandra, 2004).

On the other hand, interview data and the extant literature on politics in Trinidad and Tobago suggests that ethnicity may affect the level of trust as well as interest in politics and, consequently, the level of information about politicians' performance. More specifically, in Trinidad and Tobago, the polarization of the political system along ethnic

lines weakened voters' trust in electoral promises and reduced their interest in politics. However, this may not be the case elsewhere in the world. Thus, another question to be answered in future research would is:

Under what conditions ethnic fragmentation negatively affects trust in electoral promises and "turns the voters off" of politics? Under what conditions does information scarcity compels voters to support candidates based on their race/ethnicity?

Vast literature on ethnic conflict has identified a number of factors that increase and decrease the likelihood of political mobilization along ethnic lines. Scholarship on consociationalism suggests that the nature of the electoral system mediates the impact of ethnicity of the intensity of sectarian conflict (e.g. Lijphart, 1977). Ethnic conflict is more pronounced in winner-take-all electoral systems that encourage zero-sum game-type of interactions between different groups. On the other hand, electoral systems that encourage power sharing, guarantee quotas, and provide participation in the government to all major groups, tend to lower the intensity of inter-communal strife (Horowitz, 1985). Other scholars focused on colonial legacy, and more specifically, the way the metropolis managed various native populations of the colonies, as the key determinants of the ethnic conflict in post-colonial societies (e.g. Mason & Athow, 2002). My dissertation suggests that even in the absence of violence, political polarization along ethnic lines can affect the important dynamics of the political system. Examining the relationship between ethnicity and trust in public institutions and interest in politics is another area to be explored in future research.

Public policy and public interest. The impact of democracy depends on the target population.

Another research hypothesis this dissertation sought to evaluate was: *The impact of democracy, mediated by the level of electoral market imperfections, will be different for policies targeting the general population and policies targeting socially marginalized groups. Specifically, the impact of democratic accountability on AIDS policy targeting marginalized groups will be less pronounced in countries with a low level of political market imperfections.*

Empirical findings suggest that the democratic accountability in countries with low levels of electoral market imperfections makes it difficult for governments to adopt policies perceived as benefiting socially marginalized groups. Quantitative analysis showed that democracy was associated with the funds spent on programming for most-at-risk populations (MSM, CSWs, IDUs) and condom use among CSWs at the medium level of the electoral market imperfections, but not at the high or the low level. Analysis of the Barbadian case confirmed those findings. In Barbados, the public very strongly condemned a proposal to decriminalize anal sex and commercial sex work on the island. Significantly, decriminalization of anal sex and prostitution was presented as necessary for the success of the fight against AIDS in the general population. It was argued that it would enable governmental agencies to provide services directly to men who have sex

with men and commercial sex workers, and prevent HIV infections in prison inmates, thus reducing not only the HIV incidence in high-risk group but also the spread of the virus to and within the general population.

I argued that it was precisely the very transparent and inclusive process based on public consultation, which engaged and occurred with the public sphere that resulted in the government's rejection of the proposal. In this respect, my findings problematize both the extant empirical scholarship on democracy and social policy and the "accountable government model" as well as some of the most prominent contemporary theories of democracy, particularly Habermas' theory of liberal democracy and the public sphere (Habermas, 1987, 1989 [1962]). My dissertation adds to the feminist critique of Habermas (e.g. Ryan, 1992) and offers a contemporary illustration of the failure of democratic processes to produce policies furthering the public interest. On one hand, my dissertation critiques the mainstream political-scientific empirical scholarship which equates the provision of public goods with good governance. On the other hand, it calls into question Habermas' suggestion that public debate encourages rational exchange of ideas and leads to outcomes promoting public interest. I argue that the rationality of "communicative action" in public debates of the issues of sex and sexuality is limited, and that broad public participation will, more likely than not, contribute to maintaining the status quo, wherein sexual outcasts are marginalized.

My findings suggest another important question that needs to be evaluated in future research:

Under what conditions do democratic countries adopt policies that benefit marginalized minorities?

Oil Wealth and Health Policy:

The comparative case study in Chapters 3 and 4 showed that, in addition to electoral market imperfections, HIV/AIDS policy was also affected by the structure of the economy. Specifically, I argued that the reliance on services - a human-capital intensive sector, made the government of Barbados feel threatened by the potential impact of the AIDS epidemic and was one of the reasons why the country became the regional leader in the fight against the disease. In contrast, the reliance on petrochemical production and the labor structure of the petrochemical sector, made the government of Trinidad and Tobago feel less threatened by the potential detrimental impact of AIDS on human resource of the island and cause its respond to the epidemic more slowly. This argument links this dissertation project to another important body of literature in political science which is sometimes called "renter state" literature and which examines the impact of resource endowment on policy and politics. This scholarship has focused on the impact of resource wealth on two types of outcomes: 1) macroeconomic policy and economic development (e.g. Beblawi, 1987, Luciani, 1987, Chaudry, 1989, Shafer, 1994, Ross, 1999, Snyder & Bhavnani, 2005) and 2) political development and transitions to democracy (e.g. Moore, 1976; Quandt, 1981; Anderson, 1995; Okruhlik, 1999, Gause 2000; Ross, 2001; Smith, 2004; Herb, 2005; Dunning, 2008). It has argued that reliance on resources makes government less able to adjust their macroeconomic policies in response to exogenous shocks (e.g. Shafer, 1994, Ross, 1999) and inhibits institutional

