Opening the black box:

The politics of allocating public resources for health in Barbados

Jamila A. Headley BA, MSc
Exeter College, Oxford

Thesis submitted to the Division of Medical Sciences for the degree of Doctor of Philosophy

Department of Public Health
University of Oxford

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For Granddad

Abstract

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Within the field of public health, there has been increasing interest in the factors that influence national priorities in health in low- and middle-income countries (LMICs), where resources are often particularly scarce and decision-making processes are often ad-hoc. Understanding how priorities are set in these countries necessitates a look at the process concealed in the black box that transforms policy inputs into outputs. However, rigorous health policy analysis of macro-level priority setting in LMICs is rare.

Using a case study approach, this thesis explores the drivers of priority for primary health care, sanitation and HIV/AIDS over the past five decades in Barbados. To do this I use process tracing techniques, drawing on analysis of public expenditure on health from 1960 to 2010, in-depth interviews with key policy actors, non-participant observation, archives, media reports, parliamentary records and other documents.

I argue that powerful individual policy actors or 'policy entrepreneurs' act as necessary drivers of macro-level priority setting in Barbados, although they do not single-handedly determine the outcomes. In particular, I find that these actors are successful in generating priority when they are able to propagate powerful framing ideas and can effectively navigate the policy context by seizing windows of opportunity and managing negative constraints. Moreover, because resources are scarce, their ability to mobilize external financial support is also important.

In particular, this thesis stresses the fact that allocating public resources for health is a political process and suggests that it is best explained by considering a set of interrelated factors. In doing so, it illustrates the utility of health policy analysis in helping to open the black box of macro-level priority setting in LMICs more broadly.

Acknowledgements

In 2007, due to difficult personal circumstances, I found myself more aware than ever before of the potentially life altering trade-offs involved in allocating limited resources for health. While that was perhaps the most trying period of my life, it is unlikely that this research project would have emerged otherwise. What follows is an attempt to make a small contribution to our understanding of how national priorities in health are set in Barbados, what we can do to influence them, and how we can improve the process by which they are set.

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List of abbreviations

A&E	Accident and Emergency
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
AZT	Zidovudine
BAMP	Barbados Association of Medical Practitioners
BDS	Barbados Drug Service
BDS $	Barbadian dollars
BOD	Burden of Disease
CAREC	Caribbean Epidemiological Centre
CARICOM	Caribbean Community
CEA	Cost Effectiveness Analysis
CMO	Chief Medical Officer
CNCD	Chronic Non-Communicable Disease
DAH	Development assistance for health
EED	Environmental Engineering Division
EPA	(United States) Environmental Protection Agency
GDP	Gross Domestic Product
GP	General Practitioner
GPA	Global Program on AIDS
HAART	Highly-active antiretroviral therapy
HEU	Health Economics Unit
HIV	Human Immunodeficiency virus
IDB/IADB	Inter-American Development Bank
MDB	Multilateral Development Bank
MoH	Ministry of Health
NACA	National Advisory Committee on AIDS
NHAC	National HIV/AIDS Commission
ODA	Official Development Assistance
PAHO	Pan American Health Organization
PHC	Primary Health Care
PLHA	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
QEH	Queen Elizabeth Hospital
SPA	Special Program on AIDS
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
UWI	University of the West Indies
WHA	World Health Assembly
WHO	World Health Organization

Chapter 1
Introduction

1.1 Introduction

Sitting in a well-lit office, with two British medical interns hanging on his every word, Dr. Roach could only reminisce about the days before 2001 when antiretroviral therapy (ART) was not widely available in Barbados, AIDS was still a death sentence, and a small, crowded pulmonary unit at the island's main tertiary-level facility was the epicentre of the epidemic. Less than ten years on, he was now the director of the Ladymeade Reference Unit (LRU), Barbados' state of the art government-run HIV treatment centre, and the patients in the spacious waiting room appeared healthy. We joked that the LRU had grown from a clinic to a small village since my last visit five years prior. Indeed, the growing complex of buildings (which housed a variety of support services for people living with HIV) was another visible sign of the increased priority that had been given to the epidemic since 2000. However, Dr. Roach quickly became serious again:

> "Other health professionals feel that we are spending too many resources on AIDS when we should be spending them on diabetes or asthma. On one hand, my very self-centred response is: 'well that's your problem, we are just more effective in selling it'. But it's a very genuine concern. Sometimes I feel like, my goodness, why are we really doing this when so many people are losing their legs due to diabetes? I find it quite a difficult problem to get my head around."[12]

