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Government Structures and Behavior Change in the Politics of HIV/AIDS

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Abstract

During the past decades, the worldwide spread of the human immuno-deficiency virus (HIV) has created one of the deadliest epidemics in human history. Despite widely available bio-medical knowledge about how to prevent transmission of the virus, and technologies and resources to treat people living with HIV/AIDS, the disease continues to spread, and especially in sub-Saharan Africa. However, despite the general precarious situation in sub-Saharan Africa, there is in fact great variation among African states as regards HIV prevalence. This paper builds a framework for increasing our understanding of the sources of this variation. More specifically, we argue that HIV/AIDS is a different kind of problem than other diseases in the sense that effective prevention demands sacrifices on the behalf of individuals that are costly in both material and non-material terms. The failure to recognize these costs makes standard solutions, such as for example increased access to medication, expanded funds, and health sector reforms, potentially ineffective. With the point of departure in the costs and individual sacrifices demanded for the successful combating of HIV/AIDS, this paper suggests that future research on HIV/AIDS would benefit from exploring the impact of varying institutional arrangements such as for example the degree to which state power is centralized or decentralized on HIV/AIDS outcomes. Institutions have commonly been argued to shape and constrain individual behavior. Yet, their impact on sexual behavior and behavior change remains largely unexplored.

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Overall objective

During the past decades, the worldwide spread of the human immuno-deficiency virus (HIV) has created one of the deadliest epidemics in human history. Despite widely available bio-medical knowledge about how to prevent transmission of the virus, and technologies and resources to treat people living with HIV/AIDS, the disease continues to spread, and especially in sub-Saharan Africa. Why so many deaths? Why is it that people continue to engage in sexual behavior that could lead to a slow and painful premature death?

In this paper, we argue that while previous research has provided a large number of important insights, they generally lack a deeper understanding of what kind of problem HIV/AIDS is. Accordingly, previous research has by and large treated HIV/AIDS as a disease among others. This becomes evident in the UN Millennium Development Goal number six, concerned with how to halt and begin to reverse the prevalence of HIV/AIDS, Malaria, and other diseases before 2015. In the same vein, one of the financially strongest actors in the field, The Global Fund, lumps together AIDS, Malaria, and Tuberculosis. While global initiatives to fight the disease is of course a good thing, in this paper we argue that, since HIV/AIDS is a different kind of problem than other diseases, there is a risk that standard solutions, such as for example increased access to medication, expanded funds, and health sector reforms, will only have limited impact. We argue that this lack of understanding of which kind of problem HIV/AIDS in fact is risks hampering progress in terms of the effective combating of the disease. The overall objective of this paper is to develop this argument further. In addition, we specify the implications of this argument. The paper is organized as follows. In the first section, we discuss the spread of HIV/AIDS. While HIV/AIDS continues to spread rapidly in many countries, other countries have been more successful in terms of stopping the spread of the disease. In the second section, we further explore theoretical and empirical approaches within the field. While many previous studies have provided important contributions to the field, in general they are limited in their capacity to explain cross-country variation. Recognizing the limitations of earlier approaches, in the third section, we offer a different conceptualization of HIV/AIDS which has the potential to contribute further to our understanding of why the disease continues to spread in some countries, but not in others. More specifically, we argue that HIV/AIDS outcomes depend on the willingness among the population to make behavior changes that are often costly both in material and non-material terms. Furthermore, we argue that the willingness to make the kind of sacrifices that behavior changes imply depends on

individual perceptions of the legitimacy of information and preventive care. Accordingly, if we want to increase our understanding of why some states are more successful than others in their attempts to stop the spread of HIV/AIDS, the remaining question is why some states have more currency as regards legitimacy of information and preventive care than others. We argue that political institutions are crucial in this regard. In section four, we propose a tentative research design. Finally, in section five, we provide a summary and conclusions.

