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# Is Democracy the Answer: Differential Outcomes in the Treatment of the Global HIV Epidemic

Kathleen Zhu  
kzhu@wellesley.edu

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Is Democracy the Answer: Differential Outcomes in the Treatment of the  
Global HIV Epidemic

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Kathleen L. Zhu

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**KZ**  
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## Chapter 1: Introduction

### Framework of study: Democracy to fight famine

Famines do not occur in democracies—this is one of Amartya Sen’s most well known theories. In a democracy, Sen asserts that there are political consequences if the leaders of the country do not address a famine. Leaders of democratic states face pressure coming from public criticism, elections, and opposition parties. In addition, freedom of the press allows media to publicize campaigns. Sen notes that these factors combine so that democratic countries have “the best early-warning system” against famines (Sen, “Development, 181). In non-democratic countries, famines do not affect state leaders, as the elite are insulated by their wealth, power, and easy access to resources. Because of this insulation, they are unlikely to act since the famine does not affect them. However, in democratic states, leaders face serious political consequences if they fail to act (Sen, “Development”, 180).

Sen mentions specific mechanisms of democracy in his theory—including free press, opposition parties, public criticism and discourse, and multi-party elections. In his exploration of the famine in Ireland induced by the potato blight, Sen notes that although there was a decrease in food production, had people been able to afford it, they would have been able to buy food from Britain (Sen, “Development”, 171). Thus, this is not a case of purely a fall in agricultural output but rather serves to highlight the economic deprivation of the Irish. Indeed, during the famine, food actually moved out of Ireland and into Britain. Although Britain had a robust safety net in place for “its own” people, this assistance was not extended to the Irish as they were seen to be unworthy, alluding to the strong social and cultural boundaries. This represents a great distance between the political elite (Britain) and the ruled (Ireland) that allows for this inaction. Democratic

institutions such as voting and opposition parties close this insulating distance. Through these means, the ruler becomes connected to the same problems as the ruled.

Sen further explains that democracies are most needed in times of crisis, because when “things go fine and everything is routinely good, this role of democracy may not be badly missed”(Sen, “Development”, 158). In other words, a benevolent despot may not seem objectionable when things are well or when the despot is making good decisions. However, when the state struggles and people speak up about the issues, their voices are unheard; whereas in a similar situation in a democratic state, citizens do have a means of redress and of action. Thus, when things are going well, an autocracy and a democracy are not highly distinguishable, but it is when things go bad that a democracy becomes the desirable method of governance. My thesis will test the applicability of Sen’s theory to other crises, such as the global HIV/AIDS epidemic.

### Competing Views

In a dramatic departure from the assertion that democracies are better equipped to address crises, Erwin Ackerknecht makes the opposite argument that authoritarian governments are actually better equipped to deal with crises like the HIV epidemic. Ackerknecht suggests that the policies needed to address such crises may be unpopular actions. Certainly, HIV interventions fit this description. Even if the government’s actions are empowering and conscious of personal liberties, it can be difficult for the population as a whole to come to terms with issues regarding sensitive topics like sex work, homosexuality, or drug use. Ackerknecht asserts that autocratic governments are more capable of handling the negative pressure, and that these governments are better equipped to take decisive actions which may infringe upon the liberties of people, and

thus these aggressive campaigns will allow non-democratic states to have a more effective response (Ackerknecht, 18), (Baldwin, 26). In addition, these autocratic states are often the ones with entrepreneurs who can take on new functions, and that this capability allows authoritarian regimes to be more efficient and effective (Lieberman, 54-55). In other words, perhaps the constraints of a check and balance government limited by oversight from political opponents and the media could actually slow down an effective response to a crisis that requires swift and aggressive action. Lieberman then notes that HIV/AIDS in Cuba offers a clear example of how this theory has been realized.

#### Applying Sen's Findings

Beyond his argument that famines do not occur in democracies, Sen broadens his theory and asserts that famines are just one example of a crisis that democracies prevent, stating that “the issue of famine is only one example of the reach of democracy, though it is many ways, the easiest to analyze” (Sen, “Democracy”). Sen’s argument has been applied to other cases in previous studies. Notably, Ruger’s work explores the connection between a democratic state and provision of health care services. Ruger appropriates Sen’s theory to argue that in democratic states, citizens have the ability to use institutions such as voting and the press to push leaders to provide health care universally or to the underprivileged. Implicit in this assertion is that governments can either provide universal health care coverage, or create a safety net specifically for the poor so that they have access to health care resources (Ruger, 300). In either scenario, governments are compelled to respond to the people and are held accountable for providing services so that all those in need have access.

Accordingly with Sen's theory, Ruger finds that China's lack of democratic mechanisms led to the famine of 1958-1961. The government faced neither pressure from an opposition party nor a press that was capable of holding the government accountable. Beyond this, local and regional officials attempted to conceal the problem and severely exaggerated crop yields in order to show the central government that the new policies were successful. The lack of democratic institutions blinded not only the citizens, but even central government officials (Ruger, 300-301). During the famine, China's export of food increased from 1.9 million tons before the Great Leap Forward policies, to 4.7 million tons in 1959 (Ruger, 301). This occurred despite widespread hunger in the country. Had the government done nothing else but reverse the outward flow of food, the impact of the famine would have been lessened, verifying Sen's point that to stop famines is cheap and easy work. However, the lack of accountability and open criticism for the government allowed inaction, and even counter-productive measures to continue (Ruger, 301).

Ruger extends her analysis of Sen's argument to China's handling of other more recent health issues such as the SARS epidemic, as a test of the applicability of Sen's argument to other issues. Again, the study shows that because the government was able to respond with censorship and avoid pressure from democratic institutions such as free press, the government was not incentivized to respond effectively to a problem that could bring potential embarrassment. In fact, the government was even able to cover up the SARS outbreak for an extended amount of time because of the lack of meaningful opposition parties, and the government-backed censorship of the press. The government's approach to hush news about the outbreak led people to be misinformed and fail to take

proper protective measures (Ruger, 301). Specifically, this analysis offers support that Sen's argument can be applied to other topics such as health and is not strictly limited to famines.

Other research similarly agrees with the accuracy of Sen's assertion when applied broadly to health issues. In a survey representing 98% of the world's population, it was found that once the country's wealth, size of public sector, and inequality were accounted for, democratic countries have better health outcomes in comparison to countries that are less free. This correlation was strongest for health indicators of infant mortality and life expectancy (Franco et al, 1421). Similarly, Besley and Kudamatsu have verified a robust correlation between the measurement of freedom of a state and the life expectancy of its people (313). They also corrected for other social factors such as education and political history. However, despite this strong correlation Besley and Kudamatsu note that correlation is not causation, and that it is quite difficult to attribute these positive health outcomes directly to democratic mechanisms (318).

Although these findings support Sen's theory for the benefits of democratic institutions, other findings have challenged Sen's work. For instance, South Africa officially became a democracy in 1994. According to Sen's theory, this transition would allow the previously disenfranchised black population to use democratic institutions such as voting to achieve more equitable access to services such as health care. However, in the decade after South Africa's democratization, public health indicators such as those for maternal, infant, and perinatal mortality; child nutrition, tuberculosis prevention, and life expectancy showed no signs of improvement. At the same time, there was open criticism of the government's failures to address health issues (Ncayiyana,1425). This seemingly

conflicts with Sen's assertion; despite democratic institutions that push for accountability and action from the government, there has been no progress in improving health indicators in South Africa.

### Research Question and Design

There is a conflicting field of evidence regarding the application of Sen's theory to health issues. Although there have been several studies that have correlated democracy with general health outcomes, few have made definite findings regarding HIV/AIDS. In order to fill this void in our knowledge, I hope to explore how democracy affects a state's response to HIV/AIDS. If democratic states do not have famines, then does the theory extend to assert that democratic states do not have HIV epidemics? I choose to focus on HIV/AIDS because it is a relatively modern public health dilemma that countries are still struggling with, thus my thesis will not only be a specific test of Amartya Sen's work, but will also have relevant implications today.

Since the initial discovery of Human Immunodeficiency Virus (HIV) in 1983, this disease has taken the lives of over 39 million people globally (WHO). Beyond the individual impact on families affected by the disease, there has also been a significant impact from the macroscopic view of societies, governments, and economies. When the virus was initially identified, scientists only knew that HIV attacks the immune system, ultimately leading to the onset of opportunistic infections collectively referred to as Acquired Immune Deficiency Syndrome (AIDS) (Barr é-Sinoussi et al., 1983). Although the disease was initially an almost immediate death sentence, with the invention of anti-retroviral medications and the development of scientific knowledge, HIV evolved to become a disease that can be treated, managed, and prevented (though not yet cured).

Since the initial discovery and categorization of the disease, it has garnered attention from governments and international organizations such as the United Nations and the World Health Organization.

The response from individual countries has ranged from denial of the problem to strong action. In my thesis I theorize that democratic states are more apt to recognize the threat that HIV poses, and that they will take steps to respond, ultimately leading to the best HIV response. In exploring the connection between democracy and a state's response to HIV, the goal of my research is not to isolate democracy as the single causal factor. Rather, the goal of this study is to account for the state's governance amongst a plethora of other factors such as the cultural context, the existing medical infrastructure, and the available financial resources. These factors certainly must not be ignored, and many of these factors likely have a greater causal effect on HIV outcome than the state's form of governance. However, this research seeks to consider the structure of the government as just one factor. I will explore the governmental response to HIV/AIDS by comparing four countries that will serve as case studies. South Africa will be the representative democratic country while Russia, China, and Cuba are the representative non-democratic countries. I will study how each country has uniquely addressed the HIV epidemic domestically in order to better understand the broad applicability of Amartya Sen's work. Essentially, for my analysis the government structure of the state will serve as the independent variable while response to HIV will serve as the dependent variable.

In my thesis, I apply these previous assertions about democracy to specifically argue that these traits of democratic states similarly compel leaders to respond forcefully to HIV/AIDS in their country. To that end, I will explore the meaning of democracy and

justify my interpretation of it in the context of my thesis. In order to understand Sen's analysis, a deeper exploration of democracy is necessary. The United Nations Development Programme's Human Development Report has asserted that democracy promotes all human development, including the ability of people "to enjoy good health" (UNDP, 58). The Human Development Report elaborates that democracy is characterized by the "contestation of power, the participation of people, and the accountability of the powerful" (UNDP,58). Thus, democracy is more than regularly held fair and free elections. Democracy must also include independent legislative and judicial branches that treat all citizens equally. However, democracy is not solely defined by a state's governing structure, as a strong civil society is another crucial aspect of democracy. Rich civic participation involves "engaging in deliberative processes that can bring people's concerns to the fore" (UNDP, 55). This can be done through a variety of means, be it writing a newspaper editorial, joining a union, or participating in a protest (UNDP, 55). In order to allow for meaningful and equal participation in civil society, the state must provide for and encourage the participation of marginalized or disadvantaged groups (UNDP, 55). These criteria used to describe democracy are tangible and explicit, yet they point towards another underlying, more intangible and complex measure of democracy.

A true democracy is not just "a mechanical condition" but it is one that ensures "the protection of liberties and freedoms" (Sen, "Democracy as Freedom", 10). This protection of freedoms ultimately translates to the capability to "choose a life one has reason to value" (Sen, "Development",74). This measure of freedom goes beyond an empirical measurement of wealth or the possession of capital goods, but rather it speaks

to the individual's ability to convert these goods into obtaining their own objective (Sen, "Development", 74-75). Foremost of the items highlighted in the "Capabilities Approach" are life and health. In other words, the ability to maintain good health, to avoid a premature death, or a life so compromised it is not worth living are considered crucial to freedom using this approach (Nussbaum, "Creating Capabilities", 33). Based on this framework provided by Sen, I argue that democratic institutions create an environment that provides for HIV treatment, prevention, and education for its citizens. There can be many means to reach the same ends. For instance, people can either have enough income to independently purchase anti-retroviral medications or the state can subsidize treatment. Either of these methods is essentially equivalent if the result of good health is reached.

However, this model of democracy proves problematic in the context of my thesis. Democracy requires a strong civic society that gives all people, even marginalized groups, an equal voice in the political leadership and decisions of a state. However, the goal of a democratic state is also to provide freedom, allowing people to realize their full potential, which ultimately acts as an equalizing force in society so that there ceases to be marginalization. This creates a circle, where the "structure of political action [is] a condition of possibility but...such a structure is always a contingent outcome of politics" (Held, 216). This chicken-egg paradigm is problematic in the context of my thesis as it complicates the measurement of democracy. Essentially, it creates a circle where HIV outcome is both a measure of the success of democracy, and a requirement for a functioning democracy.

