Ethnicity and the Politics of AIDS

A Discussion of *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS*

Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS. By Evan S. Lieberman. Princeton: Princeton University Press, 2009. 368p. $70.00 cloth, $26.95 paper.

Evan Lieberman's *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to Aids* proceeds from a simple question of great importance to millions of people: "Why have some governments responded to AIDS more quickly and more broadly than others?" In answering this question, Lieberman employs a range of methods and engages a range of scholarly literatures dealing with health policy, comparative public policy, and ethnic politics. Because the book addresses "big" issues and bridges conventional divides in political science, we have invited a number of colleagues working broadly in comparative politics to comment on it.—Jeffrey C. Isaac, Editor

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This is a powerful piece of scholarship, addressing an important question with sophistication, breadth, and originality. The main claim is that institutionalized ethnic boundaries result in weak policy responses to HIV-AIDS. Supporting the main claim is a pair of explanatory claims: Ethnic divisions lead to weak policy responses, first, because more highly affected groups do not lobby for action (out of concern for their relative social status), and second, because less highly affected groups falsely consider themselves insulated and fail to act (due to the way people estimate risks in divided societies).

In this review, I argue that Evan Lieberman makes a strong case for the main claim, although the causal argument for the main claim is perhaps not as strong as he suggests. The two explanatory claims give a novel and precise account for *why* strong ethnic boundaries could have negative effects on AIDS policy. These claims resonate but they do not fully convince; the empirical support for them is narrow relative to the support for the main claim, and the claims seem unable to account for the many alternative strategic possibilities open to actors. I conclude with some comments on Lieberman's principal policy conclusion—that the collection of statistics on levels of group exposure to HIV-AIDS exacerbates the problem and thus ought to be minimized.

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The Main Claim

Three types of evidence are provided for the main claim. First, there is strong cross-national evidence of a correlation between the aggressiveness of AIDS policies and the number and strength of ethnic boundaries. Second, subnational data from India demonstrate that a similar relationship holds at a micro level. Third, there is evidence from India, Brazil, and South Africa that group boundaries and AIDS policies in these cases are consistent with the expectations of the main claim.

The cross-national analysis is clear, careful, and relatively robust. The measures used are innovative, and Lieberman subjects his analyses to multiple robustness checks, varying models and measures that illustrate the relations in different areas of the world. The data analysis is elegant and a model of transparency. The basic relations survive most of the checks, although there are a few surprises. The main relationship between fragmentation and policy choices, for example, is a largely African phenomenon, and indeed there is no significant relationship outside of Africa. And while overall there is a strong negative relation

between fragmentation and references to HIV-AIDS in budget speeches, there is a strong and significant *positive* relationship outside of Africa.

The within-India study, placed within the India chapter, at first seems like supporting evidence for the claim that India's overall response is poor because of its ethnic fragmentation. But that country-level relationship, if true, has no implication for the within-country relationship (or vice versa). Rather, the within-country relation can be thought of as a second and independent test of the main hypothesis. Testing at different levels in this way nicely demonstrates the portability of the core logic examined. Here again the hypothesis is largely borne out.

Overall, some inconsistencies notwithstanding, these data and analyses give considerable confidence in the main claim.

Causal Status of the Main Claim. Establishing that the link between ethnic structures and policy outcomes is *causal* is clearly important to Lieberman. The argument for exogeneity is a simple one: Since the onset of AIDS is a relatively recent phenomenon and ethnic structures are slow moving, it is implausible that the former caused the latter; rather, the onset of HIV-AIDS can be thought of as a shock commonly applied across countries. Indeed, Lieberman argues that much previous work on the effects of ethnicity in other policy areas suffers from a "strong likelihood of endogeneity," which he avoids. The argument is seductive but I think ultimately incorrect. Normally, when one seeks a "shock" to establish exogeneity, one looks for a shock to the independent variable; in this case, one would want some shock to the structure of ethnic boundaries that is uncorrelated with potential confounds. Here, the shock is to the timing of the choice situation, but it is not clear that this solves the endogeneity problem. To see why, let us say that for some third reason, a country has difficulty implementing coherent policies in some class of areas and that this has led to a strong internal ethnic boundary structure. Say now that policymaking in the area of HIV-AIDS falls within this class. In this case, boundary structures will be correlated with, but not necessarily causally related to, AIDS-HIV policymaking. Thus, even if ethnic boundaries are exogenous to the onset of AIDS, the author's estimates of the effect of boundaries on *policy choices* suffer from the same risks of failure of identification for which he criticizes other work.