development, especially in the area of tax extraction (e.g. Chaudry, 1989, Beblawi, 1987, Shafer, 1994). Other scholars, particularly those studying the Middle East, have argued that resource wealth is a key factor explaining the persistence of authoritarian regimes. By not taxing their citizens and offering a wide array of heavily services, authoritarian regimes are able to pay their citizens off in a "no taxation - no (aspiration to) representation" quid pro quo (e.g. Quandt, 1981, Gause, Anderson, 1995; but see Okruhlik, 1999).

My dissertation adds to this debate by showing the influence of the reliance on natural resource extraction can also affect social and health policy. As I noted above, the "rentier state" literature has argued that reliance on resource extraction makes the governments of oil- rich countries less able to adjust their macro-economic policies to respond to exogenous shocks. My project suggests that this argument can be extended to health policy and that reliance on resource extraction, especially when the extractive sector is dominated by multinational companies whose management consists mostly of expatriates, may make governments slow to respond to health crises.

One limitation of the comparative case study used in this project is that the case selection did not allow to assess the impact or resource endowment on policy independent of electoral market imperfections and vice versa. However, I found no evidence that it played a role in ART provision. In fact, quite the opposite was true - ART program in Trinidad and Tobago, just like the one in Barbados, has been funded mainly through the loan from the World Bank even though most of the key informants I have interviewed believed that Trinidad and Tobago had enough of domestic resources to pay for the ART program without borrowing money from the Bank.

When statistical models presented in Chapter 2 were re-estimated with an added control variable measuring the ratio of revenue from commodity exports to GDP, the results remained unchanged, which suggests that the impact of resources on HIV/AIDS policy is independent of the impact of electoral market imperfections. In Trinidad and Tobago, oil wealth is routinely used to distribute patronage through contracts and direct transfer schemes, such as the Unemployment Relief Programs (URPs) (see Premdas, 2007).

Nevertheless, assessing the relationship between electoral market imperfections and resource endowment is another direction for future research. More in-depth analysis is needed to assess whether and under what conditions reliance on natural resources exacerbates the effects of the imperfections and under whether and under what conditions electoral market imperfections cause governments to extract rents form resource-based economies.

Limitations and Implication for Policy and Practice:

One potential limitation of this dissertation is that its findings may not be directly generalizable to health and social policy areas and issues other than HIV and AIDS. This may be the case for two reasons:

First, as I showed in the qualitative chapters, AIDS policy was being developed very much under the radar of ordinary citizens, unlike policy changes such as health system financing reforms described by other authors (see e.g. Immergut 1992), or the recent health insurance reforms introduced by in the United States by President Obama which captured the attention of the electorate. However, I argue that those highly visible

and politically salient health policy reforms are the exception, rather than the norm and that most health policy in developing and developed countries happens gradually and without much notice in the general population.

Second, AIDS may be different from other policy areas because the pressures for policy reform came mostly from the international organizations such as the World Bank and UNAIDS. It is true that AIDS has been the first specific diseases that captured the attention of global audiences to such an extent (e.g. Epstien, 2007, Pisani, 2009). However, I believe it is a part of a growing trend of internationalization of both health problems as well as health policy solutions. International organizations have engaged in aid and advocacy in the area of tuberculosis, malaria, parasitic diseases, and international funding agencies are starting to pay closer attention to chronic diseases such as cancer or diabetes. Thus, it is likely that, in the near future, the role of those international actors in domestic politics will be similar to that they play today shaping HIV/AIDS policy.

One important implication of this research for public health and policy practice is that indentifies a set of conditions - high level of electoral market imperfections, which create an environment conducive to inefficiencies and implementation failures. The results of this analysis can help identify countries where monitoring and audit mechanisms are particularly needed to compensate for low accountability of elected officials.

Another important implication concerns the relationship between democratic and participatory policy process and policies aimed at protecting the rights of socially marginalized groups.

In his recent "Letter to the Stakeholders", the director General of UNAIDS called for the democratization of the response to AIDS. In particular, his hope was that the democratization of the response to AIDS will make it easier to address the needs of socially marginalized groups such as men who have sex with men and commercial sex workers.