Further difficulties arise in considering democracy to be a means of ensuring capabilities such as life and bodily health. By conventional understanding, Cuba under

Castro's rule is not considered a democratic state. However, Cuba has done an unprecedented job of providing treatment and care to HIV/AIDS patients. To that end, it seems that Cuba meets the requirement that a democracy must provide for the life and bodily health of its citizens. This dramatic contradiction in the categorization of Cuba's political system is quite problematic and challenging, raising the question of the applicability of the "Capabilities Approach" in my thesis. I do not question the validity or accuracy of this assessment of Cuba or of the "Capabilities Approach" overall. But it appears that this approach thoroughly challenges the conventional wisdom and may meld the independent variable (extent of democracy in the state) and the dependent variable (HIV outcome of the state). Although these things are not problematic in it of themselves, my concern lies with the applicability and relevance of the "Capabilities Approach" to my research question.

In an effort to generate straightforward and non-obsolete measures of democracy that will fit the scope of my thesis, I seek to restrict the definition of democracy to the solely mechanistic view. I hope that by using a more simplified model of democracy, it will allow for a clearer analysis of the connections between democracy and HIV outcome. This mechanistic view of democracies will be based upon analysis of the state's government structure using indicators from the Human Development Report's measure of democracy such as: civil liberties, political rights, polity score, press freedom, and voice and accountability (UNDP,37).

Through a qualitative analysis of the HIV responses of the case study countries of Russia, Cuba, South Africa, and China I hope to examine how the dependent variable of HIV responses is affected by the state's government structure. These countries were

specifically chosen in order to thoroughly test Amartya Sen's theory of the benefits yielded by democratic governance. Although Russia, Cuba, and China claim to be democratic states, I will first establish in practice they are hardly democratic. If Amartya Sen is correct, then it should follow that these states have poor responses to HIV/AIDS. Russia's response to the disease fits within the expectations from Sen's theory. However, Cuba and China have far stronger responses to HIV than would be predicted from Sen's approach. Similarly, the case study of South Africa also presents a response to HIV/AIDS that is unexpected given Sen's theory. I establish that despite South Africa's robust democratic institutions, the HIV epidemic has still had a devastating effect on the country fueled by a belated government response. From these case studies, I ultimately conclude that democratic states offer citizens effective mechanisms to educate the political elite regarding desired actions, but that an already enlightened dictator can carry out a more effective response. Removing the insulating distance between the political elite and the problems of the citizens causes the leaders to become educated about the citizens' plight and respond to the crisis, but the use of democracy is not necessary for this to occur.

## Chapter 2: Russia

### Democracy in Russia

Russia's governance has undergone significant changes during the time that HIV/AIDS has been a global health problem. Prior to 1985, governance in the Soviet Union consisted of one party, the Communist Party of the Soviet Union. The General Secretary of the party was considered the head of state, and together with the Politburo composed of officials close to the Secretary, comprised the highest echelon of state leadership. The many other party members all the way down to the local level executed the decisions of these few key officials (Ostrow, 11). This large, centralized Communist state apparatus had authoritarian control over the country. The Soviet Union functioned under the "formal political monopoly" of the Communist Party (White, 29).

Gorbachev was then elected to the General Secretary in 1985, and his leadership signaled a change for the then Soviet Union, as the political structure began to move away from the system of consolidated power under one communist leader. Instead, Gorbachev pushed forth "*glasnost*", or an introduction of transparency and openness. This was intended to allow people to have a "greater awareness of the real state of affairs and of the considerations that had led to particular decisions" (White, 18). Information that had previously been unavailable to people became public, such as statistics regarding infant mortality and life expectancy. *Glasnost* also led to the public discussion of previously taboo topics such as potential drawbacks of socialism and other subjects such as prostitution and drug use (White, 25). Under Gorbachev, parties outside of the Communist Party were allowed to exist starting in 1990.

In 1991, a coup against Gorbachev ultimately caused the collapse of the Soviet Union and resulted in the establishment of a new Russian Federation. With Boris

Yeltsin's assumption of power came economic change as he led a conscious effort to move towards a capitalist system. However, the political system in Russia remained a hybrid form of government composed of both authoritarian and democratic elements. Levitsky and Way characterize this as competitive authoritarianism, or a diminished form of authoritarianism with systematic violations of the tenets of democracy (53). These consistent violations ultimately result in elections that are stacked against the opposition as the incumbent party has greater resources to undertake measures such as favorable media coverage, harassment of opposition parties, and even manipulate electoral results. However, despite this, democratic institutions are more than a façade as the democratic norms cannot be openly violated by the incumbents and opposition parties often do pose a legitimate threat (Levitsky and Way, 53-54). Putin's leadership has also been characterized as a competitive authoritarian state, but in recent years the state has demonstrated an increase in power so that the Putin regime has moved closer to a complete authoritarian regime. Elections and the media are even more tightly controlled, and dissenters experience even greater repression (Freedom House).

Although there have been significant changes in Russia's governance structure over the course of HIV's history, even at its most liberal point, it would be inaccurate to say that Russia had achieved any sort of meaningful democracy. The democratic institutions have simply not been robust enough for citizens to demand accountability from the political leadership. This is demonstrated by constant reports of Russia's crackdown on protests, with even a member of United Russia, the ruling party acknowledging that "There is a protest mood, but there are no channels to carry it" (Barry, 21). If Sen's assertions about democracies are correct— that democratic

institutions prevent famines and other negative issues that affect the people, then we would expect the Russian government to have a very poor response to HIV/AIDS.

#### Moral Conservatism and Denialism Drives Russia's HIV/AIDS Response

Russia's governmental response to HIV has been driven by traditional and culturally conservative viewpoints that have created conditions ripe for the spread and mismanagement of HIV. The Russian government has consistently failed to recognize HIV as a legitimate problem, and indeed this sentiment largely remains true even currently. Russia's response to HIV/AIDS has been driven to a great extent by denial and discrimination. The prevailing view that officials have asserted is that HIV is a disease associated with the evils of Western society. It has consistently been viewed as a disease that simply cannot affect Russia because of its superior values (Twigg, 8-9). When Russia could no longer deny the existence of domestic HIV/AIDS cases, it was seen as a disease that cleansed society (Twigg, 8). These perspectives regarding HIV have been the Russian government's driving force in response to the disease.

This trend of moral conservatism fueling the HIV epidemic is clearly exemplified by the Russian state's failure to implement effective sexual education. Since the 1980s, Russia has experienced high rates of many sexually transmitted diseases including the well-documented case of syphilis rates many times higher than the rest of the European Union (King et al, 215). Although Russia briefly collaborated with UNESCO and UNFPA to introduce sexual education into the school curriculum, this ultimately failed and the government returned to its conservative viewpoint in 1997 stating that "Russia does not need any sexual education"(Gevorgyan, 215). Currently, there is some support for introducing sexual education in some form to students, although there are concerns

about the content and whether or not it could lead students to participate in sex earlier. But overall it remains true that sexual education remains largely non-existent in Russia. This long-standing history of inadequate to non-existent sexual education has created an environment where people are not capable of knowing how to protect themselves and do not make informed decisions regarding their sexual health.

Russia's denial of HIV/AIDS has also caused inaccurate and questionable HIV/AIDS statistics reporting. This stems from the lack of testing infrastructure that exists, and from fears and pressures that dissuade people from registering with the government as HIV/AIDS positive. Because of this, even now official statistics regarding HIV/AIDS in Russia have been referred to as not credible (Twigg, 51). Although there were 300,000 officially reported cases in 2004, even Vadim Pokrovsky, head of the Russian Ministry of Health's Federal AIDS Centre asserted that these numbers could be off by a factor of three. He suggested that there could be over 1 million cases (Webster, 1355). Together, these examples demonstrate the Russian government's failure to make methodologically sound decisions in the fight against HIV/AIDS. Of course, any government democratic or otherwise could make these same critical misjudgments, but I will go on to show that only in an autocratic regime, like that of Russia's, is there no recourse for citizens to demand action.

#### Lack of Financial Commitment

Russia was first exposed to HIV in the midst of the dissolution of the Soviet Union. The instability and chaos in Russia created conditions ripe for the mismanagement of HIV/AIDS (Twigg, 61). Thus, during this transitional period Russia was a vulnerable state in terms of the HIV epidemic. Although it lacked the financial

resources to dedicate towards this public health issue, this was not the major constraint in terms of Russia's early response to HIV/AIDS. In the early years of HIV history, the government's health budget was not treated as a priority as it was simply left with the remainder of the overall budget (Blyuger) (Twigg, 40). These decisions resulted in a 1990 budget of 53 million rubles (roughly equivalent to a little over 1 million USD), a meager amount compared to a budget of over \$1.6 billion USD in the U.S (Medvedev, 934). This small budget allocation translated into a scarcity of many critical resources. For instance, into the early 1990s, Russia severely lacked necessary testing supplies and clean needles (Twigg, 21, 25). Even more affordable prevention techniques were hampered by the government's lack of financial commitment as basic supplies like condoms were very difficult to obtain for most people (Twigg, 18).

This pattern of little financial commitment continued up until 2006, even as Russia was becoming wealthier it still continued to barely fund its own domestic HIV programs. On an annual basis, Russia budgeted around \$4-5 million to combat domestic HIV/AIDS. This budget is in contrast to Russia's \$20 million commitment towards the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Twigg, 42). This imbalance stems from domestic hostility towards addressing HIV/AIDS and the belief that the disease is a problem for developing countries, and not established powers like itself. While before, Russia's budget for HIV/AIDS may have been constrained by a general lack of resources available to the state, this is no longer a legitimate excuse. Russia has significantly more resources available to it, as evidenced by the \$180 billion it holds in foreign reserves (Twigg, 122).

In 2006, Putin called on the State Council to address the HIV problem in the country. At the time, this was seen as a ground-breaking move as Putin called on the state to have a comprehensive response recognizing that HIV is a legitimate health problem, which requires coordination across bureaucracies and greater resources dedicated to prevention and testing (UNAIDS, “President”). This newfound recognition of HIV as a problem likely stemmed from Putin’s general realization that Russia faces a plethora of health problems across the board (Clark, 711). In 2006, the budget dedicated to the HIV/AIDS treatment effort was \$109 million, a great increase in comparison to previous years. This certainly signaled a shift towards greater financial commitment from the Russian government and has resulted in more services being available to HIV patients including free ARV medications. However, this budgetary increase has unfortunately not translated into a real step forward for many of Russia’s HIV patients. In reality, systematic discrimination is used so medical care is only accessible to patients who are perceived to be “innocent” and not part of a stigmatized group like injecting drug users or sex workers.

#### Systematic Discrimination to Prevent Treatment of Marginalized Groups

Indeed, despite the greater financial investment in this effort to fight the HIV epidemic in Russia, Putin still advocates an approach based on Russia’s superior traditions and morals. Thus, the government’s policies intentionally exclude groups such as commercial sex workers and injecting drug users because they are considered morally reprehensible. However these groups are also highly vulnerable to contracting and transmitting HIV. Russia has the fastest growing HIV epidemic in the world, which is primarily fueled by infections from injecting drug users. The severity of the problem is

reflected in estimates that suggest there are 1.8 million injecting drug users, and that more than one third of this population is HIV positive (Audoin and Beyrer). HIV is able to have this devastating impact on Russia's population of injecting drug users, because of the government's discriminatory policies and inaction to treat drug addiction.

Even though Russia's financial commitment to addressing HIV/AIDS has increased, this has translated to little improvement in reality because the government's draconian and unscientific policies towards injecting drug users exclude a large portion of HIV patients. For instance, Russia has outlawed the use of methadone, an opiate-substitute that is used to treat addicts during their recovery. This policy directly rejects the medical recommendations made by the World Health Organization (Gilderman, 45). Russia's policy of zero tolerance for drug use has effectively driven addicts underground as they fear retribution and punishment from the government. For example, heroin addicts must register with the government. They lose their driver's licenses, often face time in prison, and are not permitted to work many jobs. By driving addicts underground, the Russian government makes these groups and the general population more vulnerable to the HIV epidemic. Other examples of direct discrimination against injecting drug users include their exclusion from free medication programs. Although Russia provides free ARV medications to patients, registered addicts are exempt from this program. (Gilderman, 48). Drug users are only eligible for receiving ARV treatment when they have stopped drug use, but there is very little help available to aid them in fighting their addiction. In state sponsored drug treatment centers, addicts are locked up, coerced, and faced with violence. There are few rehabilitation services provided by NGOs or private organizations that are separate from the state (Sarang et al,687). Through measures such

as these, the Russian government has been able to directly discriminate against injecting drug users and prevent them from receiving care.