Contribution of the Main Claim. How novel is the main claim? The clear focus on ethnic structures as an explanation for health policy choices is an important contribution. But it joins an already large literature suggesting that ethnic divisions lead to poor policy outcomes in general. Abhijit Banerjee and colleagues demonstrate, for example, that social divisions in India, similar to those examined by Lieberman, are associated with worse public goods provision outside of the context of HIV-AIDS.[1] So is there really something particular about HIV-AIDS that merits specific explanation? There are two ways in which Lieberman's argument may differ from the general claim that diversity impedes public goods provision. One is to establish that the mechanisms through which diversity affects AIDS policy really are different from those in other arenas; another is to establish that the problem is particularly severe (or less severe) than in other domains. Lieberman does not address claims of the second type: There is no evidence given that the relationship between these indices and adverse policy outcomes is worse for AIDS than it is in other areas. In the following, I consider the evidence for a claim of the first type.

The Explanatory Claims

Lieberman's explanatory claims push the analysis beyond the question of whether ethnic boundaries matter to provide an account for why they might. The author provides two analytically distinct explanations: first, that groups that are exposed to HIV-AIDS do not press for help, and second, that those that are less exposed view the epidemiology through the lens of ethnic demography and infer, in essence, that the disease is someone else's problem. Those that are less affected do not see the risk; those that are more affected do not act on it. While there is a certain symmetry to the claims, either one could be true even if the other were not, and either could be in operation in a given case even if the other were not.

Together the two claims represent an elegant and welcome introduction of insights from social identity theory into a field that has been recently dominated by more rationalist approaches. Let me discuss first how persuasive the theoretical case is for each claim and then turn to the evidence for the claims.

The first claim is that affected groups will not push for policy responses, or specifically, that affected ethnic groups in a system with strong ethnic boundaries would push less than affected populations in a system without strong ethnic boundaries. The argument clearly resonates with various statements made by representatives of affected groups. Ex ante, however, the proposition is far from obvious; indeed, it runs counter to one of the most fundamental principles in political economy: that political action is more likely when needs are concentrated than when they are not. When HIV-AIDS is concentrated within a group, one might expect that the shared affliction with peers could help overcome individual shame and that those affected would have access to technologies of organization to facilitate lobbying that they would not otherwise have had. Here, then, the theoretical puzzle is why, even in the presence of status concerns, this standard logic would not be in operation for ethnic groups more generally; the empirical challenge is to assess the extent to which retarding effects associated with group status outweigh the organizational effects from group structures.

The second claim is that individuals in relatively low-risk groups assess their risks relative to high-risk groups,

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and as a result, they underestimate their true risks; they fail to see the shared nature of risks and may possibly even think of themselves as immune. These perceptions result in reduced effort. The claim is intriguing but its logic cuts both ways. If individuals in relatively high-risk groups also interpret their risks relative to others, they might overestimate their risks, pushing them toward more aggressive action. The theoretical puzzle is establishing why the negative effect for low-risk groups would dominate the positive effect for high-risk groups. The empirical challenge is to demonstrate that what is doing the work is really false perceptions of risk and not the actual distribution of risk.