My research shows that such hope is likely misplaced. At the core of democracy lays a process in which the decision is made by the majority. Consequently, marginalized minorities are, by definition put at a significant disadvantage. The experiences from Barbados shows that it was the highly democratic character of the decision making process that made the decriminalization of same sex and commercial sex impossible on the island. First, because National HIV/AIDS Commission was an open and democratic forum, it allowed access to the review process to a wide array of interests, including those who opposed the policy reform. This, in turn, enabled the opponents of the reform to mobilize. Second, the process of public consultation, which included town hall meetings, often considered to be the epitome of democratic participation, gave the individuals and groups opposing the legal reform and access to the decision making process. Third, because of the low level of electoral market imperfections and the resulting high level of accountability of elected officials, the government was particularly vulnerable to the pressures from Christian congregations opposing the reform, and eventually decided not to pursue the reform out of fear of electoral consequences and loss of large blocks of supporters. Thus, the democratic character of the process gave an ample opportunity for political mobilization for the opponents of the reform, and ultimately created incentives

In this respect my research corroborates findings on the extant literature which

suggests that minority rights and policies that protect them are better pursued through the judicial process (Smith, 2010). Thus, one practical implication of this dissertation is that, instead of public reviews, policy reform, such as decriminalization of prostitution and same sex sex, should be undertaken through the legal system.

This leads to a more broad implication stemming from this research for the public health practitioners namely, that HIV/AIDS policy making is a *political process*, with competing groups and interest, which, consequently, requires a *political analysis.* The extant public health literature as well as the dominant discourse in the practitioner community tend to neglect the political dimensions of AIDS and attribute successful policies to fight the disease in the developing world to the presence of the nebulous "political will." Ironically, in the absence of a political analysis, the concept obscures rather than elucidates the sources of variation in the ways developing nations have dealt with the epidemic. The goal of my dissertation was to replace the concept of the "political will" with a rigorous inquiry into the political factors affecting AIDS. I strongly believe that such political analysis in necessary to ensure policy practice which will help stem and eventually halt the spread of AIDS.

Bibliography:

Alesina, A., Baquir, R., & Easterly, W. (1999). Public Goods and Ethnic Divisions. *Quarterly Journal of Economics 114*(4): 1243-1284.

Alesina, A., Devleeschauwer, A., Easterly, W,. Kurlat, S. & Wacziarg, R. (2003). Fractionalization. *Journal of Economic Growth 8*:155-194.

Alesina, A., La Ferra, E. (2005). Ethnic Diversity and Economic Performance. *Journal of Economic Review 81*(5): 1170-1188.

Adoo, E. (2000). Treatment and Care of AIDS Patients in Hospital Settings. in Howe, G. and Cobley, A. (eds.) *The Caribbean AIDS Epidemic.* Bridgetown, Port of Spain: University of the West Indies Press.

Anderson, L. (1995). Peace and Democracy in the Middle East: The Constraints of Soft Budgets. *Journal of International Affairs 49*(1): 25-44.

Andrea, E., Boix, C., & Payne, 2003. Are You Being Served? Political Accountability and Quality of Government. *The Journal of Law, Economics, and Organization 19*(2):445-490.

Avelino, G., Brown, D., & Hunter, W. (2005). The Effects of Capital Mobility, Trade Openness, and Democracy on Social Spending in Latin America, 1980–1999. *American Journal of Political Science 49*(3):625-641.

Auyero, J. (1998). *Poor People's Politics. Peronist Survival Networks and the Legacy of Evita.* Durham: Duke University Press.

Baldwin, K. & Huber, J. (2010). Economic versus Cultural Differences: Forms of Ethnic Diversity and Public Good Provision. *APSR 104*(4): 644-662.

Baldwin, P. (2005). *Disease and Democracy. The Industrialized World Faces AIDS.* Berkeley, Los Angeles, London: University of California Press.

Barnett, T. & Whiteside, A. (2006). *AIDS in the Twenty-First Century: Disease and Globalization*. New York, NY: Palgrave Macmillan.

Barrow, C., de Bruin, M., & Carr, R. (2009) *Sexuality, Social Exclusion, and Human Rights: Vulnerability in the Caribbean Context of HIV*. Kingston, Miami: Ian Randle Publishers.

Barrow, C. (2009), 'Contradictory Sexualities: From Vulnerability to Empowerment of Adolescent Girls in Barbados.', in Barrow, Ch., de Bruin, M., and Carr, R. (eds.) *Sexuality, Social Exclusion, and Human Rights.* Kingston and Miami: Ian Randle Publishers. pp: 215-238.

Barrow-Giles, C. 2002. *Introduction to Caribbean Politics.* Kingston and Miami: Ian Randle Publishers.

Barrow-Giles, C. & Joseph, T. (2006). *General Elections and Voting in the English Speaking Caribbean 1992-2005.* Kingston and Miami: Ian Randle Publishers.

Beblawi, H. (1987). The Rentier State and the Arab World. in Beblawi, H. & Luciani, G. eds. *The Rentier State: Nation, State, and the Integration of the Arab World*. London: Croom Helm: 85-98.

Beckles, H. (2004). *Chattel House Blues: Making of a Democratic Society in Barbados from Clement Payne to Owen Arthur.* Kingston and Miami: Ian Randle Publishers.