Outside of direct discriminatory measures, there is also the indirect but systematic use of discriminatory practices that prevent drug users and other high risk groups from getting treatment, which only fuels the HIV epidemic. For instance, drug users infected with HIV often report working with unsympathetic doctors and nurses. Similarly, other groups like sex workers also report that the stigma and discrimination they face is so significant that it prevents them from seeking healthcare (King et al, 2601). In addition, the bureaucracy of health care in Russia can be overwhelming to any patient, but this complex and slow-paced bureaucracy is often deliberately used against HIV positive patients from these undesirable social groups. For instance, patients may be referred to another doctor before they can be prescribed ARV, but it may take months in order to meet with the other doctor (Sarang et al, 685). This administrative process results in lengthy delays that can cause great health dangers to the patients (Sarang et al, 686). This hidden but systematic use of discriminatory practices deliberately targets HIV patients from unfavorable social groups. This allows Russia's stepped-up HIV treatment program to be solely for "innocent" patients such as those who became infected through a blood transfusion, whose lives are deemed worth saving.

#### Government Repression

When domestic and international groups attempt to initiate a change in Russia's draconian HIV/AIDS policies, the government is able to use repressive techniques to silence dissent and challenges. For example, in 2003, Russia received a \$50 million loan from the World Bank to spend on HIV/AIDS initiatives (Webster, 1355). In the same

year, a group of five Russian NGOs also received a \$90 million grant to fight HIV (Twigg, 120). This international aid stemmed from the recognition of outside organizations that Russia's HIV prevalence was rapidly increasing, and that this may be a critical point where the virus can be introduced to the general population instead of remaining confined in high risk groups (Webster, 1355). Aid organizations such as USAID, CIDA, and the EC have been involved in Russia's response to the HIV epidemic. However, these organizations have encountered tension with the Russian government, and they have even been accused of "undermining 'national interests'". The Russian government has even forced some of the organizations like USAID to leave the country because of disagreements (Twigg, 118). In addition, with the recognition that although Russia faces a serious HIV/AIDS crisis, it is not lack of resources, but lack of political commitment that explains its response, many of these organizations have turned towards assisting countries that are truly limited by access to resources (Twigg, 121). The Russian state has also persecuted NGOs and doctors that do provide treatment and support for drug users. Youth groups supported by the Kremlin have harassed doctors that provide methadone treatment to addicts (Schwartz). Similarly, NGOs that provide condoms and needle exchange programs are also persecuted by the state (Gilderman, 48-49). From Russia's repression of groups whose policies it disagrees with, it is clear that the lack of democratic institutions and the totalitarian government create a situation where there is no recourse for citizens to demand change and a better response from the government.

The people that are hurt by Russia's policies have little power and very few ways of successfully forcing the government to change its policies. Because the groups that are vulnerable to the disease are marginalized in society, and already face danger from the

government based on these illegal activities, they are not empowered to act as their own advocates. For instance, injecting drug users already face harassment from the police and harsh punishments (Twigg, 170). Thus they will not act as their own advocates since that will mean incriminating themselves. Even if Russia has some weak democratic institutions, people are still not incentivized to be advocates. Besides dis-incentivizing patients from acting as their own advocates, Putin has also directly made advocacy illegal with the passage of a bill in 2013 that bans the exposure of minors to homosexual propaganda. Based on the bill's loosely defined view of propaganda, advocacy work and HIV outreach with the LGBTQ population is essentially illegal and can be liable for prosecution. Doctors who have spoken up about less sensitive issues have been known to lose their jobs or be investigated on false charges like tax evasion (Clark, 712). In this environment driven by fear, the implementation of other less sensitive health directives shows the extent of persecution and lack of power faced by advocates working on a sensitive topic health issue like HIV. Through these indirect and directly repressive measures such as the ones outlined, the Russian government has effectively limited any significant and meaningful use of democratic institutions to change the country's policies regarding HIV/AIDS.

### Conclusion

Russia's inaction regarding high risk groups has created a situation where the HIV epidemic has reached a critical mass and the disease can move from concentrated high-risk sub-populations into the general population. There is a growing recognition in Moscow that HIV/AIDS poses a threat to Russian society as even Russia's National Security Strategy has cited the disease as a security threat (Schwartz). This change signals

that although the attitude has changed to recognize that HIV is a legitimate problem the government must address. But, social behaviors such as sex work and drug use that are not in line with the country's morally superior and traditional values. Thus people who fall into these groups remain marginalized in society as the government does not feel obligated to help them.

It is unfortunate that the high-risk groups for HIV/AIDS overlap overwhelmingly with these socially marginalized groups that are intrinsically discriminated against. This has translated into a solely medical approach that ignores the larger social and public health ramifications associated with HIV/AIDS (Lussier and McCullaugh, 36). In other words, Russian policy fails to recognize that this is not health issue that can be addressed solely by doctors treating their patients; rather there are larger, underlying social issues that go hand in hand with reducing the epidemic. Positive steps such as doubling the budget for anti-retroviral medications to \$600 million in 2011 have occurred, but these steps have also been coupled with negative steps such as the rejection of aid from the Global Fund because it was contingent upon the adoption of policies that support needle exchange and methadone treatment (Gilderman, 45), (Schwartz). Overall, Russia's response to HIV has been ineffective with inadequate sexual education in schools, harm reduction programs, and training of health care workers (Lussier and McCullaugh, 36), (Burns, 35).

This analysis of Russia suggests that a lack of democratic institutions do hinder an effective HIV/AIDS response. As predicted by Sen, in an autocratic country with very little effective democratic institutions, the response to the HIV epidemic will be a failure. Although the HIV epidemic in Russia piggy-backs off the unfortunate combination of

problems in the health care infrastructure and underlying cultural attitudes that encourage discrimination and conservatism, there is no recourse available for people living with HIV/AIDS to push the government to make changes that will benefit them. Especially because the people most vulnerable to HIV are also socially marginalized groups, the use of democratic institutions to push the political elite to change the policies is simply not possible given the repressive environment. Any measures for or against the treatment of HIV patients is part of a top-down approach that originates from the political elites, and essentially Putin himself. By showing that the opposite is true in repressive states like Russia, this case study suggests that Sen is correct in saying famines and serious problems that can be corrected do not exist in countries with robust democratic institutions. Solving these problems has very little connection to the financial resources available to the state as we see that Russia's response to the disease shows little change whether financial resources are available or not.

This analysis of HIV/AIDS in Russia not only supports Sen's conclusions about democracy, but also provides evidence against other competing interpretations. This analysis also provides evidence against any efficiencies or advantages of being an autocratic state. No entrepreneurs have made any notable contributions towards fighting AIDS, and are likely disincentivized from trying by the government. Although Russia is effective at implementing draconian measures that infringe upon civil liberties, this power has not been used as part of a strong response against HIV/AIDS

### Chapter 3: Cuba

### Research in Cuba

For my thesis, I travelled to Cuba in order to better understand their HIV/AIDS response because I was interested in seeing if the published literature accurately reflects what is happening in actuality. Specifically, I was curious if there were any coercive elements of treatment and if patients actually received the high level of care that had been reported. During my research trip to Havana I spoke with many locals generally about their daily life, Cuban culture, and their perception of HIV. These included interviews with Carlos, a 28 year old man who lived in the same neighborhood I stayed in and Diego, a 23 year old man who had moved to Canada but was back to visit family. In addition, I spoke with Victoria, a woman in her mid 40s who has two daughters. She spoke about her experiences talking to her children about safe sex practices.

In addition, I spoke with several people who had more immediate connections to HIV/AIDS. Nurse Tia, a sexual health educator in the community, was able to provide excellent information about HIV care in Havana and about the country's sexual education curriculum including pamphlets and literature only made available to health care workers in Cuba. I also spoke with Gabriela, a 24 year old commercial sex worker regarding her work and experiences with clients. Santiago shared his experiences as a person living with HIV, discussing his early treatment and care and the changes to Cuba's policies since then. Lastly, I was able to interview Dr. Jorge Perez, the director of the Pedro Kouri Institute of Tropical Medicine and Cuba's most well known AIDS doctor. With the exception of Dr. Jorge Perez, all of the names have been changed to aliases.

### Democracy in Cuba

After the Revolution of 1958 when the U.S. backed President Fulgencio Batista fled from Cuba, a one-party system consisting solely of the Cuban Communist Party (PCC) was established. Cuba's system of government has been labeled as an authoritarian socialist democracy, a misnomer as it is far from democratic. Under this system, the legislative branch or the National Assembly is composed of elected deputies. Although the deputies are elected, the elections are not meaningful as the deputies are chosen from pre-screened and pre-approved lists. The elected delegates to the National Assembly are largely powerless, and act not to introduce and debate legislation, but to universally ratify the proposals set before it by the higher government bodies. While there is a judiciary system composed of lower courts such as municipal courts and higher courts such as the Supreme Courts, the judiciary system is not intended to act as a check upon the other branches of the government (Sweig, 44). Under this governmental organization, power truly lies in the Politburo, the Council of State, and the Council of Ministers. The individuals in these government bodies are those fiercely loyal to Fidel Castro, and are people that Castro trusts (Henken et al, 102-105). At the top of this hierarchy is Fidel Castro, who has held a variety of official positions including prime minister, president, secretary of the PCC. In this capacity, from 1959 until 2006, Fidel Castro as the "maximum leader" successfully consolidated power under himself as the leader of Cuba (Henken et al, 85).

In 2006, Fidel Castro faced health issues, which precipitated the transfer of power to his brother, Raul Castro. Raul Castro had also played a critical role as a revolutionary leader when Batista was overthrown, and since that he has also held key

leadership roles in the government (Sweig, 214-215). Although Raul Castro has assumed the presidency and brought some changes to the governance of Cuba, this change in leadership for the country will “modulate its moves within a policy framework that will not excessively offend Fidel’s sensibilities, nor those of the individuals in the Council of State who remain his close ideological and political comrades” (Sweig, 227). In other words, regardless of whether it is Raul or Fidel officially in charge, there has not been a significant departure from the authoritarian socialist democracy that exists in Cuba.

Beyond the lack of meaningful democratic institutions in the Cuban government, there are also other limits imposed upon the populace that circumscribes their freedoms. Political dissent in any form is illegal, and can result in imprisonment (Freedom House, 13). The government is able to relegate most political dissent to the sidelines, promoting an image of dissidents as “lackeys of imperialism, thus distracting attention from the substance of the dissidents’ allegations” (Sweig, 68).

Through the Committees for the Defense of the Revolution, the government neighborhood watch units that are designed to promote revolutionary spirit in the populace, the Cuban state apparatus is able to track political dissidents and promote the government’s agenda and values. The CDR of each neighborhood actively maintains files on people, to the extent that they know “when you leave the house, how drunk you were when you came back, and why you fought with your mother that morning” (Carlos). Beyond just the surveillance work, the CDR also work to promote the political storyline of the national government and build the revolutionary spirit of the people and often encourage and pressure people to vote or attend revolutionary rallies, so that citizens become even more indoctrinated in the one-party system of government. The CDR also

take on roles such as child vaccinations that are beneficial for the community; however, it is clear that as a whole the mission of the CDR uses soft forms of power such as community pressure and infringes upon the freedoms of the people in a non-democratic way (Henken et al, 89).

Given the lack of meaningful democratic institutions and the repressive measures the government is able to exercise, I expected that the country would have a poor response to HIV/AIDS as Sen predicts that dictatorships insulate the political elite from the plight of the people. Although Cuba is a proud socialist state, this designation must be approached with wariness as not all self-proclaimed socialist states live up to their ideological claims of protecting the health of the people (i.e. Russia). Thus, I chose to base my hypothesis off of Sen's theory in order for this analysis of Cuba to serve as a test of the applicability of his arguments.

#### Early HIV/AIDS Policies

In 1983, the same year the of the scientific identification and characterization of HIV took place, Fidel Castro asked the director of Cuba's top tropical disease hospital (Pedro Kouri Institute of Tropical Medicine or IPK) what was being done to prevent the entry of HIV/AIDS into Cuba. Dr. Gustavo Kouri, the director, responded that very little was known about the disease. In response, Castro tasked Dr. Kouri with preventing an HIV epidemic in Cuba— identifying HIV as “epidemic of this century” (McNeil). In response to Castro's belief, the National Commission for Control of AIDS was established in 1983. Aside from Castro's specific concern regarding HIV/AIDS, the Constitution of 1976 set precedent for the national response to HIV, with the guarantee

that the Cuban government is required to provide free preventative and curative treatment for its citizens (Santana,68).

When Dr. Jorge Perez Avila began to see the first HIV/AIDS cases in the country, the country was in the midst of the “Special Period”. In the early 1990s, with the dissolution of the Soviet Union, Cuba lost a major source of financial support and stability. This left the country in a state of unprecedented scarcity and poverty (Azicri, 70). As Dr. Jorge Perez describes, “We were so poor, we barely had food. In the summer it was so hot, we slept on the floor because it was cooler” (Perez). At the same time, the first generation of antiretroviral medications was invented and being used to treat patients. Dr. Perez felt that it was a moral imperative to treat everyone with HIV, but he also realized that Cuba lacked the monetary resources. He then wrote letters to the Minister of Health and President Fidel Castro, explaining the situation and asking for assistance in order to procure the drugs.