Rivals to the Explanatory Claims. Do these explanatory claims account for the patterns that support the main claim? While Lieberman entertains other explanations, he pays less attention to truly *rival* explanations—that is, alternative logics that could account for the same patterns. From the broader study of the effects of ethnic structures on policy outcomes, however, we know that there are many possible rivals. There could, for example, be a realistic assessment of the distribution of risk, but a reduction in compassion for the welfare of outgroup members who face higher risk than you do; or perhaps there could be a general inability to coordinate across group lines. Or perhaps strong ethnic boundaries structure the distribution of the disease in the first place, because of differences in behavioral patterns, because of patterns of between-group inequality, or because of greater fragmentation of social arrangements, introducing greater variation in the distribution of risk. Such unevenness in exposure may account directly for the weakness of responses.[2]

There are, in addition, other political possibilities open to groups even if they operate within the general logic suggested by Lieberman. The most obvious is for affected groups to counteract the stigma by arguing precisely that AIDS knows no boundaries, and rather than seeking no action, lobbying for broad action targeted not only at their group. A second possibility is that affected groups engage energetically in blame politics, but use this to argue more vociferously for robust responses ("They made this problem; now they should pay to fix it.").

Evidence on the Explanatory Claims. Now let us consider the evidence for the explanatory claims. Let me begin by noting two concerns related to the types of observable implications that can be used to assess these claims.

The first relates to information on perceived and actual distributions of risk. Both of the explanatory claims predict, for different reasons, a disconnect between the actual and the perceived distribution of exposure to HIV-AIDS. Understanding the relation between the two seems critical. At multiple points, however, Lieberman suggests that the actual distribution is not what is politically important, that what matters is perceptions. There is clearly some truth to this, and in some sense all data is perception. But there are risks run when the actual epidemiology is ignored. First perceptions surely reflect the actual epidemiology to some extent. But the core idea of the second explanatory claim is, I believe, precisely a claim about how perceived risks depart from some notion of actual risks. We are provided with information that some groups believed that risk was higher than others, but without understanding how these beliefs correspond to the actual epidemiology, we cannot assess whether group boundaries are really producing biases in perception or whether the language of group risk is a shorthand for describing relevant epidemiological patterns.

The second relates to the structure of the propositions. Lieberman argues that variation in ethnic boundaries creates variation in the extent to which relevant groups push for policy action. But this proposition is trickier than it might seem at first blush, since here *the outcome is defined as a function of the treatment.* A hypothesis of the form "the existence of a multiplicity of groups causes relatively underexposed groups to underestimate their risks" faces difficulties because in cases in which there is not a multiplicity of groups, there are no relatively underexposed groups; one cannot even begin to assess the evidence for the claim. The sort of statement that could be examined requires units that are independent of the treatment: "individuals that face relatively low risks underestimate their risks when they share group membership with other relatively low-risk individuals." To engage in that kind of analysis, however, would require focusing more on the distribution of actual risk than is presently undertaken.

Let us now turn to the cases. The core evidence for these explanatory claims comes from a case study of India and, to a lesser extent, the South African and Brazilian cases.

What are the observable implications for the Brazil case? It turns out that an implication of the concerns I raised earlier regarding the structure of the causal proposition is that it is hard to know what to look for in the Brazil case. If indeed there are no relevant group boundaries, then how can one begin to assess whether more highly affected groups underestimate risks while less affected groups make weak policy demands? Evidence of such effects would violate the premise of the case. Indeed, the Brazilian discussion is relatively brief and consists largely in confirming that group boundaries are weak and that there was a national response in Brazil.