_____. (2006) *A History of Barbados. From Amerindian Settlement to Caribbean Single Market.* Cambridge: Cambridge University Press.

Beckles, H. & Shepherd, V. (1996) Caribbean *Freedom. Economy and Society from Emancipation to Present.* Kingston and Miami: Ian Randle Publishers.

Birdsall, N. & Hamoudi, A. (2004). AIDS and the Accumulation and Utilization of Human Capital in Africa. In Haacker, M. (Ed.) *The Macroeconomic of HIV/AIDS.* Washington, DC: International Monetary Fund Publication Services.

Boix, C. (2000). *Democracy and Redistribution.*

Brennan, R.& Durack, D. (1981). Gay compromise syndrome. *the Lancet* 2: 1338-1339.

Brown, D. (2000). Democracy, Colonization, and Human Capital in Sub-Saharan Africa. *Studies in Comparative International Development 35*(1): 20-40.

Brown, D. & Hunter, W. (1999). Democracy and Human Capital Formation: Education Spending in Latin America 1980-1992. *American Political Studies Review* 94(4).

Bueno de Mesquita, B., Smith, A., Siverson, R., & Morrow, J. (2003). *The Logic of Political Survival.* Cambridge, MA: MIT Press

Camara, B., Shelton, N., McLean, R. (1997). Modeling and Projecting HIV and Its Economic Impact in the Caribbean: The Experience of Trinidad and Tobago and Jamaica (working paper).

Challenger, D. (2009). A Benign Place of Healing. The Contagious Diseases Hospital and Medical Discipline in Post-Slavery Barbados., in De Barros, J., Palmer, S. and Wright, D.(eds.) *Health and Medicine in the circum-Caribbean, 1800-1968*. New York and London, Rutledge. pp: 98-120.

Chandra, K. (2007). Counting Heads: A Theory of Voter and Elite Behavior in Patronage Democracies. in Kitschelt, H & Wilkinson, S. (eds.) *Patrons, Clients, and Policies: Patters of Democratic Accountability and Political Competition.* Cambridge: Cambridge University Press.

_____. (2004).*Why Ethnic Parties Succeed: Patronage and Ethnic Head-Counts in India.* Cambridge: Cambridge University Press.

Charles-Soverall, C. & Khan, J. (2004). Social Partnership: New Public Management Practice in Barbados. *AJPAM XV*(1):22-36.

Chaudry, K. (1989). The Price of Wealth: Business and State in Labor Remittance and Oil Economies. *International Organization 43*(1):104-145.

Cleghorn, F., Jack, N., Murthy, J., Edwards, J., Mahabir, B. Paul, R., et al. (1998). Direct and Indirect Estimates of HIV-1 Incidence in a High Prevalence Population. *American Journal of Epidemiology 147*(9): 834-9.

Cleghorn, F., Jack, N., Carr, J., Edwards, J., Mahabir, B., Sill, A. et al. (2000). A Distinctive Clade B HIV Type 1 is Heterosexually Transmitted in Trinidad and Tobago. *PNAS 97*(19): 10532-10537.

Cleghorn, F., Jack, N., Murphy, J., Edwards., J., Mahabir, B., Paul, R. et al. (1995). HIV-1 Prevalence and Risk Factors Among Sexually Transmitted Disease Clinic Attendees in Trinidad. *AIDS 9*(4): 389-394.

Cleghorn, R., Pape, J., Schechter, M., Bartholomew, C., Sanchez, J., Jack, N. et al. (2007). Lessons from a Multisite International Trial in the Caribbean and South America of an HIV-1 Canarypox Vaccine (ALVAC-HIV vCP1452) With or Without Boosting with MN rgp 120. *Journal of Acquired Immunodeficiency Syndromes 46*(2): 222-230.

Collier, P. (2000). Ethnicity, Politics, and Economic Performance. *Economics and Politics 12*(3): 222-45.

Duncan, N. (1994). Barbados: Democracy at the Crossroads. in Edie, J. (ed.) *Democracy in the Caribbean: Myths and Realities.* Westport: Praeger.

Dunning, T. (2008). *Crude Democracy. Natural Resource Wealth and Political Regimes.* Cambridge: Cambridge University Press.

Easterly, W. (2003). The Political Economy of Growth Without Development: A Case Study of Pakistan. in Rodrik, D. *In Search of Property: Analytic Narratives on Economic Growth.* Princeton, NJ: Princeton Univ. Press, pp. 439-472.

Easterly, W. & Levine, J. (1997). Africa's Growth Tragedy: Policies and Ethnic Divisions. *Quarterly Journal of Economics 112*(4):1203-1250.

Edie, J. (1994). *Democracy in the Caribbean: Myths and Realities.* Westport: Praeger.

Engel, S. (2001).*Unfinished Revolution: Social Movement Theory and the Gay and Lesbian Movement.* Cambridge: Cambridge University Press.