Although the Minister of Health did not respond, President Fidel Castro responded, perhaps not unexpectedly given his history of interest in the topic. Fidel Castro insisted upon taking a detailed approach to learning everything about HIV/AIDS. Dr. Perez shared stories of answering calls in the middle of the night from President Castro and bringing boxes of files to meetings in order to present data and answer his questions. From this, Fidel Castro decided that HIV was a problem that must be solved, regardless of Cuba’s lack of resources at that point in time. He insisted that they would find money in the budget in order to purchase the ARV medications (Perez). This political environment served as the basis for Cuba’s decisive and forceful response to the virus. During the early years of Cuba’s response Dr. Jorge Perez noted that they had no

choice but to resort to strategies such as recycling medications and producing the patent protected medications in violation of international trade regulations, but they were able to keep many patients alive because of these measures (Perez).

In addition, Cuba undertook a massive screening program, specifically targeting high-risk groups such as blood donors and people returning from travel abroad or with extensive contact with foreigners. Patients admitted to hospitals, women receiving prenatal care, and people who tested positive for other sexually transmitted diseases also were tested for HIV. Prisoners, army recruits, and the sexual contacts of those who tested positive for HIV were also tested. In addition, there was testing done in populations where there is a high incidence of other sexually transmitted diseases. (Santana, 74-75), (Leiner, 122-123). This testing protocol was based on United States Center for Disease Control protocol (Santana, 75). International exposure was also appropriately identified as a risk factor for HIV, as prior to 1986 there were no AIDS cases in Cuba, thus the major threat for an HIV epidemic in Cuba came not from native cases, but from transmission of the virus from foreigners to natives (Santana, 68). Although Castro used this epidemiological fact to blame American imperialists for the disease, there was a sound medical basis for using exposure to foreigners as a risk factor to justify HIV testing (Leiner, 131).

For pregnant women and patients admitted to hospitals, their explicit permission was not required for HIV testing because their blood had been obtained for other purposes (Santana,75). In neighborhood and workplace screenings, people were required to give explicit consent in order to have their blood tested (Santana, 75). However, people often felt pressured to give their consent because of the Cuban culture of “paternalistic

persuasion” where one should comply “for the good of family and nation” (122-123, Leiner). Recent statistics show that 11 million Cubans have been tested over 43 million times (McNeill). This rigorous and extensive system of sentinel surveillance has contributed to the low prevalence of HIV/AIDS in Cuba. I argue that although Cuba’s use of thorough screening ultimately promotes capabilities such as life and bodily health, it infringes upon peoples’ freedom of choice. Despite the attention paid to accuracy and confidentiality, the lack of explicit consent or pressure to consent in some cases removes the choice individuals have regarding testing.

Cuba’s well-known system of sanatoriums has also been able to provide comparatively high quality care to Cuban patients diagnosed with HIV/AIDS. During the early years of the Cuban response to the disease, HIV positive patients were quarantined in sanatoriums throughout the country. They received medication, ample rations, comfortable accommodations and medical care at no cost while still receiving their salary. In addition, the patients received education about HIV/AIDS, other STDS, and how to care for themselves. The sanatoriums also made a strong effort to care for more than just the physical well-being of the patient. Doctors took great care regarding confidentiality and elaborate alibis were even created for patients so that their absence from the community could be explained (Santana, 78). Psychologists and social workers provided counseling to the patients and the patients’ family members. There were organized trips for recreational activities and families were encouraged to visit the sanatorium. Patients were able to visit friends and family, and attend parent-teacher meetings or block association events while chaperoned by a medical professional from the sanatorium (Leiner, 120).

Although patients were well-cared for and there was a strong effort made to build community and foster connections with their family, “their quarantine [was] obligatory” (118, Leiner). In other words, by taking away their employment and limiting their freedom of choice in daily life, the patients “ must live isolated, nonproductive lives until they contract AIDS and are moved to a hospital” (Leiner, 118).

This mandatory quarantine policy occurred during the early years of Cuba’s response to HIV/AIDS as doctors struggled with identifying patients who could be trusted to deal with their illness responsibly and not infect others. At the time, this quarantine response was seen as the only way that Cuba could limit the epidemic given the resources available. Santiago, the man with HIV whom I interviewed, was diagnosed with HIV during the early 1990s at a time when patients had to move to a sanatorium for several months before they could resume their daily life at home. He acknowledged that the doctors and nurses were very caring, and that he learned extensively about his illness and how to take care of himself. However, he also repeatedly brought up the difficulty of having to be separated from his family and his job (Santiago). In applying the “Capabilities Approach” to Cuba’s initial response to HIV/AIDS, it is apparent that through Cuba’s early policies regarding sanatorium stays, the Cuban government succeeded at ensuring life and bodily health for its citizens. However, by enforcing a mandatory quarantine and removing patients from their regular lives, this infringes on the freedom of living a life of self-determination.

Cuba, in contrast to my hypothesis, has shown a strong commitment to addressing HIV/AIDS. Cuba has demonstrated the ability to prioritize HIV, and the willingness to invest financial resources. For instance, even in the early years of the global HIV

epidemic, when anti-retroviral medications were quite expensive (figures show from \$7000/year to \$14,000/year) Cuba provided these medications to patients for free in a response largely unmatched in developing and even developed countries (Leiner, 125) (Perez, 19). In addition, in the first year of its testing program, 3 million USD was used to purchase testing kits. Afterwards, Cuba has worked to develop its own testing kits (Santana, 69). This shows that beyond the investment of financial resources, Cuba has worked to build its own capacity to respond to the HIV virus.

Indeed, this commitment to building local capacity is seen at multiple points in the Cuban response to HIV/AIDS. For instance, in order to prevent contamination of the blood supply, Cuba discarded all imported blood and developed its own blood supply (Leiner, 124-125). In response to HIV, Cuba has also built a network of research institutions in order to address the many challenges and questions presented by HIV. These research institutes range from ones focused on basic science research such as the National Biotechnology Centre or the Immunoassay Centre, to ones like the Havana University School of Psychology that focus on other aspects of HIV care such as how best to counsel patients (Perez, 19). Currently, Cuba is able to manufacture many of the generic ARV medications because of earlier investments in the pharmaceutical manufacturing sector. Through this, and a grant from the Global Fund to Fight AIDS to purchase newer medications, Cuba has been able to achieve universal access to ARV. Cuba's financial investment despite its weak economy, and its development of local capacity highlight Cuba's strong and effective response to the HIV epidemic.

### Current HIV/AIDS Situation in Cuba

Cuba's current response to HIV/AIDS is also markedly different from the strategies first employed during the early years of the disease's detection in the Cuban population. Cuba's active adaptations of its HIV response has helped the country maintain its low prevalence rate. One major change has been a shift in the mandatory sanatorium stay policy. Dr. Perez explained that even within the medical community of doctors and health officials, there was a recognition that this strategy to provide care was not ideal and a somewhat inhumane practice (Perez). Even with the quarantine policy in effect at sanatoriums, doctors attempted to identify trustworthy couples who are "responsible enough to return to society" (Leiner, 120). This required an intensive evaluation process requiring approval from multiple psychiatrists, doctors, and social workers (Leiner, 120). After 1993 Cuba shifted away from this draconian policy. Since this policy shift, Cuba now allows patients to choose between an ambulatory care system and the sanatorium system. For patients who have chosen the ambulatory care system, they may continue to live at home and attend a daily clinic. After several months of close observation, patients are treated on an out-patient basis by their primary care physician. As of 2003, 60% of patients use the ambulatory care system while 40% have chosen to stay in the sanatorium (15). I argue that Cuba's current HIV/AIDS policy is one that fully promotes freedom based on the "Capabilities Approach" despite Cuba's lack of the mechanical processes of democracy such as elections.

Another major change has been Cuba's view of homosexuality. In the past, homosexuality was seen as an abnormality or illness that required treatment. In Cuba's culture of machismo, boys that were identified as effeminate experienced discrimination

and were encouraged to be act masculine (Leiner, 38-40). Now, homosexuals face significantly less discrimination than previously while health care providers have also been trained to prioritize medical needs above their own views regarding homosexuality (Leiner, 48-49). In a sign of Cuba's move towards greater acceptance of homosexuality, even Fidel Castro has noted that discrimination based on sexual orientation was a mistake (McNeill). It has been noted that a catalyst for this change perhaps came from Maria Castro, Raul Castro's daughter. Maria Castro, a doctor, argued that homosexuality is not a crime and that Cuba must embrace this population as well in an open manner (Nurse Tia). With Fidel Castro's reversal on his views towards the gay population came major public education campaigns. This is best exemplified by the curriculum in schools that tell children to take an accepting approach, and the plethora of posters in many visible community locations saying that homosexuality is not a danger to the people.

Perhaps unexpectedly, this paradigmatic shift in Cuba's view towards homosexuality has also manifested itself in other downstream effects. As previously discussed, doctors are trained to protect the confidentiality of their HIV patients. Because of this, there have even been cases where the patient was being treated for HIV, and his/her spouse did not know (Perez). However, while this seems to be highly possible *de jure*, *de facto* this practice seems much less likely and almost unheard of. It is not that doctors are not trained and prepared to handle confidentiality of the patient, but rather there are other factors that allow it to be highly unlikely. Given the Cuba's culture in which doors are always open for visits and people are densely connected by their social networks, keeping almost anything a secret is very difficult. Santiago explained that if you have HIV, you receive more rations than everyone else, so of course when people go

to pick up their rations every month it will be highly noticeable that one person receives significantly more than everyone else. Similarly, when patients go to the pharmacy to pick up their medication they meet with a special pharmacy technician and must present a particular booklet to receive the drugs (Santiago). This procedure again presents another noticeable difference. Of course there are ways to work around all of these practical constraints and protect the anonymity of the patient, but in reality this occurs rarely. Through varying degrees of connection, everyone always knows someone with HIV. This familiarity is partially the result of the culture of the small community and tight networks of association, but also because of the greatly reduced discrimination and stigma that patients face. Of course there are other reasons for maintaining anonymity, but when patients can minimize their concerns about stigma then it appears that confidentiality becomes significantly less critical.

This trend towards openness regarding Cuba's view of homosexuality is perhaps mirrored in reforms to sexual education. In Cuba's early response to HIV/AIDS, its sexual education curriculum was less developed, thus the emphasis was placed on quarantine and treatment and not education. But this dynamic has changed so that now education is a major component of Cuba's response (Perez, 20). Indeed, quite comically one student even reported that "they do so much sex education that you get tired of it" (McNeil). Although Cuban culture can be quite conservative, the attitude towards sex is that it is something that will almost inevitably occur between people, and that the appropriate safety measures must be taken. This presents itself in a sexual education curriculum that is a sharp contrast to many of the abstinence only programs seen in schools in the United States.

Outside of schools, parents speak openly with their children about sex. For instance, Victoria, the mother of two children, indicated to me that she is well aware of her children's sexual partner(s), and that she understands sex to be a natural part of life. Victoria, and other parents, would openly discuss sex with their children, and always caution them to protect themselves. Condoms and hormonal birth control are also widely accessible and very affordable or free. Perhaps the pervasiveness of sexual education and accessibility of protective measures is partially due to the difficulties for Cuba of supporting a large population; however, it has been effective in promoting safe sex practices that effectively decrease HIV transmission.

The low rate of HIV cases stemming from the high risk group of commercial sex workers exemplifies the effectiveness of sexual education in Cuba and the accessibility of these protective measures. In Cuba, although it is illegal, prostitution is widespread and certainly not difficult to find. Beyond this, there are more informal networks of transactional sex. For instance, Diego, who lived in Havana until he left the country two years ago, casually mentioned that he formerly lived by a convention center where many foreigners would go. He would become friends with the foreigners and then introduce them to his friends who are female. Everyone would go to a bar or a restaurant to socialize, and the foreigners would pay the bill and then often engage in sexual relations with the women. The foreigners would then pay Diego to use his room for the night. Although no money ever changed hands between the foreigners and the women, the loose terms of the implicit arrangement were well understood by both parties.

However, even through such informal networks, and the more formalized relationship of prostitution, these high risk groups do not have a high HIV prevalence rate.

Gabriela, a sex worker, explained that with her Cuban clients, the men know that they will use condoms and there is no argument about it. However, with around half of her clients who are tourists visiting from Europe and Canada, they often resist. “Many offer to pay me more, some say they are leaving to find someone else. But I say no because I have a daughter and family to think about. They always taught us in school to use condoms, and my mother always repeated to use condoms” (Gabriela). Sexual education has effectively promoted safe protections to members of high risk groups that could otherwise drastically increase the prevalence of HIV/AIDS in Cuba.