Few people would disagree that HIV is a major health challenge in Barbados. In 2007, the estimated prevalence stood at 1.9%—almost twice as high as the Caribbean average—and the drastic growth in public resources to address the problem after 2001, was a welcome change after more than a decade of relative neglect.[13] However, some argue that there are other health problems that should perhaps be higher on government's priority list. One in six Barbadians over the age of 25 years old is diabetic and Barbados has one of the

highest rates of lower extremity amputation in the world due to diabetic complications. Also approximately 17.3% of men and 28.8% of all women are hypertensive. Diabetes, heart disease and hypertension—all mostly preventable and/or manageable chronic non-communicable diseases (CNCDs)—come ahead of HIV in rankings of the top causes of morbidity and mortality among adults.[14]

Not long after my encounter with Dr. Roach, not far away from the LRU, I had a meeting with Professor Hassell, the chairman of the National Commission on CNCDs. After the meeting, I could not help but notice just how different the government's responses to these two health challenges were. Dr. Hassell's commission had no office, no paid support staff and almost no budget to advance its work. It is unlikely that priority for HIV was the sole reason for the lethargic efforts to prevent CNCDs at the time. Yet, against the backdrop of a global economic recession and declining public resources for health, both Dr. Roach and Professor Hassell were aware that increased priority for one area necessarily meant decreased priority for something else.

The inevitability and necessity of setting priorities

Even in times of prosperity, all health systems are faced with the basic problem of allocating limited resources in the face of limitless demands for health, making it impossible for them to do everything for everyone. As such, priority setting—the allocation of scarce resources to certain patients, interventions, or service-areas over others—is inevitable. In most countries, where governments play significant roles in the provision of health care, the need to deal with the dilemma of limited resources lies at the crux of health policy making. The criteria used to set priorities may be explicit or implicit, and decision-making processes may be deliberate or ad-hoc. Regardless, even when there is no conscious effort to set priorities, the reality of scarce resources means that some issues rise to the fore (garnering resources and attention), while others are neglected. Most importantly, because

resource allocation is concerned with who gets what, when, how, and at what or whose expense, and because there is no single self-evident way to make these decisions, priority setting is deeply contentious and value-laden.

In health systems, prioritization decisions are being made at various levels all the time (See Table 1.1). At the macro-level, policy-makers make decisions about what resources should be allocated to health versus other sectors and how best to distribute these resources between different geographic or service areas. At the meso-level, decisions are made about which interventions will be funded and which will not. Finally, at the micro-level, health professionals must make decisions about which individual patients will receive treatment and if so, what treatments they will receive. In reality, priority setting in health is a complex amalgamation of many decisions made in response to various demands on the system at all of these levels. These decisions are deeply intertwined. For example, the level of funds available in the overall health budget will have implications for decisions about how much resources will be allocated to various services within the health system. In turn this will affect the array of treatments or interventions available for health professionals to choose from.[15-18]

Table 1.1: Levels of priority setting

1. The overall level of funding to be allocated to health services. 2. The distribution of the budget between geographical areas and services.	Political/Macro-level
3. The allocation of resources to particular forms of treatment.	Institutional/Meso-level
4. The choice of which patients should receive access to treatment. 5. Decisions on how much to spend on individual patients.	Individual/Micro-level

Source: Coulter & Ham (2000)[15] and Klein (1993)[16]

There has been growing acknowledgement that priority setting is not just inevitable but that it is necessary if limited resources are to be allocated in a way that meets health needs equitably, efficiently and effectively. Since the 1980s, in the face of an ever-growing demand for health care and rising health care costs due to new technologies in many developed countries, researchers from a plethora of disciplines—from economics to

ethics—have been preoccupied with the fundamental question of how best to allocate resources across competing demands.[3, 19, 20]

1.2 The challenge of setting priorities in low- and middle-income countries

Arguably, priority setting is most important and most difficult when scarcity is severe and basic health needs are acute. This is true in most low- and middle-income countries (LMICs), where despite major health gains achieved over the last half-century, significant mismatches between available resources and those required to meet even basic health needs persist.[21, 22] A number of factors have contributed to this gap. On the supply side, economic crises, low allocations to health on the part of governments, pressure from global economic institutions to reduce social spending, out-migration of critical health care workers, unpredictable flows of donor funds, and unrealized promises of economic growth, have placed significant constraints on the resources available for health. Meanwhile, there is mounting demand for health care driven by epidemiological transition (which has resulted in large dual burdens of communicable and non-communicable diseases), demographic pressures, and escalating health care costs due to technological and medical advances, among other factors.[3]

