

## Appendix B: Rival Arguments

### 4.1 Accounting for rival arguments

In his research on economic policy reform in Africa, Van de Walle (2001) considers “ideological preferences of decision makers” as one of the major factors in determining policy outcomes (p. 50). Typically, the problem with individual characteristics in predicting policy outcomes is the inability to measure individual idiosyncrasies, rendering it difficult to produce general explanations (Geddes, 1994). Building on van de Walle’s proposition that elite preferences matter, I argue a preference to enact HIV policy may be necessary for a politician to intervene against HIV, but the stated preference is not sufficient to predict state intervention against AIDS. Political leaders could publicly proclaim a preference for allocating resources to HIV policies, but do they “put their money where their mouth is?” I propose the following hypothesis to account for van de Walle’s argument that preferences of policymakers will affect policy outcomes:

**H3: Countries whose political leaders express ideological preferences supporting AIDS intervention will have a higher level of state AIDS intervention than countries whose leaders do not express such ideological preferences.**

To test the elite preferences argument, I use the political support score measure from the API. USAID et al. (2003) used elite survey responses to score countries from 0 to 100 based on whether heads of state publicly support HIV/AIDS initiatives and whether there has been an establishment of a national AIDS commission. Higher scores indicate more elite support for HIV intervention.

On the importance of regime type, Lake and Baum (2001) argue that more democratic countries should produce a higher level of public services because democracies have more contestable political markets than autocracies. Following the logic of the regime type argument, one should expect democratic regimes to put forth more effort in AIDS intervention than authoritarian regimes. Given the nature and life cycle of HIV, I am not convinced democracy is a necessary and sufficient condition for a high level of effort in providing HIV resources. In fact, democracy could work against the movement to provide more policies and programs to address the AIDS pandemic. As an illustration, rulers beholden to the voters who consider other matters to be more pressing than HIV will allocate resources towards matters with which voters are concerned. Even in democratic regimes, rulers are not beholden to all voters. In their discussion of economic growth, Alesina et al. (1996) point out that subject to the pressures of interest groups, policymakers might short-sightedly follow opportunistic policies with their eyes on re-election rather than long-term growth (p. 193). Geddes (1994) points out how rulers respond only to the “politically useful” (p. 41) and Bueno de Mesquita et al. (2003) give importance to the “winning coalitions” in a “selectorate.” In consideration of the Lake and Baum (2001) argument, however, I propose the following hypothesis to test the importance of regime type:

**H4: More democratic countries will have higher levels of state AIDS intervention than more autocratic countries.**

To test the level of democracy argument, I use a measure from the POLITY IV dataset that scores countries on a scale from -10 (strongly autocratic) to +10 (strongly democratic).

The veto players theory argues that increasing the number of and distance between veto players constrains the ability to change policy (Tsebelis, 2002). Veto players are individual or collective decision makers whose agreement is required for a change in policy. According to this theory, we should expect countries with fewer decision-makers to be more successful in aggressively enacting HIV policy. HIV/AIDS is a relatively new problem for governments, so generating policy for HIV intervention would be a change from the status quo, and therefore another interesting space to test the veto players theory. The veto players argument has largely been successful in its application to countries with longer histories of democracy, but I am unsure whether I can properly test the argument in this analysis because available veto players datasets are limited to institutional and partisan veto players. Local governments and public opinion leaders outside of government (such as traditional and religious leaders) play an important role in politics in SSA, but are left out of these datasets. HIV is a sensitive subject because of the very personal nature in which the disease is transmitted, and like many sensitive subjects, there are very strong opinions on prevention of HIV transmission. Both religious institutions and international donors have strong opinions regarding intervention and their role in crafting and/or implementing HIV policy cannot be overlooked. Given that the fight against HIV requires a multi-faceted effort, it necessitates buy-in from a number of actors, effectively creating a larger group of veto players to negotiate HIV policy. The general idea of the veto players theory is therefore fitting for the study of HIV and politics. Unfortunately, veto players datasets for east and southern Africa fail to account for all of the actors involved in HIV policy-making. Despite the constraints of a veto players analysis, I propose testing the following hypothesis to explore whether institutional veto players have an impact on state AIDS intervention in east and southern Africa:

**H5: Countries with fewer institutional veto players will experience a higher level of state AIDS intervention.**

To test the veto players argument, I use a measure from Henisz’s veto players dataset named *polconIII\_2002*; the range of the veto players variable is continuous from 0 to 1, where a higher measure indicates more veto players. Veto players are measured by the number of independent branches of government (executive, lower and upper legislative chambers) with veto power over policy change in 234 countries from 1800 to 2001 (Henisz, 2002, 2). Table 6 below provides summary statistics for data on rival arguments.