The spread of HIV/AIDS

The spread of HIV/AIDS now presents a major social and economic crisis in much of the developing world, as well as a public policy crisis of virtually unprecedented proportions. A total of 39.5 million people were living with HIV in 2006 (2.6 million more than in 2004). The number of new infections in 2006 rose to 4.3 million (400 000 more than in 2004). Sub-Saharan Africa is clearly the most affected area of the world with more than twenty-four million people estimated to be infected with HIV in 2006 (UNAIDS 2007). Being home to merely 10 percent of the global population, sub-Saharan Africa is also home to a total of 64 percent of the HIV-positive people in the world (UN 2006). In 2005, AIDS killed 2.8 million people in Africa, making the disease even more lethal than wars that year (Patterson 2006). Life expectancy in sub-Saharan Africa, which had risen by fifteen years in the early 1990s, was projected to drop to forty-five years by the end of the decade. In the most severely affected countries, infection rates are above twenty-five percent of the population.

In addition to leading to great human suffering, increased morbidity and mortality have important consequences for political and economic development. On the micro level, negative economic implications of having family members that are infected by HIV have been documented in many parts of the world. Negative economic implications range from increased medical costs and expenditures on funerals to withdrawal of family members from work or school to look after those who are ill (UNAIDS 2006). The illness of a household breadwinner has the potential to undermine a poor household's ability to cope financially (Claeson et al. 2002). Widows and elderly women often lack financial, legal and moral support when, as the sole adult within the family, they take on responsibility for the care of children and young people (Sida 2003).

On the macro level, widespread illness among a population undermines the prospects for poverty reduction, as well as for economic and social development in general. As a consequence, health is increasingly seen as one of the key ultimate goals of development, and as a dimension of poverty in its own right. The

loss of civil servants, with their training, expertise, and networks of personal contacts, hampers the state's ability to provide services, including AIDS prevention and treatment programs (de Waal 2003). Over the last couple of decades, the demand for health services, including drugs, has risen as more people develop HIV/AIDS. The capacity of the health care system to cope has, however, been gradually diminished by the loss of staff through AIDS-related deaths, and increased costs may arise from the introduction of new safety procedures (Sida 2003). Along with health sector workers, among civil servants, especially teachers stand out as one of the groups most severely affected by the virus. For example, in 2006 it was estimated that as many as 21 percent of the teachers in South Africa were living with HIV/AIDS (UNAIDS 2006).

The inability of governments to respond to societal problems in addition has the potential to increase citizen discontent and divisions within government. On a continent where many countries have weak state institutions, these demands may contribute to political instability. In fact, a large and growing literature, relates the spread of HIV/AIDS not only to national but to global insecurity. For example, Chow (1996) argues that an intimate relationship exists between disease, conflict and instability that can threaten the national security interest of the United States. According to Chow's argument, political instability and disease reinforce one another. Military deployments spread HIV/AIDS and HIV/AIDS in turn places strains on government resources. Lack of government resources, in turn, leads to political dissatisfaction and potential instability which makes further military deployments necessary; the vicious circle is closed. Kelley (2000) offers a similar analysis, noting the Unites States' national security is threatened by major health epidemics that undermine military readiness. The HIV/AIDS pandemic has also been addressed in relation to security issues by a large number of politicians and by the donor community. In a groundbreaking address to the United Nations Security Council in January 2000, then Vice President Al Gore declared:

> "Today marks the first time, after more than 4,000 meetings … that the Security Council will discuss a health issue as a security threat. We tend to think of a threat to security in terms of war and peace. Yet no one can doubt that the havoc wreaked and the toll exacted by HIV/AIDS do threaten security. … when a single disease threatens everything from economic strength to peacekeeping – we clearly face a security threat of the greatest magnitude." (as cited in Bartels 2003)

Following Vice President's Gore's address, James Wolfensohn, ex-President of the World Bank Group, argued forcefully that:

> "many of us used to think of AIDS as a health issue. We were wrong. … nothing we have seen is a greater challenge to the peace and stability of African societies than the epidemic of AIDS. … in AIDS we face a war more debilitating than war itself … we face a major development crisis, and more than that, a security crisis. For without economic and social hope we will not have peace, and AIDS surely undermines both." (as cited in Bartels 2003)