Epstien, H. (2007). *The Invisible Cure: Africa, the West, and the Fight Against AIDS.* New York, NY: Farrar, Straus, and Giroux.

Epstein, S. (1996). *Impure Science: AIDS, Activism, and the Politics of Knowledge.* Berkeley, CA: University of California Press.

Fassin, D.& Schneider, H. (2003). The Politics of AIDS in South Africa: Beyond the Controversies. *British Medical Journal* 326.

Fearon, J. (2003). Ethnic and Cultural Diversity by Country. *Journal of Economic Growth 8*(2): 195-222.

Fourie, P. (2006). *The Political Management of HIV/AIDS in South Africa.* New York: NY Palgrave McMillan.

Gause, G. (2000). The Persistence of Monarchy in the Arabian Peninsula: A Comparative Analysis. in Kostiner, J. (ed.) *Middle East Monarchies: The Challenge of Modernity.* New York, NY: Lynne Rienner.

George, A. & Bennett, A.. (2005). *Case Studies and Theory Development in Social Sciences.* Cambridge, MA: MIT Press

Government of Barbados. (2008). UNGASS Country Progress Report. Bridgetown, National AIDS Programme.

Government of Trinidad and Tobago. (2008). UNGASS Country Progress Report. Port of Spain: National AIDS Coordinating Committee.

Haaker, M. (2004) *The Macroeconomic Impact of HIV/AIDS.* Washington: International Monetary Fund.

Haider - Markel, D. Joslyn, M. & Kniss, C. (2000). Minority Group Interest and Political Representation: Gay Elected Officials in the Policy Process. *Journal of Politics 62*(2): 568-577

Herb, M. (2005). No Taxation Without Representation? Rents, Development, and Democracy. *Comparative Politics 37*(3): 297-317.

Hintzen, P. (1994). Trinidad and Tobago: Democracy, Nationalism, and the Construction of Racial Identity. in Edie, J. (ed.) *Democracy in the Caribbean: Myths and Realities.* Westport: Praeger.

Horowitz, A. (1985). *Ethnic Groups in Conflict.*

Howe, C. & Cobley, A. (2000). *The Caribbean AIDS Epidemic.* Bridgetown, Port of Spain: University of the West Indies Press.

Immergut, E. (1992). The Rules of the Game: The Logic of Health Policy-making in France, Switzerland, and Sweden. in Steinmo, S., Thelen. K. & Longstreth, F. (eds.) *Structuring Politics: Historical Institutionalism in Comparative Analysis.* New York, NY: Cambridge University Press.

Janssen, R., Satten, A., Stramer, S., Rawal, B. O'Brien, T., Weiblen, B. et al. (1998). New Testing Strategy to Detect Early HIV-1 Infection for Use in Incidence Estimates and for Clinical Prevention Purposes. *JAMA 280*(1): 42-47.

Kapmadoo, K. (1999). *Sun, Sex, and Gold: Tourism and Sex Work in the Caribbean.* New York, NY: Rowman & Littlefield.

Kaufman, R. & Nelson, J. (2007). *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America.* Washington, DC: Woodrow Wilson Center Press.

Keefer, P. & Vlaicu, R. (2007). Democracy, Credibility, and Clientelism. *Journal of Law, Economics, and Organization 24*(2): 371-306

Keefer, P. (2005). Does Democracy Help? In Zagha, R., Nankani, G. (eds.) *Economic Growth in the 1990s: Learning from A Decade of Reform.* Washington, DC: World Bank Publications.

Kitschelt, H & Wilkinson, S. (2007a). *Patrons, Clients, and Policies: Patters of Democratic Accountability and Political Competition.* Cambridge: Cambridge University Press.

_____. (2007b). Citizen-Politician Linkages: an Introduction. in Kitschelt, H & Wilkinson, S. (eds.) *Patrons, Clients, and Policies: Patters of Democratic Accountability and Political Competition.* Cambridge: Cambridge University Press.

Lake and Baum. 2001. The Invisible Hand of Democracy. *Comparative Political Studies 34*(6): 587-621.

La Porta, R., Lopez-de-Silanes, F., Shleifer. A., & Vishny, R. (1999). The Quality of Government. *The Journal of Law, Economics, and Organization 15*(1): 22-79.

Lee, R., Poon-King, C., Legall, G., Trottman , C., Samiel, S. and O'Neill, C. (2005). Risk behaviors for HIV among men who have sex with men in Trinidad and Tobago. : AIDS 2006 - XVI International AIDS Conference: Abstract no. CDD0366.

Lieberman, E. & Gauri, V. (2007). Boundary Politics and HIV/AIDS Policy in Brazil and South Africa. *Studies in Comparative International Development 41*(3): 47-73.

Lieberman, E. (2007). Ethnic Politics, Risk, and Policy-Making: A Cross-National Statistical Analysis of Government Responses to HIV/AIDS. *Comparative Political Studies 40*(12):1407-1432.