Table 6: Data for Rival Arguments

Variable	N	mean	sd	min	median	max
API Political Support	15	80	12.07	49	79	95
Polity Score	15	1.73	4.91	-6	1	9
Veto Players	15	0.21	0.18	0	0.19	0.46

Table 7 reports regression estimates of the API policy and planning score; Table 8 reports regression estimates of government health expenditures. In both regression tables, the first model (1) is an estimate of the impact of the two control variables: log HIV prevalence and log GDP per capita. Model (2) adds the executive time horizon measures (to test Hypotheses 1 and 2). Model (3) includes control variables, executive time horizons, and data measuring elite support for intervention (to test Hypothesis 3). Model (4) includes control variables, executive time horizons,

and data measuring level of democracy (to test Hypothesis 4). Model (5) includes control variables, executive time horizons, and data for institutional veto players (to test Hypothesis 5). Given my very small sample size (N=15), statistical significance is difficult to achieve.

Table 7: Estimated influences on API Policy and Planning Score 2003

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	96.97*** (21.75)	49.36 (32.15)	37.6 (33.38)	46.43 (35.92)	51.47 (32.59)
Log HIV Prevalence	7.89 (10.03)	20.6* (9.82)	17.09 (10.17)	19.43 (11.37)	19.30* (10.03)
Log GDP per capita	-7.59 (8.04)	6.06 (10.48)	5.44 (10.35)	7.32 (12.18)	5.18 (10.65)
Dem. Time Horizon		-47.49* (23.03)	-47.01* (22.71)	-50.84 (27.78)	-48.3* (23.30)
Auth. Time Horizon		-172.79* (74.06)	-143.12* (77.66)	-173.9* (78.37)	-191.17** (77.63)
Auth. Dummy		-17.48* (8.75)	-17.97* (8.64)	-17.18* (9.31)	-19.64* (9.17)
API Political Support			0.24 (0.21)		
Polity Score				0.21 (0.82)	
Veto Players					13.04 (14.54)
Observations	15	15	15	15	15
R-squared	0.08	0.51	0.58	0.52	0.56

Standard errors in parentheses. \* significant at 10%; \*\* significant at 5%; \*\*\* significant at 1%.

*Table summary: Executive time horizons had more significant effects on level of HIV intervention than did elite preferences, level of democracy, or number of veto players. Contrary to what I hypothesized in Hypothesis 1 and 2, longer time horizons are associated with less AIDS intervention, here measured as lower values on the API policy and planning score.*

## 4.2 Explanatory Power of Rival Arguments

When added to my model of HIV intervention, measures for rival hypotheses fail to show statistical significance. Measuring elite preference for HIV intervention, the API score of elite political support is the predicted (positive) sign in both regressions, but is statistically insignificant. Therefore, the hypothesis that elite preferences determine level of intervention (Hypothesis 3) cannot be confirmed.

The level of democracy, as measured by the Polity Project, has standard errors larger than its estimated effects. Based on this evidence alone, the hypothesis that the level of HIV intervention can be predicted by the level of democracy in a country (Hypothesis 4) cannot be confirmed. It

Table 8: Estimated influences on Government Health Spending 2002

	Model 1	Model 2	Model 3	Model 4	Model 5
Constant	12.22 (9.22)	13.95 (14.34)	10.94 (15.65)	11.28 (15.82)	14.23 (15.19)
Log HIV Prevalence	5.77 (4.25)	2.47 (4.37)	1.58 (4.77)	1.41 (5.01)	2.3 (4.67)
Log GDP per capita	-2.51 (3.41)	-3.5 (4.68)	-3.65 (4.85)	-2.34 (5.36)	-3.61 (4.96)
Dem. Time Horizon		13.16 (10.27)	13.28 (10.65)	10.1 (12.23)	13.05 (10.86)
Auth. Time Horizon		62.11* (33.02)	69.71* (36.41)	61.1 (34.51)	59.69 (36.17)
Auth. Dummy		9.68** (3.9)	9.56** (4.05)	9.95** (4.1)	9.4* (4.27)
API Political Support			0.06 (0.09)		
Polity Score				0.19 (0.36)	
Veto Players					1.72 (6.78)
Observations	15	15	15	15	15
R-squared	0.13	0.50	0.52	0.51	0.50

Standard errors in parentheses. \* significant at 10%; \*\* significant at 5%; \*\*\* significant at 1%.

*Table Summary:* In these regressions, the measure for Authoritarian Executive Time Horizon held up better than the measure for Democratic Executive Time Horizon, but not much better. Though statistical significance was not constant, the coefficients for both measures changed little across the different models, as did the standard errors. As predicted, longer time horizons are associated with higher government expenditures on health.

would be misleading to think the authoritarian dummy measure may be capturing the effects of regime type on HIV intervention. Even running separate regressions of Polity measure against the API policy and planning score and government health expenditures without my measures of executive time horizons provided no evidence of a relationship between the level of democracy and level of HIV intervention.

Finally, in testing the veto players hypothesis (Hypothesis 5), I found the opposite of the predicted (negative) effect. However, the measure of veto players fails to achieve statistical significance as well. Though the veto players theory predicts more veto players leads to less policy change, Hypothesis 5 failed to be confirmed in the case of institutional veto players and state HIV intervention in east and southern Africa.