In sum, the spread of HIV/AIDS has the potential to impact negatively on the development of the individual as well as of the larger community. Yet, despite heavy investments and a number of global initiatives – the maybe most comprehensive one being the UN Millennium Development Goal number six[1] – widespread disease continues to severely hamper the prospects for economic development and human well-being in many developing countries. Importantly, however, when it comes to the prevalence of HIV, incidence of new infections, and annual number of AIDS-related deaths, there is in fact large variation between states, and even among the countries of sub-Saharan Africa, in general the most severely affected countries in the world (see Table 1 for prevalence rates for the sub-Saharan African states). That is, international recommendations, health interventions, and policies have actually produced quite different outcomes in different countries. As will be clear from the following section, previous research has been to slow grasp this variation.

[1] Millennium Development Goal number six includes the specific target of halting and beginning to reverse the prevalence of HIV/AIDS, Malaria and other major diseases before 2015.

Table 1. HIV/AIDS in sub-Saharan Africa

Country	Percentage of adults, 15-49 years old infected by HIV
Angola	3.9
Benin	1.9
Botswana	37.3
Burkina Faso	4.2
Burundi	6.0
Cameroon	6.9
Central African Republic	13.5
Chad	4.8
Congo	4.9
Cote d'Ivoire	7.0
Democratic Rep. of Congo	4.2
Djibouti	2.9
Eritrea	2.7
Ethiopia	4.4
Gabon	8.1
Gambia	1.2
Ghana	3.1
Guinea	3.2
Kenya	6.7
Lesotho	28.9
Liberia	5.9
Madagascar	1.7
Malawi	14.2
Mali	1.9
Mauritania	0.6
Mozambique	12.2
Namibia	21.3
Niger	1.2
Nigeria	5.4
Rwanda	5.1
Senegal	0.8
South Africa	21.5
Sudan	2.3
Swaziland	38.8
Tanzania	8.8
Togo	4.1
Uganda	4.1
Zambia	16.5
Zimbabwe	24.6

Source: UNAIDS 2004.

Previous research

While the literature on health sector development is quite extensive, earlier literature has mainly focused on the biomedical aspects of the disease, i.e. treatment programs and diagnosis instruments. The limited social scientific research on the subject has, on the other hand, mainly focused on the consequences of the spread of HIV/AIDS in terms of social marginalization and vulnerability. There are also quite a number of studies focusing on the economic issues associated with widespread illness (Young 2005). Within this line of research, the major issues have been to account for varying cost-efficiency of health service delivery and the loss of productivity resulting from widespread illness. As such, current social scientific research is reasonably strong with respect to theorizing and measuring the detrimental effects of widespread illness, but less strong in explaining cross-country variation in the spread of the disease. However, a few explanations aiming at explaining cross-country differences in HIV/AIDS outcomes have been put forward. To start with, there are reasons to believe that the spread of HIV/AIDS is related to the prevalence of other diseases. If an individual is already infected by for example Malaria, the impaired immune system makes this person more likely to be infected by HIV/AIDS. The same is true for the reverse relationship. Nevertheless, while this explanation to why states vary in terms of HIV/AIDS outcomes in many ways makes sense, there is still a lot variation left to be explained. For example, while Malaria rates in Botswana and South Africa are low compared to most other African countries, HIV/AIDS prevalence rates are still among the highest on the African continent.

Another commonly put forward explanation to differences in HIV/AIDS prevalence rates is varying state capacity. In this context state capacity refers to measurable skills, systems, health facilities and personnel available to the state to carry out its functions in terms HIV/AIDS prevention (Lieberman 2004; Swidler 2003). However, this explanation has limitations as well. Once again, if we look at Botswana and South Africa, these states are among the strongest and wealthiest in Africa. Still, they are among the weakest when it comes to the capacity to stop the spread of HIV/AIDS.