Because in LMICs available resources often lag significantly behind health needs and because the trade-offs involved in making prioritization decisions at the macro-level can sometimes literally be a matter of life and death, it is especially pertinent that governments allocate public resources in a way that maximizes health gains. Yet priority setting in LMICs often appears to be ad-hoc, decisions seem idiosyncratic, and resource allocation is often inefficient. For example priority is often given to more expensive specialized services while lower-cost public health interventions, with the potential to have wide-scale impacts, go unfunded. Moreover, too frequently, public investments in health

fail to reach the poor. Furthermore, priority-setting criteria is often implicit, leaving a great deal of uncertainty as to why certain things are given priority and others neglected.[23, 24]

Several authors have noted that a number of factors contribute to poor resource allocation decisions in LMICs. Among these, is the fact that priority setting is often set against a backdrop of weak health information systems and basic data on which to base decisions is often lacking. Also, there is generally limited institutional capacity to systematically evaluate, set and implement priorities once they have been identified. In addition, policy-making in these settings is marked by a growing number of regional and global actors, who may have conflicting agendas and who often play powerful (albeit sometimes less visible) roles in the health policy process.[21, 25, 26]

Growing attention for the challenge of allocation in LMICs

There has been increasing attention on macro-level resource allocation in LMICs among a wide range of actors, including academics, donors, multilateral organizations, civil society groups, and decision-makers. This has been driven by a number of factors. Firstly, there is robust evidence to suggest that better health is not only a desired outcome of economic growth, but that investments in health is a necessary input to the achievement of economic growth and development—a central (and often elusive) goal of governments.[27]

Accompanying this, there has been mounting evidence that *how* governments chose to invest scarce resources for health is an important determinant of the health of their populations. There is convincing evidence that it is possible to achieve more, with even the smallest health budgets. For example, in 1985 a Rockefeller Foundation report entitled "Good Health at Low Cost" explored the factors that accounted for why some countries with relatively few resources had been able to achieve substantial health gains. One consistent factor among the countries, which had managed to achieve considerable health gains on relatively small budgets, was that they had prioritized investment in primary level

and community based services and prevention, over secondary and tertiary-level, specialized and curative care.[28]

Lastly, more informed citizens in LMICs are calling their governments into account and demanding more transparent and fair priority-setting processes. Similarly, due to increasing pressure from citizens at home, donors have begun to call recipient governments into account with regards to their spending decisions and overall investments in the health sector.[20]

Efforts to improve macro-level priority setting in LMICs

Much of the effort aimed at improving priority setting at the macro-level in LMICs thus far, has focused on the development of technocratic tools to inform decision-making. Perhaps the most influential of these is the World Bank's 1993 World Development Report, which argued that developing countries had a duty to ensure that they achieved the greatest bang for their 'health buck' i.e. that they obtained the maximum health gain possible for each dollar allocated to the health sector. To do this the authors presented a new comparable measure of burden of disease called Disability Adjusted Life Years or DALYs[i] and suggested that priorities be set by evaluating and ranking the cost-effectiveness of interventions for particular diseases in terms of cost per DALY gained.[29] Critics have identified several problems in using this approach. For example, they have pointed to the limitations of using a single global measure to evaluate priorities, problems with data quality, its neglect of equity concerns, its tendency to look at diseases and interventions in isolation, and the failure of a technocratic expert-driven method in capturing public views on priorities, among others.[30-34]

[i] The WDR report defines DALYs as "the present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year" (p. x).