Medical officials in Cuba have also worked with the government in order to establish practices that have limited the spread of HIV in the country. Prostitution is illegal in Cuba, and the government often prides itself on creating a country where people do not worry about drugs, shootings, and prostitution. Paradoxically, the government also perhaps turns a blind eye to prostitution that does occur. Dr. Jorge Perez explained that before, police would catch women with a large number of condoms and use that as evidence that they are prostitutes committing a crime (Perez). This practice similarly occurs in the United States. However, Dr. Perez then told the police that the women were simply being safe and that was not a bad thing (Perez). Although Dr. Perez himself stops short of saying the police turn a blind eye, I argue that because the police take this approach it is actually safer for the women and clients as they are able to use condoms without a fear of harassment, ultimately mitigating the danger of the high risk commercial sex worker cohort.

### Conclusions

In contrast to the prediction that Cuba would have a poor response to HIV, it is clear that Cuba's form of authoritarian socialist government actually facilitates the effective implementation of the national response to HIV/AIDS. For instance, such an open approach to sexual education can certainly be controversial. But instead of having to face backlash about the content of the sexual education program, Fidel Castro, as the "maximum leader" of Cuba can overrule this and effectively implement a program that has produced beneficial results in terms of fighting the transmission of HIV/AIDS in Cuba. Other aspects of Cuba's government, like the CDR units, are certainly repressive of the people, but at the same time these units promote a culture where people feel collective pressure to be tested, a move that can lead to beneficial results for their health. Of course, freedom and health should not be counted as mutually exclusive entities, although this does not show freedom and health to be mutually exclusive, this case study does demonstrate that a trade-off in freedom can equal a gain in health for the people. This lends support to Ackerknecht's assertion that an autocratic regime can more effectively respond to a crisis because it can successfully sidestep the inefficiencies of a checks and balances system and that without limits in their power, these countries can take broader, more decisive actions.

Although an initial examination suggests that Cuba completely disproves Sen's conclusions and lends support solely to Ackerknecht's argument for the merits of autocratic countries, a deeper analysis shows that the case study of Cuba actually supports both theories. Returning to Sen's theory, it is clear that Sen allows that dictators can be benevolent and pursue policies that work well for the country. In the case of Cuba,

although leaders did not face the pressures of being voted out of office or of challenge by an opposition party, the political elite still responded forcefully to the epidemic. Indeed, Cuba's HIV/AIDS policies can be attributed to the direct orders of its president, Fidel Castro, who would be categorized as a benevolent despot at least in regards to HIV/AIDS. According to Dr. Kouri, Castro's "luz larga" ,slang for "big lights",—in reference to Castro's prediction regarding HIV, allowed Castro to make this critical decision. With Castro making the ultimate decision, the policies were able to be implemented without the inefficiencies encountered in a democratic system as Ackerknecht's theory suggests. Had Castro's "luz larga" led him to decide that HIV is a sin, then the opposite would have happened, with Cuba failing to effectively respond to the epidemic (McNeil).

An exploration of Cuba's HIV/AIDS policies shows that non-democratic countries can have effective responses to crises, perhaps even more effective than a government restrained by checks and balances. This is reflective of the concept that an autocratic regime can function perfectly fine with a benevolent ruler, which in this case would be Fidel Castro. However, had Castro made the incorrect decision, then there would be no recourse for citizens, unlike in a democratic state. Thus, I argue that this analysis of Cuba provides support that Ackerknecht and Sen's theories are not mutually exclusive. Indeed, this case study provides support that Ackerknecht's theory of the benefits of autocratic regimes is an addition or advancement of Sen's theory. By this I mean that Sen allows for a benevolent dictator, and Ackerknecht's theory builds upon this to say that a benevolent dictator may actually be more efficient. This argument still acknowledges the pre-condition of a *benevolent* dictator, but this pre-requisite is great enough of a gamble that the benefits of democracies cannot be overlooked

## Chapter 4: South Africa

### Democracy in South Africa

At the beginning of the global HIV epidemic, South Africa was still under apartheid rule led by the National Party. The National Party, composed only of white South Africans retained a monopoly on political power. Under this system, black South Africans were resettled into segregated townships and continued to experience discriminatory practices such as segregated access to public services like education and health. Interracial marriage was also prohibited (Worden, 102). Although organized resistance movements against apartheid existed, the government was able to repress these movements and avoid a complete handover of power until the 1990s. Through the disenfranchisement of black citizens and then additional measures such as the outlaw of the ANC party, the National Party was able to maintain its power and systematically take away the political power of black South Africans (Worden, 106).

The apartheid system was able to remain in place until the early 1990s. President de Klerk faced pressure from issues such as both popular movements and the international economic sanctions targeted towards ending apartheid in South Africa (Worden, 147). As a result, in 1990 de Klerk removed the ban against parties such as the ANC. This decision was followed by the release of political prisoners including Nelson Mandela, and then free elections in 1994 where the ANC were able to participate and black South Africans were able to vote. These elections began a transition towards the establishment a new representative form of government that guaranteed freedoms regardless of race, gender, and sexual orientation (Worden, 152). The constitution provided for a system of democratic election and proportional representation. The president would be selected from the majority party, and a deputy president would be

selected from another party if they could reach 80 seats in the National Assembly (Worden, 152). The 1994 elections occurred peacefully and resulted in the ANC taking 62.6% of the seats in the National Assembly, so that Nelson Mandela became president and de Klerk became deputy president (Worden, 154).

The adaptation of the 1996 constitution cemented the values of a liberal democracy that reaffirms the participation of people and their rights. (Waldmeir, 262). It is a constitution that has been internationally lauded for its liberalism and promotion of rights:

“Widely seen as a ‘state of the art’ document, it contains a wide array of classic political and socioeconomic rights, institutional innovations such as the National Council of Provinces, a range of independent watchdog agencies and commissions, and an activist Constitutional Court. The electoral system (pure proportional representation with no thresholds) has induced virtually all parts of political society to play the electoral game and has allowed the representation of a wide range of organized tendencies. (Mattes, 24).

With the legislative, executive, and judicial branches of the government comprised of the parliament (National Assembly and National Council of Provinces), the president who is elected by the National Assembly, his appointed cabinet, and the courts; checks and balances are enforced so that no single group can gain too much power (Butler, “Contemporary” 88). Of course, South Africa is an imperfect democracy and experiences problems such as a corruption or instances of judicial misconduct. Since 1994, the ANC has won every election and “dominates the political landscape” (Freedom House). However as a whole the democratic institutions such as freedom of press or freedom to assemble are strong in the country (Freedom House).

Based upon Amartya Sen's assessment of democratic states, in democratic states with the institutions for citizens to pressure the political elite to respond to crises such as famines, I hypothesize that as a democratic state South Africa will have a strong response to HIV/AIDS. In particular, governance in South Africa underwent a major transformation with the end of apartheid and the adaptation of a new constitution, all of which occurred in the midst of the HIV epidemic. Thus, if Amartya Sen's assertions are correct, it seems that the state's response to the virus will not be adequate during the apartheid but with the transformation of the government, the response will become much more robust as patients gain access to democratic institutions that allow them to advocate for their treatment and care.

#### Social and Cultural Factors Underlying the Epidemic

South Africa has experienced one of the most severe HIV epidemics globally. South Africa's first cases of HIV were found in the white, homosexual population in the early 1980s. But by the late 1980s, the virus was found in heterosexual, black communities. From there the prevalence rates increased rapidly (van der Vliet, 49). The epidemic has been devastating, with 2013 estimates placing the prevalence rate amongst 15-49 year olds at 19.1% (UNAIDS).

Endemic social and cultural reasons contribute to the high rate of infection in South Africa. For example, the Zulus, South Africa's largest ethnic group, do not practice male circumcision, a procedure shown to decrease the likelihood of transmission (Kauffman, 22). During the early years of HIV in South Africa, there was little awareness and accurate knowledge regarding the mechanisms of HIV transmission and prevention, thus the disease remained heavily stigmatized (Kalichmani and Simbayi, 572). This

stigma along with the lack of education regarding HIV/AIDS in the general public has driven the high prevalence rate. Sexual education was greatly limited at this time by the government's concern that education would compel youth to engage in sexual activity earlier. When sexual education did occur, it promoted a moralistic approach that did not align with the reality of the needs in South Africa. For instance, in a pilot AIDS awareness program in 1991, educators were not allowed to teach the students how to use condoms as parents' views were too conservative to allow this (Feldman, 111). Although this is not an exhaustive review of the underlying social and cultural factors that created an environment ripe for an explosion of HIV cases, these issues certainly played a substantial role in the current state of the epidemic in South Africa.

One of the most important reasons why South Africa's HIV epidemic has been so devastating is because of the inequality in society and the long lasting effect of apartheid. Given South Africa's history of apartheid, there were and continue to be racial conflict and inequality. A 2002 study indicated that blacks accused white South Africans of introducing the disease as a weapon or a form of punishment for blacks (Lieberman, 150-151). At the same time, white South Africans argued that blacks would be able to infect them with HIV by sharing public toilets (Lieberman, 151). These scientifically unfounded ideas, publically expressed at a late stage in the epidemic when accurate scientific information was available, demonstrate how a lack of knowledge along racial lines drives stigmatization of HIV/AIDS and racial conflict.

The legacy of apartheid manifested as societal and financial inequality between blacks and whites has also created conditions ripe for a major HIV epidemic in South Africa. With blacks disproportionately affected by poverty, this dynamic created

conditions where they do not have access to information and education regarding HIV and also lack access to services such as testing (Wahiri and Taffa, 1037). This has resulted in a situation where HIV prevalence rate in black South Africans is around 18%, while it is just 0.6% in whites (Shisana et al, 8). Although a variety of social, cultural, and economic factors have contributed to South Africa's HIV crisis, one of the other major reasons is the lack of initial response from the government—indeed the reactions of the government actually fueled the HIV epidemic.

#### HIV/AIDS Policies Before Democracy

For many years, the South African government failed to effectively fight the HIV epidemic, and its policies were even counter-productive. During the 1980s, the National Party led government did take measures such as securing the blood supply. However, despite clear indications that HIV would pose a significant problem to the country in the years to come, the government dedicated very little financial resources towards addressing HIV as a public health issue (Feldman, 110). In 1987, the government budgeted approximately \$357,000 to fund the nation's HIV related programs, with this trend of sparse funding continuing for several years. It has been suggested that the South African government that was still led by the National Party failed to adequately fight the problem HIV posed to their country as the disease was seen as a greater problem for blacks than for whites (Feldman, 110).

The government's limited initiatives involved attempts to use sex education and HIV prevention programs to address the epidemic. However, given the turmoil from apartheid that South African society experienced during these years, these initiatives largely failed to reach the black community in an effective manner (van der Vliet, 49).

For example, in 1988 the government used an advertising campaign to publicize the danger posed by HIV/AIDS. The poster targeted towards white South Africa communicated the message to limit sexual contacts, as HIV is a sexually transmitted disease. However, posters directed towards black South Africans employed an entirely different approach. The poster showed black South Africans at a funeral in front of a grave, with the text stating that “AIDS is now in South Africa”. In contrast to the poster directed towards white South Africans, this poster employed scare tactics so that black South Africans saw it as yet another example of racist government propaganda, and failed to understand the legitimate public health threat posed by HIV (Feldman, 110). The problem with the South Africa’s apartheid government is three fold – the government failed to see HIV as a legitimate threat, especially as it was an issue perceived to not affect white South Africans; the government’s limited response was intentionally designed to not resonate with black citizens; and black South Africans viewed the racist state apparatus with such little credibility and trust that even a scientifically accurate message would not have been believable. Tragically, the disbelief in scientific fact based on a perception that it is a racially motivated political ploy has endured in South Africa, to the great detriment of the HIV/AIDS response.

#### HIV/AIDS After Democracy

In 1994 as South Africa held elections and Nelson Mandela became the country’s president, HIV/AIDS experts were hopeful that these political changes and the new democratization of South Africa would lead to a strong response to the disease and genuine progress in combatting health disparities (Crewe, 28) (Benatur, 30). However, this failed to be the case as the government struggled to address other issues, perhaps not

without justification (van der Vliet, 54). In 1992, with the beginning of the transition away from apartheid rule, the National AIDS Convention of South Africa was formed which brought together both the National Party and opposition parties to establish a plan for fighting HIV. Although the formation of this high-level committee appeared to be a positive step forward, this would prove to be too optimistic of a view. During Mandela's presidency the national AIDS plan faced a plethora of obstacles, including a lack of human and financial resources available and the difficulty of coordination through a labyrinthine health administration system with conflicts between the national and provincial levels (Butler, "South", 591-592). Thus HIV/AIDS failed to be a priority for the government during Nelson Mandela's administration, and the failure to address this epidemic was then greatly aggravated by the policies under Mbeki's presidency.