Finally, previous studies have also stressed the importance of leadership (Parkhurst & Lush 2004). More specifically, it has become conventional wisdom to attribute the policy successes of countries such as Uganda to good leadership, and South Africa's stalled response to poor leadership (for a further discussion, see Lieberman 2004; Swidler 2003). More generally, the international HIV/AIDS policy community repeatedly looks to good leaders to address the issue of

HIV/AIDS prevention. Probably no world leader has been more rebuked for his statements on HIV/AIDS than the South African president Mbeki, leading many to conclude that it is due to his personal negligence that the South African response has been so weak. Mbeki has publicly questioned the link between HIV and AIDS. In addition, he has rarely made the problem a significant point of discussion in more general policy addresses. Also his health minister has questioned more conventional methods of combating HIV/AIDS, and instead emphasized the importance of good diet in order to avoid the disease. Similar to other researchers such as Lieberman and Gauri, while recognizing that Mbeki's words and deeds certainly have had a negative influence on the prevention of HIV/AIDS, we still think it is problematic to attribute variation in HIV/AIDS prevalence only to individual leaders. Most importantly, the very assumption that any given leader's whim will become effective policy must be problematized since the impact of leadership is in itself dependent on whether people find the policy trustworthy and act upon it. In this sense, it is important to ask the counterfactual question whether the same kind of leadership would have become as influential in another context. In addition, empirical facts on the ground work against the argument that leadership plays a decisive role. Botswana is far ahead most other African countries in terms of openness and commitment of its leaders on the HIV/AIDS issue. Still, HIV/AIDS continue to spread.

Taken together, previous explanations have come a long way but there is still a lot of variation among states that is unaccounted for. In this paper, we argue that previous approaches lack a broader understanding of the HIV problem. The UN, the Global Fund, as well as other donors and policymakers by and large tend to treat HIV/AIDS as a disease among others. However, HIV/AIDS displays a number of specific characteristics. To begin with, since it is primarily a sexually transmitted disease that involves a large number of taboos, it is in many aspects quite different from most other diseases. In addition, the incubation period is extremely long compared to most other diseases. Most importantly, protection from HIV/AIDS demands sacrifices in the form of behavior changes within the (very) private sphere that are often costly. Since the disease differs in these regards, the combating of it demands a different approach compared to, for example, the combating of Malaria and Tuberculosis. In the next section, we further develop this argument.

The argument

Sexual behavior change is generally put forward as a crucial component for preventing the spread of HIV, and understanding changes in behavior is thus

important for designing appropriate policy responses to the epidemic (Oster 2007). Yet, previous research points to limited changes in sexual behavior in many parts of Africa, which in fact is quite surprising given the behavioural responses among high risk groups such as gay men in for example the United States (Stoneburner and Low Beer 2004; Caldwell et al 1999; Winkelstein et al. 1987; Francis 2005) How can we understand this? Why is it that people continue to engage in sexual behavior that could lead to a slow and painful premature death? In this project, we argue that the reason why people continue to dice with death by taking sexual health risks is that engaging in safe sex demands sacrifices on behalf of individuals. The long incubation period of AIDS implies that behavior changes often imply higher costs at least in the short term than getting infected by the disease (Oster 2007). The costs can be both material and non-material in kind as they involve such things as condom use, partner reduction, interventions in the process of child birth, refraining from breast feeding, the testing of blood, and the monitoring of knowledge. More specifically, HIV/AIDS prevention demands individual sacrifice in the sense that it involves the acceptance of new information, including public sexual education campaigns and/or discussions about abstinence and partner reduction. As argued by Lieberman, such campaigns can be upsetting because they implicate members of society in the practice of sexual behavior that they often would prefer to remain completely private. AIDS policies have also involved the testing of the blood of citizens, and monitoring knowledge of the epidemic and sexual behavior which has often been viewed as a nuisance and/or potentially embarrassing and quite frightening (Lieberman 2007). In the process of childbirth, AIDS policies have included direct interventions such as mandatory blood tests, the placement of HIV-positive women on drug therapies, and the requirement that they deliver babies by caesarean-section in order to prevent viral transmission. AIDS policies have furthermore demanded that HIV-positive women refrain from breast-feeding, which is a particularly significant sacrifice in societies where breast-feeding is widely practiced and valued. Not to breast-feed in such societies is often understood as a public display of HIV-status (Lieberman 2007).