Subsequent efforts have worked to address some of these concerns. For example, since 1993 there has been an on-going effort to update and improve the quality of the burden of disease and cost-effectiveness data included in the World Bank study. And, the World Health Organization's Choosing Interventions that are Cost Effective (or WHO-CHOICE) project has taken a more generalized or health systems approach by allowing for the evaluation of a mix of existing and new interventions at the same time. WHO-Choice has also worked to provide more nationally and locally relevant evidence for decision-making by providing regional databases of cost-effectiveness information and by allowing for the incorporation of several other health sector constraints (e.g. health care worker shortages, or the economic situation) into its models. This new body of evidence and its accompanying tools are freely available to policy makers as open-source software accessible via the Internet.[35, 36]

Good tools aren't enough

In their 2006 update of the original Disease Control Priorities in Developing Countries Project, the authors assert that:

> "At the most general level, priorities in health are clear: identify the cost- effective interventions for those diseases that impose the largest burdens—around the globe or in target regions or populations that exhibit grave need or inequity—and determine how to deliver those interventions effectively, efficiently, and equitably." (p.23)[37]

Yet, despite major strides in creating and refining cost-effectiveness tools to aid priority-setting since the 1993 World Development Report, the actual use of these to guide prioritization decisions in LMICs remains minimal.[22, 26, 35, 38] In light of this, there is now increasing awareness that good tools and accurate information are not enough.[20, 22, 38] One fundamental reason for this is that evidence is only one of a plethora of factors affecting priority-setting processes. In particular, several authors have pointed out that current efforts have neglected other critical issues including the influence of social values on prioritization

diseases, the bureaucratic and institutional implications of shifting priorities and, perhaps most importantly, the nature of the political process by which public resources are allocated.[17, 22, 39]

It seems obvious to state that health policy (and policy making in general) is by its very nature a part of the political process. Indeed, in a 2006 Inter-American Development Bank report, ironically titled *The Politics of Policies*, the authors assert that: "A strictly technocratic approach toward policymaking short-circuits [the] steps of discussion, negotiation, approval, and implementation, which have at their core the messy world of politics…. The political process and the policy making process are inseparable."[40] Yet technocratic tools aimed at improving priority setting have largely been developed in the absence of an effort aimed at understanding the political process they are intended to influence.[22, 32]

1.3 Rationale for the thesis

A need to capture how priorities in health actually emerge in LMICs

Several public health scholars have suggested that current attempts to improve priority setting in LMICs are putting the cart before the horse. They argue that these efforts, mostly driven by the World Bank and World Health Organization, have tried to alter the input (by providing new evidence on which to base decisions) in the hope of achieving the right output (priorities that maximize health gain), all the while knowing very little about the existing process by which national priorities in health are determined. These authors assert that efforts to improve the uptake of research evidence in resource allocation decisions in LMICs should begin with robust understandings of how priorities are currently set in practice.[38, 41, 42]

Indeed, Martin and Singer caution that "[a]ny model of priority setting that is not empirically grounded may not make sense to those it concerns, and consequently interventions generated from such a model may be impractical".[42] Understanding how these governments allocate scarce resources for health necessitates a look at the process concealed in the black box that transforms policy inputs into outputs—a process that is deeply political. Yet rigorous empirical studies of the factors that influence macro-level priority setting in LMICs are limited.[22, 43]

Opening the black box of macro-level priority setting in Barbados

This thesis seeks to open up the black box of priority setting in health at the macro-level in the small island of Barbados. Barbados provides an excellent setting for this research. Firstly, since its independence from Great Britain in 1966, Barbados has been distinguished by its high-degree of economic and political stability.[44] Secondly, the country has achieved considerable gains in health and development, and the government has invested heavily in the health sector, over the last half-century [45-47] Lastly, its small geographical size and population of less than 300,000 mean that the number of actors involved in making or influencing a given policy is relatively small. In such a setting, connections between various actors and between actors and outcomes are often much more clear than in larger contexts that are marked by much larger and more complex networks of policy actors. To the extent that the challenges faced by health policy makers in Barbados are similar to those faced by their counterparts in other middle and lower-income countries, the case of Barbados serves as a microcosm through which the nature of national-level resource allocation in health can be closely studied.

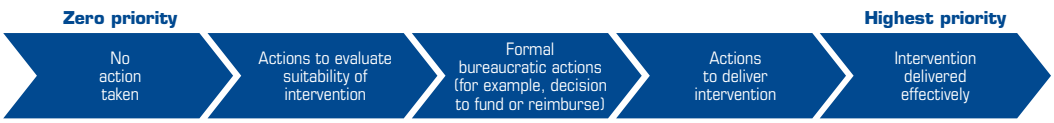
1.4 Defining priority

Before I go any further, it is important to define the dependent variable being explored throughout this thesis. The American Heritage Dictionary (2004) defines priority as "an authoritative rating that establishes precedence, by order of importance or urgency (sic)".[48] [ii] However, while priority may seem to be a relatively simple concept, because prioritization decisions are often made implicitly, defining priority in practice is less straightforward. Providing a functional definition, Shiffman suggests that we can say that priority is present for an issue when: national leaders proclaim their concern or support publicly and privately, policies are enacted to address it, and adequate funds from public budgets are allocated towards it[49]. Similarly, in a recent report by the Center for Global Development's on priority setting institutions for health in LMICs, the authors define priority as follows:

> "In a practical sense…priority is often revealed by action and actual spending choices. Over any time span, some things are done and others are not; one reasonable distinction between these two groups would recognize the former as prioritized in some way over the latter."[3]

The authors of this report suggest that all health interventions or issues, within a given context, exist along a spectrum of relative priority ranging from zero, where no action is being taken, to highest priority, when policies or interventions to address the issue are being delivered effectively (See Figure 1.1 below).

Figure 1.1: A spectrum of relative priority of interventions based on actions



Source: Glassman and Chalkidou (2012)[3]

[ii] Glassman and Chalkidou (2012) also draw on this definition in their report on building institutions to inform priority setting in health in LMICs[3]

Like these authors, I share the assertion that national priorities in health are detectable in the actions of government. Among the most measurable and influential of these is the public budget—what Aaron Wildavsky referred to as "the most operational expression of national priorities in the public sector."[50] While it is true that money is not the only scarce resource that must be allocated by governments, it is well known that this is often critical for action. Furthermore, a look at changes in government spending patterns can reveal priorities that are not publicly articulated by decision-makers. This thesis therefore relies on budgetary analysis as a primary means of selecting the case studies explored in Chapters 4-6.

1.5 Aims of thesis

The aim of this thesis is to explore how national priorities in health are set in Barbados, through budgetary analysis and qualitative case studies of policy making in three areas—primary health care, sanitation, and HIV/AIDS. In particular, I hope to examine the role and nature of evidence used in the prioritization process. In order to do so, the research is necessarily interdisciplinary, drawing from the fields of public health and politics, and focuses on the key elements of *process* and *power* in exploring how health policy priorities emerge in a national context. Ultimately, I hope that this research will add to the limited empirical literature on the nature of macro-level priority setting in LMICs more generally.

1.6 Structure of thesis

In this chapter, I have given a brief introduction to the challenge of setting priorities in health in LMICs and have argued that there is a pressing need to understand how priorities are set in practice.

Chapter 2 provides a brief review of the small body of empirical literature on national-level priority setting in health in LMICs. I identify and evaluate four unidimensional hypotheses that are ubiquitous in the literature, and find that these do not provide adequate explanations of the empirical reality. I then discuss a number of methodological and conceptual weaknesses that help to explain why more robust, empirically grounded explanations of priority setting in LMICs have not surfaced, before discussing the handful of studies that provide thicker, more rigorous accounts. I conclude by identifying three gaps in the literature, to which this thesis hopes to make a contribution—greater understanding of the relationship between evidence and ideas, of how global and domestic forces interact in the prioritisation process, and of who the principle domestic actors are and how they wield influence over the resource allocation decisions.

Chapter 3 details my research methods and presents a brief description on Barbados' health policy context. I begin the first part of this chapter with a discussion of the methodological concepts that have driven my overall approach to this thesis. I go on to describe my methods of case selection, data collection, and data analysis. Finally, I discuss several challenges related to the reliability and validity, and highlight a few ethical considerations. In the second part of this chapter, I briefly survey Barbados' health policy context, painting the backdrop for the remaining chapters of the thesis. I describe the evolution of Barbados' health care system—its historical roots, current structure, scope of service provision, financing mechanisms and the role of non-state actors.

Chapters 4, 5 and 6 present three cases studies of the emergence of political priority for health (care) issues. Instead of taking a snapshot view of priority, I look at the status of priority over longer-term horizons, tracing the historical evolution of public policy to ensure access to primary health care, improve sanitation and most recently, to address HIV/AIDS.