President Mbeki drew the most international attention and ire for his conflicting views of recognizing South Africa's HIV epidemic but questioning the accepted scientific findings about the treatment and prevention of the disease (Cohen, 590-591). Mbeki's criticized actions ranged from questioning the scientific accuracy of the progression of HIV to AIDS, to suggesting that it in reality AIDS can be attributed to socioeconomic factors and not a virus. Thabo Mbeki's other questionable activities included appointing AIDS denialists to the HIV/AIDS presidential advisory council and questioning the use of anti-retroviral medication as he felt they resulted in more harm than benefits (Butler, 594-595). Mbeki also advocated for further study of Virodene, an industrial solvent that he believed falsely to have anti-retroviral properties (Lieberman, 161). The approach led to a rejection of providing antiretroviral medication in South Africa. Even when Boehringer Ingelheim, a pharmaceutical company, offered free drugs

to prevent the transmission of HIV from mother to children, the South African government was slow to introduce these drugs into the country (van der Vliet, 64). Because of policies such as these that have been led by Mbeki, HIV/AIDS has had a devastating impact on South Africa.

Of course Mbeki's actions and beliefs are condemnable—there have been estimates that Mbeki's policies have killed 330,000 people—but it is also important to look at his beliefs from a wider context (Chigwedere, 410). Mbeki made numerous incorrect judgments despite the fact that he had access to numerous scientific and medical advisors who had an appropriate understanding. Given the historical and cultural context of racialized misunderstanding promoted by the apartheid government, it seems more understandable though no less forgivable that Mbeki struggled to make the correct assessments. Research has shown that in populations that receive extensive amounts of biomedical education regarding HIV/AIDS, even though people believe what they have been taught, they still retain more traditional, local and biomedically inaccurate knowledge. Because people have this multi-dimensional knowledge of HIV/AIDS, they often simultaneously believe contradictory beliefs. For instance, one woman noted that she knows there is no cure for HIV/AIDS and only ARV treatment, but she also explained that traditional healers can cure the illness (Schatz et al, 98).

Because of the complex cultural dynamics in South Africa, Mbeki's decisions regarding HIV policies were clouded by this contradictory, multi-dimensional knowledge. In addition, we need to take into account the difficulty of being scientifically literate especially at a time when the knowledge regarding HIV/AIDS was still evolving. Mbeki's decisions were absolutely incorrect, but they were rooted in a misinterpretation

of scientific fact. For instance, his assertions to use traditional herbs to treat HIV seems less absurd when we consider that many commercial drugs have been developed based on the study of herbal plant derivatives. His assertions about the toxicity of Western medications also become somewhat more understandable when it is taken into account that early generation anti-retroviral medications did cause significant side effects, although their benefits clearly outweighed these costs. Besides these issues, for years Mbeki also faced the issue of the cost of providing ARV treatment and the financial affordability. Pressure from pharmaceutical companies and the United States government to sue based on international trade laws provided yet another obstacle to explain the Mbeki administration's focus on a less effective but cheaper response to HIV/AIDS (The Observer). This more nuanced analysis of the Mbeki administration's actions is necessary in order to determine the effect of democratic institutions on changing the course of the national response to HIV.

#### The Use of Democracy to Promote Change

Despite the failures of the Mbeki administration, South Africa has ultimately been able to make great improvements in its management of HIV. This is because South Africa's democratic institutions have allowed for civil society activity to create changes in governmental policies. The Treatment Action Campaign (TAC) was formed to change government policies so that South Africans could get much needed access to medical care. From the establishment of the TAC in 1998, it acted as an organized national grassroots movement using strategies such as protests and media campaigns to push the Mbeki administration to reverse their HIV treatment policies. TAC has over 12,000 members in hundreds of branches around the country (Kapczynski and Berger, 3). The TAC used

civil disobedience measures like sit-ins at hospitals and the dissemination of HIV education materials to build support from the people in communities and raise awareness regarding the government's failure to act.

One of their major actions was to partner with the AIDS Law Project to sue the Ministry of Health in 1998 in order force the government to implement a program that would provide pregnant women antiretroviral medications to reduce the chances of transmission to their children (Nunn et al, 1036). Out of the TAC's many campaigns, this action has precipitated in the most direct and dramatic change from the South African government. The premise of this lawsuit was based on the South African Constitution's guarantee of healthcare access. Mbeki's administration argued that South Africa could not afford to provide access to treatment for pregnant mothers because of the cost, although Mbeki's AIDS denialism was another key factor. Ultimately, this case was settled by the Constitutional Court of South Africa, the highest court, with the decision being that the South African government must implement a program to provide medication to pregnant mothers (Kapczynski and Berger, 20-21). The ruling recognized that it is a legitimate argument that South Africa may not have the financial resources to provide treatment. However instead of allowing the Mbeki administration to use this as an excuse to not provide treatment, the court determined that there must be justification and transparency regarding these financial calculations (Heywood, 22). The use of democratic institutions like the judicial system was effective in creating change in the South African policy despite the lack of support exhibited by many in the Mbeki administration. The Constitutional Court was able to make Health Minister Tshabalala-

Msimang implement a program that would provide medication to pregnant mothers in order to prevent transmission to their children (Nattrass, 159).

The TAC successfully used the judicial system to check the executive actions of President Mbeki and his Minister of Health Tshabalala-Msimang. The definitive push for the government to change course came from the Constitutional Court's ruling. But the TAC's use of the legal system to promote change was also coupled with its use of other democratic institutions that helped hold the government accountable to the ruling. TAC's tactics meant that "litigation was not left to lawyers, but used to strengthen and empower a social movement and backed up by marches, media, legal education, and social mobilization... Without an accompanying social mobilization, the use of the courts may deliver little more than pieces of paper, with a latent untapped potential" (Heywood, 22). Thus, because of the high level of social mobilization and awareness in the public, which was made possible because of coverage from the free press, Mbeki's administration had to uphold and carry out the ruling. In addition, the South African Constitution demands the government to be transparent in its use of resources, which was reinforced by the court's demand of justifications in financial assessments. Of course it is unfortunate that the government would not have voluntarily implemented such programs, but it is clear that checks and balances do work in the government and that it is possible to use a combination of democratic institutions such as the judicial intervention and civil disobedience to force the political elite to change course.

The TAC has continued to be an excellent example of how robust democratic institutions in South Africa have been used to demand change from the government. For instance, the TAC continued to push for greater access to antiretroviral medication for all

South Africans, and not just pregnant mothers. The TAC has also been successful in bringing attention to international pharmaceutical companies who were so profit driven that their actions caused people to die. Although the South African government had a lackluster response to the epidemic, TAC's successes in harnessing civil society and using legal measures to push the government to respond to the virus demonstrates the value of democratic institutions in dealing with HIV/AIDS.

Through the use of these democratic institutions, South African citizens were able to push for reforms that ultimately resulted in better prevention and treatment of HIV. In the time period between 2004 and 2011, the number of people starting ARV medication each year increased by more than a factor of 10, going from 50,100 people to 557,300 people (April et al, 494). This translated to a total of over 2.2 million people who started ARV treatment during this time frame (April et al, 494). Between 2004 and 2008, researchers also found that stigma towards HIV/AIDS had decreased while people had greater knowledge regarding the disease. In addition, the percentage of people who had been tested for HIV increased from 40% to 70%, and a greater proportion of people had also used services provided like counseling (Mall et al, 194). From this, we can see there has been tangible and meaningful progress from the actions of the TAC and the reforms that they have brought about in South Africa.

Of course there have been limits and obstacles even though it appears that South Africa has robust democratic institutions that can be used to effectively bring about change. For instance, even though Minister Tshabalala-Msimang was forced by pressure from the Cabinet to implement the program providing HAART to AIDS patients, she was able to take many measures that interfered with and slowed down the program. For

example, she stalled collaboration with the Global Fund and continued to publicly announce that natural remedies are a viable and better alternative than ARV treatments even after the court ruling (Nattrass, 157). Although democratic institutions had worked to effectively initiate a change in the government policies, the actors of the political elite, like Minister Tshabalala-Msimang were able to slow down the actual implementation in an effect comparable to having a fox guard the hen-house. Thus, it is clear that the use of democracy to induce change is problematic and not as straight-forward or simple as would be expected; in other words on-paper changes to policy may be more successful than the reality since it can be more difficult to use democratic measures to police the actual implementation. Although this is an important caveat, it must be noted that overall real change has occurred in South Africa.

### Conclusions

South Africa presents an interesting case study to further test and examine Amartya Sen's hypothesis because the country's government has changed drastically during the time of the HIV epidemic. At the start of the epidemic, South Africa was not a democratic state, although by the early 1990s, South Africa had begun a transition towards democracy. From looking at the country's response to HIV, as predicted by Sen's argument, the country did not tackle the problem posed by HIV very aggressively during the apartheid years. Indeed, its response during that time can be characterized as a failure. However, if Sen is correct, it would be expected that once the country transitioned to a more inclusive representative democracy policies regarding HIV/AIDS would also improve.

This is not the case as the issue was either side-lined or for many years of the Mbeki administration there were even backwards policies that caused more damage. President Mbeki failed to lead the country to address a health issue that has been devastating for millions of South Africans. Because of his actions, he has come under sharp criticism. An initial assessment suggested that in contrast to Sen's theory, South Africa's status as a democratic state has not benefited the country in the face of a health crisis. However upon a closer examination, it becomes apparent that actually the citizens of South Africa were able to use a host of democratic mechanisms to push for the government to establish positive reforms. Through a combination of actions like the TAC initiated court case, civil disobedience campaigns, and the attention from the free press, these measures were able to force the government to change. In other words, even in South Africa's flawed democracy it is clear that these democratic institutions do work in compelling political elites to respond to the concerns of citizens.

Once these reforms and biomedically correct initiatives were implemented, they were met with success in improving a number of measures of this public health problem. Although these reforms have been successful, and demonstrated the power of democratic institutions to initiate change, it is problematic that it takes so long for new measures to be implemented. The timeframe for these processes to occur is so long that significant damage, measured in human lives lost and new infections transmitted, occurs before any actions happen. Thus, while democracy works, it works on such a delayed time scale that even when the country's response to HIV undergoes significant improvement, it may already prove to be too late. This points towards the inefficiencies of a democratic state that Ackerknecht recognizes in his assessment. Thus, while the case study of South

Africa clearly proves Sen's point, it again demonstrates that Sen's argument is not mutually exclusive of Ackerknecht's theory.

Chapter 5: China

### Democracy in China

Since 1949, the Chinese Communist Party has retained a monopoly on political power in the country, as China functions as a communist party-state. The functioning of the Chinese government is absolutely dependent upon the actions and decisions of the Communist party; in other words the Communist Party is not just a party but the entirety of the state (Li, 165-166). The Politburo and the Standing Committee are the most powerful bodies in the Communist Party, and the members of these groups occupy the most important positions in the government. Although the Constitution formally asserts that the Central Committee of the National Party Congress elects the Standing Committee and Politburo, in reality the opposite occurs. In a top down process, the state leaders in the Standing Committee and the Politburo control the selection of the members of committees ranked below them. These lower ranked members then “vote” for the President, vice president, and other top government positions, but the voting is symbolic and non-competitive as the official positions are pre-determined (Li, 175).

Although China is under one party rule, divisions and competitions within the Communist party exist. The leadership of the political elites in China has changed from being run by a single leader (as exemplified by Mao’s leadership) to a system of government that relies on collective leadership between different factions in the Communist party. These factions both compete and cooperate with each other so that there is some balance of power with the political elites working together to reach a compromise (Li, 187). China’s political system may be more pluralistic with more checks and balances than during the Mao or Deng eras, but government and policy decisions are absolutely still in the hands of the select political elite. The power-holders are often

technocrats with a background in engineering, and have ties to the political elite whether it is through their work or through their family background (Li, 181). Perhaps Li describes China's government most eloquently:

The People's Republic of China is still an authoritarian communist party-state that can be brutal in repressing dissent and opposition. Factional politics within the CCP, although not nearly as opaque to the public as during the Mao era, are not transparent. The lack of an independent press means that the public mostly knows only what the party leadership wants them to know about the policy-making process and the contenders for power. The seats in the most powerful bodies in the party-state are still decided by a very small number of top leaders through deal-making, not through open competition (Li, 189).