Attempts to stop the spread of the disease have in addition involved demands for behaviour changes such as condom use, abstinence, and partner reduction (Oster 2005). These behaviour changes can potentially be costly in many different ways. For example, since women often depend economically on their husbands or boyfriends, it is often impossible for them to refuse sex or negotiate for condom use even if they know that their partner has had other sexual relationships (Patterson 2006, see also Walker et al. 2004). Furthermore, since motherhood is crucial for many women's identity, women may also be less likely to request their

husband use condoms, since this protection prevents pregnancy. For the very same reason, marriage has in fact become an additional risk factor for contracting HIV in countries with high HIV prevalence levels (Patterson 2006, see also Baylies 2002). Additionally, since the welfare system is under-developed in most poor countries, children act as an economic as well as social insurance for the household. Consequently, the alternative cost for giving up children is rather high in most developing countries not only for personal reasons, but also for economic ones.

While previous attempts to stop the disease has recognized some of the costs involved, they have focused more on the direct economic costs such as, for example, expenses for condoms and tests. Consequently they have commonly ignored other important costs involved such as taking in new information, and accepting the need for behavior changes and preventive care. Without such acceptance of intrusions into the private sphere, reducing the cost of condoms risks having only limited impact. In addition to the access to material resources, what is at stake if the spread of the pandemic is to be stopped is, in other words, that individuals in a first step perceive such intrusions into the private sphere to be legitimate. First when this is case, they will act upon the recommendations given by the state or other actors. Furthermore, we argue that it is reasonable to assume that the ability of the main actors involved in trying to stop the spread of HIV/AIDS to intrude into the private sphere and foster behavior conducive to the prevention of HIV/AIDS depends on the degree to which citizens perceive their recommendations and actions as legitimate. The more currency in terms of perceptions of legitimacy available to main actors, the stronger capacity they will have to prevent the spread of the disease. The overarching question hence becomes why main actors, such as the state, vary in terms of their legitimacy to intrude into the private sphere and induce behavior changes which, in turn, prevent the further spread of HIV/AIDS.

With the point of departure in theories about how political institutions shape and constrain individual behavior, we argue that there is reason to believe that the varying abilities of states to prevent the spread of HIV/AIDS depends on the design of institutions, through the intervening effects of individual perceptions of the legitimacy of the main actors involved and the acceptance of intrusions into the private sphere. At the most fundamental level, institutions can be understood as ‘the rules of the game’ (North 1990; Steinmo 2001a; Steinmo 2001b). As such, the organization of political institutions systematically structures actors’ preferences and behavior (March & Olsen 1984; March & Olsen 1989; Rothstein 1996; Steinmo et al. 1992). Accordingly, they can, in the words of Hall, be understood as ”the formal rules, compliance procedures, and standard operating