Lizzeri, A. & Persico, N. (2001). The Provision of Public Goods under Alternative Electoral Incentives. *American Economic Review 91*(1): 225-239.

Luciani, G. (1987).Allocation vs. Production States: A Theoretical Framework. in Beblawi, H. & Luciani, G. eds. *The Rentier State: Nation, State, and the Integration of the Arab World.* London: Croom Helm: 85-98.

Marquez, P. (2004). Taking Decisive Action: The Barbados HIV/AIDS Prevention Project. *En Breve 45*(April):1-4.

Mason, D., & Athow, B. (2002). Colonial Style and Post-Colonial Ethnic Conflict in Africa. *Journal of Peace Research 39*: 693-710.

Medina, L. & Stokes, E. (2007). Monopoly and Monitoring: An Approach to Political Clientelism. in Kitschelt, H & Wilkinson, S. (eds.) *Patrons, Clients, and Policies: Patters of Democratic Accountability and Political Competition.* Cambridge: Cambridge University Press.

Meighoo, K. (2003). *Politics in a Half-made Society: Trinidad and Tobago 1925-2001*. Kingston, Miami: Ian Randle Publishers.

Milesi-Feretti, G.M., Perotti, R., Rostagno, M. (2002) Electoral Systems and Public Spending. *Quarterly Journal of Economics 117*(2):609-657.

Misztal, B. & Moss, D. (1990) *Action on AIDS. National Policies in Comparative Perspectives.* New York, Westport, London: Greenwood Press.

Moore, C. (1976). Petroleum and Political Development in the Maghreb. in Sherbiny N. & Tessler, M. eds. *Arab Oil: Impact on the Arab Countries and Global Implications.* New York, NY: Praeger.

Murray, D. (2009). Positively Limited: Gender, Sexuality, and HIV and AIDS Discourses in Barbados. in Barrow, Ch., de Bruin, M., and Carr, R. (eds.) *Sexuality, Social Exclusion, and Human Rights.* Kingston and Miami: Ian Randle Publishers. pp: 116-129.

Nicholls, S., McLean, R., Henry, B. & Camara, B. (1998). Modeling the Macroeconomic Impact of HIV/AIDS in Trinidad and Tobago. Paper presented at the Annual Review Seminar, Research Department, Central Bank of Barbados, July 20-31, 1998.

Nicholls, S., McLean, R., Theodore, K., Henry, B. & Camara, B. (2000). Modeling the Macroeconomic Impact of HIV/AIDS in the English Speaking Caribbean. *South African Journal of Economic 68*(5): 405-412.

North, D. & Weingast, B. (1989).Constitutions and Commitment: Evolution of Institutions Governing Public Choice. *Journal of Economic History*, XLIX(4).

Oxaal, I. (1961). *Black Bourgeoisie Come to Power*. Massachusetts: Schenkman.

Patterson, A. () *The Politics of AIDS in Africa*. Boulder, London: Lynne Rienner Publishers.

Padilla, M. (2007). *Caribbean Pleasure Industry: Tourism, Sexuality, and AIDS in the Dominican Republic*. Chicago, IL: University of Chicago Press.

Persson , T & Tabellini, G. (2003). *The Economic Effects of Constitutions*. Cambridge, MA: MIT Press.

Pisani, E. 2007. *The Wisdom of Whores: Bureaucrats, Brothels, and the Business of AIDS.* New York and London: W.W. Norton and Company.

Poku, N. &Whiteside, A. (Eds.). (2004). *The Political Economy of AIDS in Africa.* Burlington, VT: Ashgate Publishing Company.

Posner, D. (2004). Measuring Ethnic Fractionalization in Africa. *American Journal of Political Science 48*(4): 849-863.

Putnam, R., Leonardi, L., & Nanetti, R. (1994). *Making Democracy Work: Civic Traditions in Modern Italy.* Princeton, NJ: Princeton University Press.

Premdas, R. (2007). *Trinidad and Tobago. Ethnic Conflict, Inequality, and Public Sector Governance.* Basingstoke, New York: Palgrave Macmillan.

Okruhlik, G. (1999). Rentier State unruly Law and the Rise of Opposition. *Comparaitve Politics 31*(3): 295-328.

Quandt, A. (1981). *Saudi Arabia in the 1980s: Foreign Policy, Security, and Oil.* Washington, DC: Brookings Institution.

Reddock, R. (1994). *Women, Labour and Politics in Trinidad and Tobago: A History.* Kingston, Miami: Ian Randle Publishers.

Ross, M. (2001). Does Oil Hinder Democracy? *World Politics 53*(3): 325-361.

_____. (1999). Political Economy of Resource Course. *World Politics 51*(3): 297-322.

Ryan, S. 1972. *Race and Nationalism in Trinidad and Tobago: a Study of Decolonization in a Multiracial Society*. Toronto: University of Toronto Press.