Since HIV/AIDS first became a global problem, China has gone through several generations of leaders. At the start of the epidemic, Deng Xiaoping was in charge, and since then there have been a series of power transitions. Although there are nuanced differences with each new generation of leadership, overall the driving philosophy since Deng has been that China must pursue economic reform but a complete maintenance of political dictatorship of the Communist Party (Lu, 61). This is supported by frequent reports of the use of repressive practices such as the use of violence against protesters, the requisition of land from peasants, or restrictions on religion (Lu, 69). With this as the underlying theme, China has not made (nor shown any desire to make) any significant progress towards democracy during the timeframe of the HIV epidemic.

Based on Sen's assertions regarding the benefits of democracy in stopping famines and similar humanitarian problems, I hypothesize that as an authoritarian state, China would be expected to have an inadequate response to HIV. With the lack of

democratic institutions such as free press and free elections, citizens would not be able to push the political elite to recognize and address the problems presented by HIV in China. I expect that when activists attempt to organize and advocate for policies to address HIV, they will face repression from the government creating a situation where the political elites continue to feel isolated and unaffected by these problems so that they are not incentivized to act. Given that the theme government repression and denial can be seen with many other issues in China such as after a high speed rail crash in 2011 and the forced displacement of land-owners in preparations for the 2008 Olympic Games, I expect that HIV will be no different of an issue and that any activism will be silenced by the government and will ultimately lead to weak HIV policies.

#### Early HIV/AIDS Policies in China

HIV first entered China in the early 1990s through the infection of intravenous drug users in China's southwest provinces that border Myanmar. Although there were a very small number of sporadic cases before this, the epidemic within this sub-population was China's first significant one. Heroin entered China from Myanmar through the border towns in Yunnan Province, and the virus likely followed this path as dirty needles were shared (Wang, S3), (Shao, 87). By the mid 1990s, there was a high prevalence of HIV/AIDS in populations of injecting drug users in Yunnan. In Ruili county, 70-80% of injecting drug users were HIV positive, while this figure was around 40% in Longchuan county (Grusky et al, 385). In the 1990s, contaminated blood also became a major vector for HIV transmission. Because giving blood is culturally stigmatized and seen as weakening the body, there were frequent shortages of blood. This prompted the rise of illegal blood banks in rural areas of China particularly impoverished villages in Henan

province (Rosenthal). Donors often only gave plasma, and had the rest of the blood returned to them. Frequently, the plasma from multiple donors was combined, and the equipment was re-used for the next donor and not sterilized. These practices contributed to HIV prevalence rates that some studies have estimated to be around 8.6% although other estimates suggest the number is closer to 20% (Li et al., S4), (Rosenthal). Women made up a greater share of blood donors because their blood was seen as less vital for work and more replaceable. As women became infected, they transmitted the virus to their husbands and to their children (Kaufman, 247). Contaminated blood products also infected the recipients of blood transfusions (Kaufman, 112).

Since the 1990s, HIV has spread from these 2 sub-populations of injecting drug users and blood donors/recipients. Populations such as commercial sex workers and men having sex with men are now also identified as high-risk groups. As the virus reaches these new bridge populations, it can infect more people who are not identified by these risk factors. This occurs as men who have solicited sex workers, or had sex with other men (and who often do not identify as homosexual) transmits the infection to the their wives (Kaufman, 190-191). Dr. Wang Ning, an AIDS specialist from the Chinese Center for Disease Control and Prevention explains that “Now it has entered cities, and universities where the so-called elite groups are...The kinds of people suffering from AIDS have grown more varied and complex. The direction of the development of the disease is from high-risk groups to groups that have traditionally been understood as low-risk groups” (Tatlow). Thus, China currently presents itself at a precipice of a larger, more wide-spread HIV epidemic which has grown out of an epidemic concentrated in specific, isolated populations.

For many years, the Chinese governmental response to HIV/AIDS was insufficient and characterized by a lack of leadership and transparency. The lack of effective action is due both to intrinsic weaknesses in the health care system and the stigma surround HIV. Prior to 2003, the Chinese government took limited action to combat the HIV epidemic. Although very few cases stemmed from direct foreign contact, the government banned HIV positive foreigners from entering the country in 1989 (Wines). Similarly to Russia, in 1990 China also instituted policies that sought to crack down on prostitution and drug use. However similar to the approach of the Russia government, by creating harsh penalties instead of promoting treatment and rehabilitation, this may have accelerated the HIV epidemic by pushing these activities further underground (Wu et al, 680).

The Chinese government did attempt to take steps to address transmission through the contaminated blood supply. In 1996, laws were implemented which banned the commercial collection of blood, so that all blood had to come from voluntary donors (Cui et al, 324-326). However, given the cultural attitude towards giving blood as losing a non-replenishable source of life, the ability to meet the need for blood without purely voluntary donation is highly unlikely. Thus, even recently, it was found that HIV was still being transmitted through illegal blood collection (Grusky et al, 385). In 1998, the government also developed Medium and Long-Term Strategic Plans for HIV/AIDS. The plans focused on prevention and education, and outlined goals such as containing the spread of HIV amongst drug users (Wu, 681), (Grusky et al, 385). Prior to 2003, China certainly took steps to combat HIV/AIDS, but these steps were not highly productive or meaningful and unfortunately did not lead to substantive progress. This issue was not a

priority for government leaders and there was a lack of political capital to compel action. Part of the government inaction stemmed from the low social status of the populations affected by HIV, and the severe stigma surrounding the disease itself (Kaufman, 10).

China's weak and ineffective response to the HIV epidemic also stemmed from inherent inequalities and issues with its health care system. During the 1980s, China's health care system underwent restructuring which made local governments, instead of the national government, carry most of the burden in terms of providing care. Because of this decentralization of healthcare, the central government's share of health care expenses was reduced from 40% to 18% in the period in the period spanning the early 1980's to 2005 (Tang et al., 1497). This pushed hospitals to shift the financial burden on to patients finding ways to charge for "administrative costs" and items such as syringes and needles (Grusky et al, 382). Thus, this corresponded to a rise in out of pocket payments for patients, specifically rural populations as the government provided greater financial support for urban areas (Tang et al., 1497). This new system ultimately decreased China's rural, impoverished populations' access to healthcare, a major cause for concern given that the HIV epidemic was concentrated in the areas that were most neglected by the healthcare system (Brown et al, 306) (Sutherland and Hsu, 101). Although the government provided HIV testing in cities, rural areas were neglected creating a situation where "HIV testing in rural areas [was] rare" and "antiretroviral drugs [were] very expensive, virtually no access to this treatment exist[ed]" (Grusky et al, 384).

Compounding to the economic inaccessibility of healthcare in general, especially HIV treatment, was the lack of trained medical professionals in rural areas capable of recognizing the symptoms and appropriately making an HIV/AIDS diagnosis (Grusky et

al, 384). China's response to HIV has also suffered from its ability to collect accurate statistics and document the epidemic. Although China does have a sentinel surveillance system, there have been problems with the transparency and aggressiveness of data collection. Given the context of a "potentially explosive HIV/AIDS epidemic [there] are shortcomings in data collection and data use for planning a response" (Kaufman, 48). China was limited by intrinsic weaknesses with its health care system, although since 2003 the government has made significant improvements to the way HIV prevention and care is delivered in the country.

#### A Major Change in HIV/AIDS Policy

The 2003 SARS outbreak brought negative international attention to China. This experience served as a "wake-up call for the Chinese government and society as a whole" as it became clear that public health problems are also security issues (Shao, 87). The SARS outbreak highlighted important factors in modern China such as the close proximity of livestock and humans and the easy movement of people. These factors create an environment ripe for new diseases to develop and for diseases to easily be transmitted. It was in this environment that SARS cases first began occurring in Guangdong in November 2002. As the epidemic grew, local officials covered up the problem so that the World Health Organization (WHO) was not made aware until several months later. When the WHO came to investigate, central government officials in Beijing did not allow the researchers to travel to Guangdong until months later (Kaufman, 291). Both the provincial and central government were complicit in preventing an effective action. By drawing negative international attention to China, the SARS epidemic became a legitimate political issue that warranted attention instead of a health issue that could be

delegated to the relatively powerless Ministry of Health. Once the Chinese government recognized the seriousness of this threat, they were able to act decisively, by firing the health minister and budgeting \$250 million towards emergency SARS control funding. In addition, the government was able to make use of historical public health strategies such as patriotic health campaigns that encouraged people to report fevers and self-quarantine (Kaufman, 291-292). The government's actions to stop SARS show that the government has the inherent capability to effectively act in response to health crises once the political will has been established.

China's response to the HIV epidemic, although delayed, has largely been made possible by lessons learned from the SARS outbreak. Once China's leaders realized that health problems they had previously ignored or failed to make a priority could bring negative international attention just as China is trying to establish itself as a rising power, they were able to change their unresponsiveness. The reversal of China's previous stance is also explained by the new understanding that if health issues such as HIV become a destabilizing force, this would directly threaten China's leadership's grasp on power. These realizations ultimately compelled meaningful and significant action from the Chinese government.

On World AIDS Day (December 1<sup>st</sup>) in 2003, Premier Wen announced the "Four Frees and One Care" program. This program would provide free medication for residents of rural areas, free voluntary counseling and treatment, free medication for pregnant mothers, and free schooling for AIDS orphans (the "Four Frees"). The program also provided care and economic assistance to people living with HIV/AIDS and their families (the "One Care") (Kaufman, 97), (Shao, 87), (Cui, Liao, and Wu, 2255). This program

has been China's most significant action taken to combat HIV. It has also marked a major shift in the government intentionally transitioning away from discrimination and denial.

This new initiative from the government has had a major impact on healthcare for HIV positive patients. For instance, a nurse who works for an outreach program for high risk groups sponsored by the Department of Public Health explained that her job involved educating sex workers and the LGBTQ population. The Department of Public Health had established relationships with brothels in the city, to the extent where the brothels accepted the nurses to visit the brothel to provide education services and distribute condoms (Nurse Wu). The nurse explained that this took awhile as many of the sex workers did not trust them and worried that they would be reported. But over time the sex workers saw that the nurses were simply focusing on medical outreach and education and not focused on reporting illegal activity. In addition, the nurse also explained that health care professionals are also exhibiting a deeper understanding and acceptance of people with HIV/AIDS. She mentioned that as medical professionals they knew that HIV could not be transmitted through sharing food or shaking hands, but initially when the doctors and nurses started working with HIV patients they would wash their hands after shaking hands and other similar measures. However, after the health care workers gained more exposure to patients and developed genuine relationships based on empathy and understanding, they stopped taking such measures, indicating that health care workers and had a greater respect and acceptance for patients (Nurse Wu).

The major shift in how China views HIV/AIDS can best exemplified with China's first lady, Peng Liyuan's role as a World Health Organization Goodwill Ambassador for HIV/AIDS. In this role, she has starred in public service announcements

broadcast in China showing her playing with and hugging AIDS orphans. She emphasizes that HIV is not easily spread and that the children must be included in society and provided for (Unite for Children Unite Against AIDS).

Despite this high-level turnaround there are still deeply engrained issues regarding stigma and discrimination. For example, the nurse explained that when they worked with patients who tested positive for HIV, they often would work with patients in order to develop elaborate aliases. For instance, she described a male patient who identified as gay but was getting married to a woman. In order to protect his wife, the nurse worked with the man to create an excuse that he had another sexually transmitted disease so that he could not have sexual relations with her. They used this excuse to protect the male patient from the stigma associated with having HIV, while also protecting the fiancé. (Nurse Wu). This shows that medical professionals are equipped to handle sensitive issues such as patient confidentiality but that the discrimination faced by patients is still a major concern despite the fact that there have been significant improvements in decreasing stigma. Because the most vulnerable, high risk groups are ones that are typically marginalized in society, there has been significant progress in reducing stigma associated with people who contracted HIV from contaminated blood as they were seen to be innocent (Kaufman, 294).

As a reflection of how deeply engrained the stigma surrounding HIV/AIDS is, even after the ‘Four Frees, One Care’ policy, HIV/AIDS remains a sensitive subject in China. For example, even this year there have been reports of activists attending international AIDS conferences being prevented from leaving China by the government (Yu). Despite China’s approach towards HIV/AIDS undergoing a paradigmatic shift in

the wake of the 2003 SARS epidemic, Chinese government and society in general still show signs of discrimination and a lack of openness.

It is also important to recognize that the 'Four Frees, One Care' policy is a major turning point, but that China still faces problems of implementation. This policy is a national policy led by the central government in Beijing, but because of the decentralized system of governance in China, local governments will play a large role in how the policy is implemented. The local governments have significant autonomy in controlling the budget and details of the program, to the extent where regional governments pursued policies that the central government frowned upon (Kaufman 295). Besides the issue of regional autonomy, the 'Four Frees, Once Care' initiative is a costly measure that the government still does not prioritize as highly as goals such as economic growth (Kaufman, 295). Even now, there is resource scarcity in terms of the supply of ARV treatment. Thus, patients may have to wait several months before they begin treatment or their treatment may be interrupted until more ARV medication can be obtained (Nurse Wu). In contrast to the United States, where a 20 year old with HIV on average can live into his/her early 70s with treatment, the nurse estimated that patients in China who receive treatment will only live 10 years since the time they were diagnosed (Samji et al, 1), (Nurse Wu). This major discrepancy is a result of the scarcity of resources and the difficulty of obtaining later-generation medications that are costlier.