The South African case is richer. The observable implications here are that less affected groups should underestimate their risks and not support action, while more affected groups should be concerned about status and not demand action. Lieberman finds instances of both types of behavior. But South Africa remains puzzling. One would expect that if there were any place where the effects Lieberman describes would *not* be determinative, it would be in a

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case in which the affected group was both a large majority and in control of policymaking. More puzzling is why even when there were responses in South Africa they were so misguided, ranging from the naive (advocating better diets and vitamins) to the misguided (promoting alternative medications without the basic research behind it) to the criminal (raping babies). Perhaps this reflects the challenges facing attempts to construct a well-informed and effective lobby for serious HIV-AIDS responses in the country, but the fact that responses were "divorced from scientific best practice" (to use Lieberman's phrase) and not simply absent sits uncomfortably with the explanation that the driving force was fear of a loss in status that is associated with recognition of HIV-AIDS. President Thabo Mbeki's desire to find an African cure does of course reflect race politics in some way, but not in the way suggested by Lieberman's theory. A final puzzle is that although there is ample evidence of a politics of blame in South Africa, much of the blame that Lieberman discusses is in fact blame about the *origins* of HIV-AIDS. But such a politics of blame (unlike the politics of pure denial, which also exists) does not necessarily imply inaction, particularly by a dominant majority. Indeed, the blame could in principle provide a rhetorical basis for strong action. The African National Congress government had an opportunity to blame past governments for inaction and reorient policy in the area in favor of their constituencies.

The India discussion is broadly consistent with the theory, but some of the questions from the South Africa analysis arise here also. While there is evidence of denial, much of this is actually from the Hindu nationalists; while there is blame, much of this is blaming foreigners; while there appears to be a lack of national-level response, the national distribution of the infection rates does in fact appear to be very uneven (in the author's data, prevalence rates vary across regions from 0.05% to 2.27%, a rate almost 40 times as great).

Other cases discussed more briefly also provide mixed evidence. In Nigeria, according to Lieberman, groups in AIDS hotspot areas are the ones that criticize the lackluster response of governments as being part of a plot to destroy them, while the low-prevalence groups describe AIDS as a Western gimmick intended to destroy indigenous values. Neither of these patterns seems consistent with the theory. Gambia is cited as a case in which weak group boundaries have not led to adverse effects, but the government responses to AIDS in that country seem no better than the patterns seen under Mbeki in South Africa (President Yahya Jammeh is reportedly running a program based on an herbal cure for AIDS that was revealed to him by ancestors in a dream). Finally, the Uganda case also continues to puzzle. Uganda has strong ethnic divisions on multiple dimensions and has had weak responses in many policy areas. But it has been a leader in combating HIV-AIDS. Lieberman discounts the case because of the early rapid diffusion of the disease there and the fact that multiple groups were affected. Yet there was considerable variation in rates across Uganda, with still greater variance in early years. Moreover, his focus is on perceptions of prevalence, which he expects to be endogenous to group structures.

Do the cases convince? It depends on what one hopes to get from a small set of cases. Lieberman's breadth of research is exceptional—he undertakes masterful analysis of three cases on three continents. But three cases are few for assessing a general relationship and, as a result, too much gets asked of the cases; he tries to show not just that the dynamics he describes are at work but also that his explanation is *the* correct one in all cases. To do so, he tries to discount all other explanations (including the unsatisfying but possibly correct explanation that leadership matters). But establishing that Lieberman's story is *the* story in this small set of cases is neither necessary nor sufficient for the claim that the logics he identifies are universally critical. In the end, the evidence from the cases is mixed. But we should probably expect mixed evidence in particular cases even if the theory is right on average. A more modest ambition for the small set of cases is to demonstrate that the logic Lieberman identifies has face validity. In this, he is successful.

Implications for Policy

In his concluding chapter, Lieberman mixes prediction with prescription and moves from the careful reasoning characteristic of the earlier sections in the book to make larger claims regarding the role of categories in everyday life and the perils of multiculturalism. A key implication for the author is that the gathering of statistics on group exposure and the establishment of targeted programs risk undermining solidarity and facilitating the adverse dynamics he describes. Brazil is what South Africa could have been, and if Brazil starts collecting race-based statistics, South Africa is what it might become. There are reasons, however, to be cautious of these conclusions and the evidence that is used to support them. I point to five. First, these claims extrapolate largely from the explanatory claims and not the main claims. But it is the evidence for the explanatory claims that is the least satisfying. Second, Lieberman's evidence does not directly address the effects of data collection on outcomes, and in particular, at no stage in the analysis is there an examination of information structures conditional upon group structures. Third, there are theoretical reasons for concern: Finer data collection could in principle have beneficial effects; for example, information broken down by groups could be empowering for groups. Fourth, there are also theoretical reasons for concern emanating from Lieberman's own account: His analysis depends on false risk perceptions, and finer data could in principle help eliminate these false perceptions. Finally, there is a concern that the policy conclusion drawn is based on partial analysis: Even if it were true that a given