Chapter 4 charts Barbados' progression from laggard to a leader, among the islands of the English-speaking Caribbean, in terms of public investment in primary health care

between 1950 and 2000. In doing so, the chapter focuses on two periods of increasing priority. First, it discusses the factors that led to the establishment of the country's first three primary health care centres between 1953-1957. Then, it explores the renewed emphasis on primary health care that began to emerge in 1975 and which led to increased investment in primary health care infrastructure and a widened array of primary-level services offered by the state. However, failed attempts at mobilizing resources for primary health care prior to 1950 and a lull in priority status between 1963 and 1975 are instructive as well. In this chapter PHC advocates, working in coalition with powerful authoritative decision-makers, appear to be at the centre of explanations of why and how priority emerges, declines or fails to materialize altogether.

Chapter 5 begins by describing the absence of priority for sanitation for more than a century after a devastating cholera epidemic. I then explain how the work of international organizations, along with fetid conditions in the capital city due to poor sewage disposal, contributed to mounting attention for sanitation during the 1960s. Then, focusing on financing for municipal sewage systems, the chapter then traces the role of technocrats in helping to move sanitation up on the domestic agenda between 1975 and 2002. Again, these domestic policy advocates emerge as key protagonists, linking sanitation to the highly salient issue of tourism, to successfully mobilize resources. However, despite their key role in driving the priority setting process, in this case, that they do not single-handedly determine the outcomes. External financing and the impact of previous policy on the context in which subsequent priority generation efforts take place are other key factors (though not decisive ones) that affect the likelihood that priority will emerge.

Chapter 6 traces priority for HIV/AIDS in Barbados from 1984 to the present. Two very different policy actors appear to be key drivers of priority at various points in this case. First, in explaining the emergence of the government's response a civil society leader appears to be critical. Then, in explaining what seems like the unlikely rise of HIV to the top of the government agenda at the turn of the 21st century, an appointed politician appears

to be the driver. Despite holding different positions in society, these actors share several characteristics. They both leverage authority accorded to them (either because of their expertise or political positioning) and their personal connections to (other) powerful authoritative decision-makers, in order to influence resource allocation. This chapter describes how these actors with 'authority' and 'connections' are able to influence priority for HIV/AIDS by taking advantage of windows of opportunity in the global context, propagating powerful ideas, and generating external financial resources.

Chapter 7 consolidates the insights from the case studies presented in the three preceding chapters, drawing on relevant theory from across the policy sciences. I find that powerful domestic actors or 'policy entrepreneurs' act as necessary drivers of macro-level priority setting in Barbados, although they do not single-handedly determine the outcomes. Three other factors each appear to affect the likelihood that priority will emerge—the extent to which powerful ideas come to characterize an issue, the presence of opportunities or constraints in the wider policy context, and the availability of external financing. However, these factors do not operate in a deterministic fashion, but interact through the agency of policy entrepreneurs to shape priorities in health.

Finally, **Chapter 8** concludes the thesis. It begins by reflecting on the methodological approach and highlighting its main strengths. I then discuss several limitations, potential sources of bias, and consider what scope for generalizability exists. I then go on to consider the thesis' contribution to the gaps in the literature identified in Chapter 2, before discussing the implications of my findings for influencing and improving priority setting in Barbados and further afield. Finally, I close by reflecting on the prospects for future research on macro-level priority setting in Barbados and elsewhere.

Chapter 2

A review of empirical perspectives on macro-level priority setting in LMICs

2.1 Searching for insights on why governments choose to do some things and not others

This chapter begins by placing this literature review within the broader context of scholarly work about prioritization decisions and policy change more broadly. I then define the scope of the review. I go on to evaluate four unidimensional hypotheses about how priorities in health are set in LMICs, which are prevalent in the health policy analysis literature. Later I turn to the smaller number of studies that offer more robust, multi-factor explanations of macro-level priority setting, paying special attention to what differentiates this work from the rest. Finally, I identify several gaps in the existing literature, which the remainder of thesis seeks to address.

The policy sciences—a starting point

The study of "what governments do, why they do it, and what difference it makes"[51 (p.1)], has been at the heart of the policy sciences since its emergence as a distinct field in the 1950s. Lasswell, widely acknowledged as the father of this field, described the function of policy analysis as "concerned with explaining the policy making and policy-executing process, and locating data and providing interpretations which are relevant to the policy problems of a given period."[52 (p.14)] Work in this field is characterized as being multi-method, problem-oriented, contextual, and multi-disciplinary.[53] More than a half-century later, the associated body of theoretical and empirical scholarly work, which seeks to understand the factors that influence what governments choose to do and what they choose to neglect, why and how, is incredibly vast—spanning several sub-fields of political

science, public administration, economics, political economy, and sociology.[7, 53] The sheer volume of perspectives offered by this work, make narrowing the scope of this literature review an unavoidable task.