### Conclusions

Throughout its history, the Chinese government has shown both positive and negative response to the HIV epidemic, an unexpected phenomenon based on Amartya Sen's theory. Thus, HIV/AIDS in China presents a case study that challenges the hypothesis that autocracies do not have positive HIV outcomes. China, like Cuba, shows that a non-democratic state can indeed respond effectively to the crisis presented by HIV/AIDS. Even more compelling is that there was a major volte-face from the government regarding HIV policy. Amartya Sen's theory asserts that such a dramatic turnaround is impossible in a state without democratic institutions, thus China poses the most serious challenge to Sen's analysis of democracy.

From an in-depth analysis of how China came to its current stance on HIV, an unexpected phenomenon is observed where the political elite becomes threatened by the issue of HIV/AIDS not because of pressure from democratic institutions such as protests or competitive elections, but rather through international embarrassment and the fear of domestic instability. Typically, the Chinese government is known to prioritize issues of economic development above issues of health, which are seen as less important. But I theorize that the political elite responded to the HIV crisis because of recognition that this health problem can bring negative international attention while the country is trying to establish itself as a new global power. In addition, the leadership also saw that this could be an issue that could challenge stability in the country and the political elites' hold on power. This re-framing of HIV as not a health issue, but an issue of international scrutiny and domestic stability, created a unique situation where the political elites felt "close" to an issue troubling the populace and could no longer remain unaffected so they had to act.

This “closeness” of the political elite to the citizens’ problems is exactly the effect the Sen argues is achieved through democratic institutions that cannot be replicated in other forms of government. Thus, this careful study of China shows that democratic institutions are not necessary to change the governmental response, but as long as the political elite can feel “close” to any issue through whatever possible means, than decisive actions will occur.

In addition, this study of China’s response to HIV provides evidence for Ackerknecht’s theory of the efficiency of autocratic regimes. Once the Chinese political leadership genuinely recognized HIV as a problem that they must respond to, they were able to quickly introduce a decisive plan to fight the disease. Had an expensive bill that prompted such dramatic changes been introduced in a democratic country, it would have been slowed by the inefficiencies introduced by government checks and balances and the difficulty of reaching a consensus among all the political elite. Thus, similarly to what is demonstrated in Cuba, we see that autocratic regimes do provide benefits in terms of their efficiency in responding.

## Chapter 6: Application of Sen's Theory

By examining the HIV/AIDS response in several representative case studies, I hoped to analyze Amartya Sen's theory that famines do not occur in democratic countries. Sen asserts that because democratic countries have institutions such as free press and opposition parties, the political elite must respond to problems the citizens face even if they themselves are isolated from the problems. Therefore, the leadership of a democratic country will not experience a scarcity of food as they are insulated from such problems, but the leadership will face pressure from democratic institutions so that they feel obligated to act or they face losing power. In other words, democracies create a unique situation where the political elite are "close" to the problems of the people, and can institute solutions with ease once the problem has been identified. By testing this theory, not on famines, but on the country's response to HIV/AIDS, I wanted to not only identify broader applications with real-world ramifications but also test the accuracy of Amartya Sen's assertion. Based on Sen's theory, I hypothesized that democratic countries would have an effective response to HIV/AIDS while non-democratic countries would struggle to address the epidemic.

From my analysis, I certainly found proof for Amartya Sen's argument—most clearly in the case of Russia's response to this health crisis. As an effective dictatorship, Russia has consistently failed to take effective measures against the country's epidemic. Furthermore, the lack of democratic measures for citizens to demand recourse directly contributed to the failure of the government to take action. In Russia, the repressive environment simply does not allow people to effectively demand any change from the government's lackluster measures. Indeed, the functioning of the state apparatus makes it dangerous to push the government to reform as people who speak up will face retaliation.

In fact, the Russian government has perhaps even amplified the epidemic by pursuing measures that drive high risk groups further underground. The political leadership faces no significant domestic consequences if it fails to take steps to address the epidemic, which provides strong evidence for Amartya Sen's theory.

Russia presented the most clear and straightforward vindication of Sen's theory. I found that the Cuban HIV response does offer support for Sen's theory, but at the same time the story of the Cuban government's response to HIV also points towards a more complex reality of Sen's assertion. Cuba, as a non-democratic state, has actually had a very strong response to HIV/AIDS—a conclusion that seems to fundamentally contradict Sen's case for democracy. However, Sen actually theorized that in autocratic states with a benevolent despot, he/she recognizes that a famine (or in this case, an HIV epidemic) poses a grave threat to the nation. Then the enlightened despot will take the proper steps to address the problem. When a leader is taking appropriate actions, then a dictatorship does not appear to be problematic. Fidel Castro's leadership in Cuba, at least on the issue of HIV/AIDS, clearly exemplifies the benevolent despot phenomenon that Sen describes.

The analysis of Cuba also yields a more provocative addition to Sen's theory. With its response to HIV/AIDS, Cuba demonstrates that a dictatorship may actually be more effective than a democracy. Fidel Castro was able to create such an effective response because he had absolute power. It would be unimaginable in a financially strapped democracy to smoothly fund expensive ARV treatments the way that Cuba's government was able to do so during the Special Period. Even if a democratic state was dedicated towards procuring drugs, it would only be done after a thorough and time consuming deliberation process involving coordination between the branches of the

government. Thus, some aspects of Cuba's response to HIV could only be highly effective because of the lack of democratic mechanisms that would have slowed it down. The case study of South Africa's reaction to HIV/AIDS further demonstrates the problematic use of democratic institutions in driving a state's policy response.

As the government's response in South Africa suggests, democracy does work to push the government to be responsible to the needs of the people. Initially, the government failed to recognize and act to eliminate the threat posed by HIV. However, with movements such as the one led by the Treatment Action Campaign, democratic institutions were used to compel the political elites to act even though it was against their desires. This has led to a positive change in direction for the status of the HIV epidemic in South Africa. It is also a striking example of how robust democratic institutions can bring about reform, even in an administration backed by AIDS denialists. This certainly provides evidence for Sen's claims that democracy absolutely can bring about positive changes that otherwise would not be possible in a non-democratic state. If the Mbeki administration existed in a non-democratic state, there would be absolutely no course of action for citizens to put pressure on the political elites to change. However in a democratic state like South Africa it is possible to for Mbeki to sacrifice his own ideals in order to fulfill his obligations as a democratic leader. But a deeper analysis of the state of the epidemic in South Africa points toward the flaw in the democratic approach. It took many years for these democratic institutions to work and produce tangible change, in these intervening years, people died without access to treatment and millions more became infected. Even when robust democratic institutions work well, the time scale that

they work on can be so slow that it is dangerous, an important caveat to keep in mind about the effectiveness of democracy.

The case study of China's response to the epidemic does the most to challenge Sen's theory regarding the benefits of democracy. Even though China is a non-democratic state, it has proven itself capable of reversing its policy of inaction into a concerted effort to fight HIV. Such a strong reversal would be more expected of a democratic country, such as the one seen in South Africa; however in China this volte-face was accomplished without the use of democratic institutions. Instead, it was international scrutiny and the fear of internal instability that propelled the Chinese government to act. This is perhaps the finding that is most unexpected given Amartya Sen's theory. Without a political elite that inherently believed in fighting the threat posed by HIV, they were still able to change course without the pressure posed by citizens' use of democratic institutions. The same effect of closeness and the removal of insulation of the political elites was achieved through an entirely un-democratic means. The political elite had to be embarrassed and reminded of their tenuous grip on power in order for change to occur. This proposes an alternative to Sen's assertion for the use of democracy: if political elites in a non-democratic country are made to feel close to the problem, through any means, not solely democratic mechanisms, then there will be action. In addition, the analysis of China similarly to what was found for Cuba, indicates that autocratic regimes can be more efficient without the checks and balances inherent in a democratic state.

Sen recognizes that "democracy does not serve as an automatic remedy of ailments" (Sen, "Development", 155), as he notes that "the opportunity it opens has to be

positively grabbed in order to achieve the desired effect” (155). From my study of these countries, it is clearly that democracy is not sufficient to automatically produce benefits, and that this would be an oversimplification. My study shows that Sen’s theory provides a highly useful framework for studying problems such as famines or disease epidemics. But that Sen’s theory is 1.) not always correct in placing the emphasis on democratic institutions to bring about change and 2.) can be furthered by Ackerknecht’s theory of autocratic efficiency.

As countries such as China and Cuba have demonstrated, democracy may not be the key factor at all in Sen’s chain of reasoning. Rather, this analysis suggests that the most critical factor is actually that the political elites are not insulated from the problems of the people. Certainly, democratic mechanisms provide a ready-made method of precipitating a removal of insulation, but other mechanisms are also valid and cannot be discounted. Although it may be more difficult in a non-democratic country and also less visible, there are still methods of removing this insulating distance. In China, it was accomplished through international embarrassment of the political elite and the insinuation that health problems can challenge their hold on power. The process of removing this insulating distance between the political elite and the people effectively induces the leaders of China to become what Sen characterizes as benevolent despots. In the other case of the benevolent despotism, Fidel Castro did not undergo such a strong conversion. Although his policies and beliefs shifted over the years, he was essentially enlightened and benevolent with his “luz lurga” even at the start of the epidemic. Sen certainly recognizes the phenomenon of the benevolent despot, but his theory does not acknowledge that there can be an education process to create benevolent despots. This

points to the underlying issue that democracy may not always be necessary to remove the distance between the political elite and the populace.

As previously mentioned, the second issue with Sen's analysis is that democratic governments contain inherent inefficiencies—so that despite the fact that democratic institutions are fully capable of bringing about change and an accountable response, it may occur on such a slow time scale that the damage is irreversible. In cases like this, it suggests that an enlightened dictatorship may actually be more productive than a democracy. The inefficiency was best exemplified in the analysis of South Africa. Although democratic institutions forced the government to change, it was such an inefficient process that the epidemic had already caused serious damage. In other words, a victory for democracy does not necessarily translate into a victory against HIV. The analysis of Cuba and China presented an alternative to this approach. These countries demonstrate that once the pre-requisite of having a benevolent dictator was met, the government could respond highly effectively against HIV/AIDS. In fact, these states are can respond so well because they are not restricted by constraints on the extent of their power unlike democratic states. This provides support for Ackerknecht's theory of the efficiency of non-democratic states. Although it would appear that these are directly opposing and mutually exclusive theories, this analysis actually shows that Ackerknecht's theory builds off of Sen's theory and serves as a useful extension because the pre-requisite of a benevolent dictator must be met.

Overall, I find that Sen's assertions provide an important general framework of analysis, with two additional extensions: 1.) democratic institutions are not always necessary to close the insulating gap between the political elite and the people, and 2.)

benevolent despots can be more efficient. Do these findings indicate that non-democratic regimes provide a better alternative than democratic states? For several reasons, the answer is no. First off, although democratic institutions are not necessary to close the gap, they provide a built in solution. In a non-democratic state, alternatives must be thought of and then implemented, something that is not an easy process. Furthermore, although benevolent despotism may be more efficient, having a benevolent leader poses quite a gamble. Thus, although my thesis points out possible benefits of non-democratic states, it stops short of saying they are the better alternative.

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When I first submitted my thesis proposal, I had no idea of the adventures that would come. I certainly did not expect to be boarding a flight to Havana, Cuba. When I decided to go to Cuba, I thought it would be a manageable trip and Professor Murphy had nothing but encouraging things to say. As time went by, it seemed I had hit every obstacle in terms of making contacts in Cuba. But because Professor Murphy did not tell me failure was an option, I kept trying. Eventually, I made contact with Professor John Kirk at Dalhousie University. Like most other people, he told me that the trip would be almost impossible as it is “extremely difficult to make contact with Cuban medical personnel except through very close friends.” Although discouraged at first, I realized I had been looking in the wrong places and that I should instead be reaching out to my extended personal network. With that, I met Beatriz Aldereguia ('15) who introduced me to her extended family in Cuba, many of whom are doctors. Without help from her and her family, my research trip would not have been possible. I am profoundly grateful to them for help with my research and for embracing me as their own *nieta*. Before I left for my research trip, Professor Kirk said that there are three P's when it comes to Cuba: passion, persistence, and patience. After my trip, I know them as *pasi3n*, *persistencia*, y *paciencia*.

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