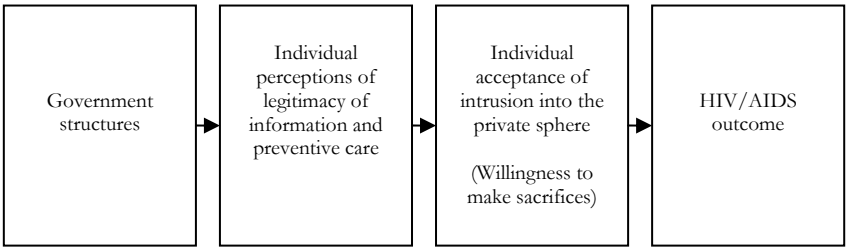
practices that structure the relationship between individuals in various units of the polity and economy" (Hall 1986: 19). North provides a similar definition, viewing institutions as the "humanly devised constraints that shape human interaction" (North 1990: 3). Given the theoretical importance of institutions, we argue that future research within the field of HIV/AIDS would benefit from exploring and comparing the impact of different institutional designs on HIV/AIDS outcomes. An empirical investigation could for example compare the effects of government structures on HIV/AIDS outcomes, i.e. the effects of different ways to allocate power within the political system (centralized or decentralized). A *centralized* government structure refers to a political system in which power is concentrated in a central authority to which local governments are subject. A *decentralized* government structure is, on the other hand, broadly understood as a system in which the central government has formally ceded powers to actors and institutions at lower levels in a political, administrative, and territorial hierarchy (Ribot 2004: 8). A decentralized system has furthermore been divided into four different categories: deconcentration, devolution, delegation, privatization (Crook & Manor 1998; Ribot 2004). In this project, we add a fifth category of potential importance; decentralization to traditional groups. *Deconcentration* (administrative decentralization) refers to a process in which power is transferred to local branches of the central state such as prefects, administrators, or local technical line ministry agents. These upwardly accountable bodies are appointed administrative extensions of the central state. They may have some downward accountability built into their functions, but their primary obligations are to the central government. Deconcentration is considered to be among the weaker forms of decentralization since downward accountability is not as well-established as in other forms. *Devolution* broadly means the transfer of power to local governments that are accountable to and representative of local populations, typically elected local governments. By and large, devolution aims to increase public participation in local decision-making. As such, it is considered among the stronger forms of decentralization since downward accountability is generally more well-established compared to in other forms. Through *delegation* central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous branches not wholly controlled by the central government, but ultimately accountable to it. Governments delegate responsibilities when they create public enterprises or corporations, housing authorities, transportation authorities, special service districts, semi-autonomous school districts, regional development corporations, or special project implementation units. Usually these organizations have a great deal of discretion in decision-making. In addition, they may be exempt from constraints on regular civil service personnel and may be

able to charge users directly for services. *Privatization* means the transfer of power to any, non-traditional and non-ethnic, non-state entity, including a number of different forms of private-public partnerships. However, even though privatization is often carried out in the name of decentralization, it is often not perceived as a pure form of decentralization since it operates on an exclusive logic rather than on the inclusive public logic of decentralization. Finally, by *decentralization to traditional groups* means the transfer of power to traditional authorities.

The idea that government structures in the form of centralization and decentralization could potentially have important effects on development outcomes in general and health outcomes in particular is not very controversial. On the contrary, in the last two decades, health sector decentralization policies have been implemented on a broad scale throughout the developing world (Bossert & Beauvais 2002; Litvack et al. 1998). The process has largely been driven by international donors and has been argued to promote an enabling environment for, among other things, the health sector by improving allocative efficiency; by allowing the mix of services and expenditures to be shaped by local user preferences; improving technical efficiency through greater cost consciousness at the local level; facilitating service delivery innovation through experimentation and adaptation to local conditions; improving quality, transparency, accountability, and legitimacy owing to user oversight and participation in decision-making; and greater equity through distribution of resources toward traditionally marginal regions and groups (Sida 2002; Bardhan 2005; Bossert & Beauvais 2002; World Bank 1993; World Bank 2004; Pritchett and Woolcock 2004; Besley & Ghatak 2007). Yet, despite the fact that health sector decentralization policies have been implemented on a broad scale throughout the developing world over the last decades, few systematic comparisons have been conducted that evaluate the impact of decentralization on health outcomes in general, and on the spread of HIV/AIDS in particular. The few studies that have been conducted have most commonly been single case studies and have not explored the impact of different types of decentralization. As such, what is still lacking in the literature is, on the one hand, a deeper understanding of how decentralization policies overall perform in comparison to non-decentralized systems and, on the other, how different *types* and *aspects* of decentralization policies affect health outcomes. While traditional authorities still have a lot of at least non-institutionalized influence in many African societies, this group of power-holders has often been dismissed in the earlier literature on the relationship between decentralization and health outcomes.

In the end, as illustrated in Figure 1, according to the tenets of institutional theory, depending on how government structures are organized, it is reasonable to believe that they will induce different types of individual behavior, ultimately leading to varying HIV/AIDS outcomes. If individuals do not perceive the government structures which provide preventive care and information about how to prevent HIV/AIDS as legitimate, they will not be willing to change their behavior.