_____. 1999a. *The Jandhi and the Cross: The Clash of Cultures in Post-Creole Trinidad and Tobago*. St. Augustine: The University of the West Indies Press.

_____. 1999b. *Winner Takes All: The Westminster Experience in the Anglophone Caribbean.* St. Augustine: The University of the West Indies Press.

_____. 2003. *Deadlock: Ethnicity and Electoral Competition in Trinidad and Tobago 1995 - 2002.* St. Augustine: Sir Arthur Lewis Institute of Social and Economic Studies.

Sen, A. (1999). Democracy as a Universal Value. *Journal of Democracy 10*(3): 3-17

Shafer, M. (1994). *Winners and Loosers: How Sectors Shape the Developmental Prospects of States.* Ithaca, NY: Cornell University Press.

Shumpeter, J. A. (1942). *Capitalism, Socialism, and Democracy*. New York: Harper.

Smith, B. (2004). Oil Wealth and Regime Survival in the Developing World, 1960-1999. *APSR 48*(2): 232-246.

Smith, Ch. A. (2010). Gay, Straights, or Questioning? Sexuality and Political Science. *Political Science and Politics 44*(1): 35-38.

Snyder, R. & Bhavai, R. (2005). Diamonds, Blood, and Taxes: a Revenue-Centered Framework for Explaining Political Order. *Journal of Conflict Resolution 49*(4): 563-597.

Stasavage, D. (2005). Democracy and Education Spending in Africa. *American Journal of Political Science 39*(2): 343-358.

Stokes, S. (2005). Perverse Accountability: A Formal Model of Machine Politics with Evidence from Argentina. *APSR 99*: 315-326.

de Waal, A. (2006). *AIDS and Power. Why There is No Political Crisis - Yet.* London, New York: Zed Books.

van de Walle, N. (2007). Meet the New Boss, Same as the Old Boss ? The Evolution of Political Clientelism in Africa. in Kitschelt, H & Wilkinson, S. (eds.) *Patrons, Clients, and Policies: Patters of Democratic Accountability and Political Competition.* Cambridge: Cambridge University Press.

Zorn, C. (2001). Generalized Estimating Equation Models for Correlated Data: A Review with Applications. *American Journal of Political Science 45*(2): 470-490

Primary Sources:

Altman, L.K. (1982) 'New homosexual disorder worries officials', the New York Times, May 11

Barbados Evangelical Association (2005). 'Faith, Hope, Love, and Human Sexuality.' September, 2009
http://www.caribbeanevangelical.org/programmes/#

The Government of Barbados. (2008). UNGASS Country Progress Report. United National Joint Programme on AIDS.

The Government of Barbados. (2010). UNGASS Country Progress Report. United National Joint Programme on AIDS.

The Government of Trinidad and Tobago (2008). UNGASS Country Progress Report. United National Joint Programme on AIDS.

The Government of Trinidad and Tobago (2010). UNGASS Country Progress Report. United National Joint Programme on AIDS.

Trinidad and Tobago National AIDS Coordinating Committee (2009). National HI and AIDS Spending Assessment.

World Bank (2009). Proposal to Restructure the Trinidad and Tobago HIV/AIDS Prevention and Control Project (Loan 7184-TR). Project Paper 51277

World Bank (2003). Project Appraisal Document on a Proposed Loan in the Amount of US$20.0Million to Trinidad and Tobago for a HIV/AIDS Prevention and Control Project (Second Phase of the Multi-Country HIV/AIDS Prevention and Control Adaptable Program Loan for the Caribbean). June 9, 2003.

World Bank (2003b).World Bank Approves $20 Million For HIV/AIDS Prevention And Control In Trinidad And Tobago. Press Release No: 2003/464/LAC, 27 June, 2003.

World Bank (2000). HIV/AIDS in the Caribbean: Issues and Options. Report No. 20491-LAC.

Ministry of Education, Youth Affairs, and Sports (2001). Report on the National KABP Survey on HIV/AIDS. Barbados: Division of Youth Affairs, Ministry of Education, Youth Affairs, and Sports.

_____.(2004). Report on the Secondary School Behavioral Surveillance Survey 2003/2004. . Barbados: Division of Youth Affairs, Ministry of Education, Youth Affairs, and Sports.

National HIV/AIDS Commission Barbados (2001). Status Report: May 15th to August 15th 2001. Author.

National HIV/AIDS Commission Barbados (2008). Barbados National HIV Policy: A Framework for Action. Author.

Barbados Labour Party (2007). Barbados Better Than Ever. The Barbados Labour Party 2007 Report on Promises and Performance. Author.

World Bank (2008). Project Appraisal Document on a Proposed Loan in the Amount of US$35.0Million Equivalent to Barbados for a Second HIV/AIDS Project. 10 July 2008 Report No.: 42194-BB. Author.