Box 1.1: Approaches to studying public policy

- **Political science:** emphasis on the process by which policy decisions are made
- **Public administration:** emphasis on the role of bureaucracy in shaping policy and implementing decisions, theoretical and empirical work on public budgeting.
- **Political economy:** emphasis on how the political and economic context shape the incentives faced by actors (either policy elites or interest groups), decision-making and policy outcomes
- **Economics:** emphasis on concepts such as scarcity of resources, rationality, evidence, cost/benefits, maximization, and specific economic policies
- **Sociology:** emphasis on class, status, and social problems

Sources: Potucek and LeLoup (2003); Grindle and Thomas (1989)[7, 8]

Narrowing the scope

Given that this thesis is primarily concerned with understanding how priorities in health are set at the macro-level in LMICs, I have chosen to narrow the focus of my literature review accordingly. The studies reviewed here have been limited to published articles that consider the policy process at the macro-level in LMICs. This includes articles that capture priority setting or agenda setting processes, as well as several that consider the factors influencing health policy change or reform more broadly. Also, given my emphasis on understanding how priorities are actually set in practice, I have limited the articles reviewed here to those that present empirical analyses of prioritisation processes or policy change and have excluded pieces that are mainly conceptual in thrust.

Finally, the articles reviewed were limited to those available in English and those published between 1994 and December 2010 (when this review was conducted). The choice to look at articles since 1994, was influenced by the fact that a pioneering article calling for analyses of health policy in LMICs that went beyond the consideration of technical content to exploring the concepts of politics, process and power, was published in this year.[54] This

article by Walt and Gilson, and the work of Gill Walt in particular, has been credited with stimulating the health policy analysis in LMICs—a field that had not been well-established prior to this time (See Box 2, below).[43, 55].

Box 1.2: Criteria for studies reviewed

The studies explored here:

1. Focus on health;
2. Are set in one or more low- or middle-income countries;
3. Consider the prioritisation processes, priority setting or the factors influencing policy change (more broadly) at the macro-level;
4. Are predominantly empirical, not conceptual;
5. Were published after 1994;
6. Were published in English.

In 2008, Gilson and Raphaely published findings of a systematic review of the health policy analysis literature on LMICs since 1994.[43] A small subset of this work has explored policy change or prioritization in health at the national level. In the remainder of this chapter I draw heavily on this systematic review, along with my own search of the literature, which incorporates articles up to December 2010. (See Appendix 2.1 and 2.2 for the search terms used in my own literature search, as well as those used by Gilson and Raphaely). For the purpose of this thesis, it was not necessary to conduct a systematic review of the literature as my primary goal was simply to sketch the main contributions that have been made and the gaps that persist.

Notably, the wider theoretical literature from the policy sciences is not reviewed here because, although often grounded in rigorous empirical work, much of this work has been undertaken in high-income countries—principally in the United States (U.S.), where the field has its earliest roots.[3] Pointing out that Kingdon's widely used model of agenda setting has its roots in the pluralistic and fragmented landscape of American politics[57], Buse (2008) suggests the theories that emerge from such empirical work "do not travel particularly well".[58] Indeed, as highlighted in Chapter 1, there are sharp divergences

[3] One note-worthy exception is the work of Grindle and Thomas (1991)[56] whose work on the political economy of reform is focused specifically on developing countries, and includes a case study of the health sector in Mali.

between the policy context in high-income countries and that in LMICs. Generalising about LMICs, Grindle and Thomas (1991)[56] describe a context marked by a greater deal of uncertainty due to a lack of information for policy-making, the centralized nature of decision-making structures, and major economic and social development challenges. Others have also pointed to the degree of political patronage that characterizes political systems in LMICs and the significant (and growing) influence of external actors, such as foreign donors.[22, 58, 59] Acknowledging that the broader policy analysis literature has paid relatively little attention to the health sector and to LMICs, Walt et al. (2008) point out that while "much of the theory from policy analysis in high income countries has resonance for health in developing countries… transferring such concepts needs to be undertaken with caution."[60] Indeed, rich empirical knowledge of the nature of macro-level priority setting in health in LMICs, which considers the inherently political nature of the resource allocation process, is a necessary input to wading through the diverse and vast theoretical terrain.