Figure 1. The analytical model



A tentative research design

In order to test the argument developed above, we argue that a suitable design would be to select cases that vary with respect to the dependent variable, i.e. HIV/AIDS outcome. With respect to the different cases, the relationship between government structures (as ultimately specified in legislation and key policy documents) and the dependent variable, i.e. HIV/AIDS prevalence could then be explored. Uganda, South Africa, Botswana and Senegal would for example be of interest to investigate in a comparative framework. Uganda and Senegal are generally put forward as success cases in terms of the effective combating of HIV/AIDS. Senegal is arguably the only country in sub-Saharan Africa that has prevented a generalized HIV/AIDS epidemic, its adult prevalence never rising much above 1 percent. Uganda's situation has been different, but is still generally put forward as a success case. When Uganda's AIDS Control Programme formulated a five year plan with WHO assistance in 1987, it faced the worst HIV epidemic in the world, with a 24 percent adult prevalence. In the early 1990s, the HIV/AIDS prevalence rate had already decreased to 13 percent, and in 2003 it was down to 4.1 (Iliffe 2006). Botswana and South Africa, on the other hand, are two of the countries with the highest prevalence rates of HIV/AIDS in sub-Saharan Africa. In fact, Botswana rates as number one in the world as the country with the highest prevalence of HIV/AIDS. More than one third of the population is infected.

A second step to further test the argument above would be to investigate the sources of variation in HIV/AIDS prevalence between different regions within more and less successful countries. Are there any less successful regions within the more successful countries, and are there any successful regions within the less successful countries? And if this is the case, can the different rates of success be explained by differences in the government structures affecting these particular regions?

Taken together, a design like the one suggested above would provide valuable theoretical and empirical knowledge concerning the relationship between varying forms of government structures and HIV/AIDS outcomes. Are certain structures perceived to be more legitimate than others? That is, do they vary in terms of their effectiveness in inducing the behavior changes necessary to stop the spread of HIV/AIDS?

Summary and conclusions

In this paper we have argued that while previous research has provided a large number of important insights about how to hamper the spread of HIV/AIDS, they have commonly overlooked the fact that HIV/AIDS is in many ways different from other diseases in the sense that the prevention of it demands intrusions into the (very) private sphere and demands a large number of sacrifices on behalf of individuals. More specifically, we argue that while previous research has recognized some of the more direct costs involved in the prevention of the disease, they have commonly ignored sacrifices associated with the acceptance of intrusions into the private sphere such as taking in new information and accepting the need for behavior changes and preventive care. First after individuals perceive such intrusions as legitimate, they will act upon the recommendations given by the state and other main actors. The degree to which individuals perceive information and preventive care as legitimate and is in turn argued to depend on the organization of government structures. As political institutions, government structures have the potential to shape and constrain individual behavior. However, our empirical knowledge concerning the impact of institutional arrangements on HIV/AIDS outcomes up to today remains rather limited.

By exploring the impact of the design of government structures on the spread of HIV/AIDS, the suggested research design has the potential to contribute a deeper empirical understanding of how we can stop one of the biggest threats to human well-being, as well as to social and economic development, in human history. Furthermore, from a social scientific perspective, the suggested research design has the potential to contribute to an increased knowledge about the political sources of variation in the spread of HIV/AIDS. While during the past decades decentralization policies have been implemented on a broad scale throughout the developing world, there is still only limited knowledge concerning whether such policies are more conducive than policies of centralization when it comes to inducing behavior change. Moreover, we still lack knowledge about whether different types of decentralization have the same effects on social and political development. The suggested research design in addition offers a new way to theoretically think about the problem of HIV/AIDS by focusing on the behavior change necessary for preventing the spread of the disease. By recognizing the costs involved in behavior change, the project distinguishes itself from previous social science research which has, by and large, assumed that people lack information or are ignorant. That is, we argue that the reason why people do not change their behavior is that they do not perceive the messenger as a legitimate actor. In the end, for people to change their behavior, the perceived long-term

benefits of engaging in safe sex must be larger than the perceived short-term benefits of not doing so.

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