World Bank (2001). Project Appraisal Document on a Proposed Loans in the Amount of US$25.0Million to the Dominican Republic and US$15.15Million to Barbados In

Support of the First Phase of the US$155.5 Million Multi-Country HIV/AIDS Prevention and Control Adaptable Program Lending (APL) for the Caribbean Region. 5 June 2001 Report No.: 22184-LAC.

World Bank (2008). Implementation Completion and Results Report (IBRD-7066) On a Loan In the Amount of US$15.15 Million To Barbados for a Barbados HIV/AIDS Prevention and Control Project. 27 June 2008 Report No.: ICR0000741. Author.

World Bank (2008). Barbados: World Bank Approves US$35 Million for HIV/AIDS Prevention and Control. Press Release No.: 2009/053/LCR, 7 August 2008.

The Washington Blade (1982) 'Gay cancer focus of hearing', April 16

APPENDIX A: In-depth Interview Sectors and Dates

ID1 (B)	ID2	Sector	Date
Barbados	1	Media/Academic	8/11/2009
Barbados	2	NHAC	8/14/2009
Barbados	3	NAHC	8/14/2009
Barbados	4	Academic	10/2/2009
Barbados	5	FBO	10/6/2009
Barbados	6	Government	10/6/2009
Barbados	7	FBO	10/7/2009
Barbados	8	FBO	10/2/2009
Barbados	9	Government	7/12/2009
Barbados	10	Health/Academic	8/14/2009
Barbados	11	NGO	8/19/2009
Barbados	12	Academic/IO	8/19/2009
Barbados	13	Government	8/20/2009
Barbados	14	Health	8/25/2009
Barbados	15	FBO	8/27/2009
Barbados	16	Health	8/7/2009
Barbados	17	Academic	8/7/2009
Barbados	18	NHAC	8/14/2009
Barbados	19	Government	9/10/2009
Barbados	20	NGO	9/10/2009
Barbados	21	Health	9/11/2009
Barbados	22	INGO	9/16/2009
Barbados	23	Government	9/17/2009
Barbados	24	FBO	9/2/2009
Barbados	25	Health	9/22/2009
Barbados	26	Private Sector/NGO	9/8/2009
Barbados	27	Government	9/9/2009
Barbados	28	NGO	7/28/2009
Barbados	29	NGO	7/29/2007
Barbados	30	NGO	8/19/2009
Barbados	31	Government	7/30/2009
Barbados	32	Government	7/28/2009
Barbados	33	NHAC	8/18/2009
Barbados	34	Government	7/27/2009
Barbados	35	NGO	7/28/2009
Barbados	36	NHAC	8/18/2009
Barbados	37	Government	12/2/2009
Barbados	38	Health	8/10/2009
Barbados	39	Government	7/24/2009

Barbados	40	NGO/Government	8/19/2009
ID1 (TT)	**ID2**	**Sector**	**Date**
Trinidad and Tobago	1	Government	3/1/2009
Trinidad and Tobago	2	Government	12/11/2009
Trinidad and Tobago	3	Health/IO/Government	1/22/2010
Trinidad and Tobago	4	Government	1/26/2010
Trinidad and Tobago	5	IO	1/6/2010
Trinidad and Tobago	6	IO	1/7/2010
Trinidad and Tobago	7	INGO	1/11/2010
Trinidad and Tobago	8	NGO	1/11/2010
Trinidad and Tobago	9	IO	1/14/2010
Trinidad and Tobago	10	Government	1/21/2010
Trinidad and Tobago	11	Government	1/25/2010
Trinidad and Tobago	12	NGO	1/27/2010
Trinidad and Tobago	13	Health	1/27/2010
Trinidad and Tobago	14	Government	1/29/2010
Trinidad and Tobago	15	NGO	1/11/2009
Trinidad and Tobago	16	NACC	11/17/2009
Trinidad and Tobago	17	FBO/NGO	11/17/2009
Trinidad and Tobago	18	FBO/NGO	11/18/2009
Trinidad and Tobago	19	NACC	11/19/2009
Trinidad and Tobago	20	Health/NACC	12/10/2009
Trinidad and Tobago	21	NGO	12/10/2009
Trinidad and Tobago	22	Government	12/16/2009
Trinidad and Tobago	23	Government	12/17/2009
Trinidad and Tobago	24	IO	12/4/2009
Trinidad and Tobago	25	Academic	12/7/2009
Trinidad and Tobago	26	Government	2/21/2010
Trinidad and Tobago	27	Health	12/7/2010
Trinidad and Tobago	28	NGO	11/20/2010
Trinidad and Tobago	29	Health	11/16/2010
Trinidad and Tobago	30	IO	1/13/2010
Trinidad and Tobago	31	Academic	11/23/2010
Trinidad and Tobago	32	Health	2/10/2010
Trinidad and Tobago	33	Government	11/30/2010
Trinidad and Tobago	34	NGO	1/10/2010
Trinidad and Tobago	35	Government	2/24/2010
Trinidad and Tobago	36	Government	2/25/2010
Trinidad and Tobago	37	IO	2/13/2010