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policy has an adverse effect in one area, the decision whether to adjust it should depend on the total effects of the policy *across* areas, which are not considered in this work.

Of course, even if Lieberman's policy conclusions are at a remove from his evidence, it is still possible that his conclusions are correct. To that extent the wealth of ideas in his concluding chapters can be seen as a challenge to researchers in the area seeking to test strong theory-based policy hypotheses.

Conclusion

Boundaries of Contagion is a deeply engaging piece of research. It takes on a substantively important puzzle and suggests fruitful approaches for addressing it. The politics of health policy in the developing world has been a badly neglected one, but Lieberman demonstrates that first-rate scholarship can and should be done in this area. The seriousness of his topic and the originality of his ideas demand our attention.

Notes

1 Banerjee, Iyer, and Somanathan 2005.

2 Say that each individual can contribute $x_i \in [0,1]$ to a solution and that the benefits to individual i is $r_i \Sigma x_j - \exp(x_i)$, for sensitivity r_i in $[1, e]$. Then Nash equilibrium contributions yield $\Sigma x_i = \Sigma \ln(r_i)$, which is maximized when risks (r_i) are distributed evenly.

Reference

Banerjee, Abhijit, Lakshmi Iyer, and Rohini Somanathan. 2005. "History, Social Divisions, and Public Goods in Rural India." *Journal of the European Economic Association* 3 (2/3), 639–47.

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Why do similar types of democracies respond differently to health epidemics, such as AIDS? In his book, Evan Lieberman is startled by the fact that although Brazil and South Africa share similarities in levels of political and economic development, they responded differently to AIDS. This is surprising if one considers the recent transition to democracy and proclaimed political elite commitments to human rights and elections in both cases. How and why did this happen?

In explaining this puzzle, Lieberman provides a unique explanation for differences in policy response—measured in terms of bureaucratic development and prevention and treatment policy, as well as human rights. In contrast to other approaches focusing on the impact of democratic institutions, state capacity, and civic mobilization, Lieberman's emphasizes the impact of boundary politics: that is, the informal and formal categorization of ethnic groups that shape policy preferences and the government's perceptions of the wider systemic threat of AIDS. These boundaries also shape civic perceptions and incentives to approach the state for reform. As seen in South Africa, when boundaries are thick, measured in terms of formal measures of ethnicity such as census data, or active pubic discussion such as newspapers and/or legislative debates, policymakers have few incentives to respond aggressively. The risk of AIDS is relegated to isolated pockets of communities behaving in a devious manner. At the same time, thick boundaries in society generate few incentives to approach the state for resources to combat AIDS, as communities fear disclosing their health status due to the stigma of having the disease.

Conversely, when boundaries are weak, as seen in Brazil, AIDS is not described in boundary terms. Politicians view the risk of AIDS as a grave national concern, not to be associated with any particular group. Politicians are thus more likely to aggressively implement policy. Likewise, civic organizations, such as nongovernmental organizations (NGOs), are more likely to work with the state for a timely and effective response.

Lieberman evaluates his theory by using qualitative and quantitative evidence. He combines case study analysis not only of Brazil and South Africa but also of India in order to test for the wider applicability of his theory. This is followed up with multivariate regression analysis, using multiple sources of data, as well as brief case studies supporting his statistical results. Altogether, the book provides a very impressive package of multimethodological techniques.

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