Policy analysis of macro-level priority setting in LMICs

Although there is a growing body of literature that aims to capture the empirical reality of the health policy process in LMICs, only a very small subset of this work presents accounts of macro-level agenda/priority setting in LMICs. Examples of such work include a collection of case studies and a comparative piece on priority for safe motherhood in Guatemala, Honduras, India, Indonesia, and Nigeria by the same author[6, 61-65], a piece looking at the factors affecting priority for new-born survival in Nepal over time[66], an article on the politics of priority setting comparing priority for breast and cervical cancers in Nigeria[23], and prospective analysis of how national nutrition policy advanced over a two-year period in Vietnam[67]. In general, as Gilson and Raphaely note, most policy analysis articles failed to identify their work as addressing a specific phase of the policy process (for example, agenda setting, policy formulation, or implementation). However, several other

studies are instructive for understanding macro-level priority settings in LMICs. Most of these articles evaluated specific hypothesis regarding the factors that influence macro-level priorities (for example, the role of political leadership, civil society, or international actors in accounting for policy change)[68-72].

Other relevant work includes, articles that address the politics of policy change more generally (for example, a brief piece on the factors that have shaped Brazil's successful HIV response, and a more analytical piece comparing three instances of reforms and draws lessons about the changing process and politics of health policy in Korea), or that consider the factors influencing the presence or absence of global priority for health issues (for example, articles on the emergence of attention for new-born survival and communicable diseases and a theoretical piece proposing an explanation for why some issues ascend on the global health agenda by the same author[73-75]).

Although empirical studies that explicitly consider macro-level priority setting in LMICs are minimal, the relevant studies that exist cover a wide range of health issues and country contexts—from HIV to nutrition, and from sub-Saharan Africa to Southeast Asia. In this chapter, I first focus on highlighting key points of convergence in this body of literature. Much of the research on national-level priority setting in health in LMICs has been centred on a number of unidimensional hypotheses. I will evaluate the evidence to support four of these hypotheses, which are particularly prominent in the literature. I then turn my attention to the very small number of studies that offer more complex, multi-dimensional explanations of how priorities emerge. Where there have been more robust explanations, attention is given to what methodological, analytical and design factors might have contributed to this. The chapter concludes with a discussion of the contribution this thesis hopes to make, within the context of the gaps that persist in empirical understandings of how national priorities are set in LMICs.

2.2 Exploring four prominent (but uni-dimensional) hypotheses

In surveying the health policy analysis literature in LMICs, I have found that four factors are repeatedly used to explain the emergence of priority for health issues, and policy change more generally:

1. The availability of evidence (either of disease severity and/or the cost-effectiveness of solutions to address it)
2. The presence of political champions
3. The influence of foreign donors
4. The impact of civil society pressure

Other factors, which have featured in the wider policy analysis literature or in analyses of health policy change in high-income countries—such as the agenda-setting power of the media or the role of health care professional associations—are not discussed here simply because they have been given little or no attention by analysts of health policy in LMICs.

These four explanations are treated as hypotheses. This is because I find that generally, the empirical evidence and theoretical basis to substantiate them is limited. Also, many of the supporting studies lack methodological and analytical rigour. The degree of support for each of these is explored and evaluated in Sections 2.2.1 to 2.2.4.

2.2.1 Priorities are based on careful consideration of epidemiological or cost-effectiveness evidence

One claim put forth in the literature is that priorities are (and indeed should be) determined in a 'rational' way. In the field of public health this is generally thought to mean that policy makers determine priorities through a systematic consideration of epidemiological and economic evidence i.e. via an 'evidence-based' process. For example, Claeson and Alexander (2008)[76] describe how evidence from HIV surveillance sites, a

national population-based health survey and a large cross-sectional study on HIV risk-behaviours was used to guide policy-making in India. The authors describe a strictly rational process in which Indian decision-makers invested in collecting data, used the data to understand how the disease was spread, and then employed that knowledge to inform public planning and budgeting. Similarly Kapiriri and Martin (2007)[77], report that the government of Uganda used Burden of Disease data to determine what should be included in the country's essential health care package and then sought to prioritize the most cost-effective interventions in allocating very scarce resources for health.

While empirical studies that describe a strictly rational approach are rare, many of the articles reviewed did note the importance of evidence, regarding the severity of problems and the costs and benefits of alternative strategies to address them, in shaping health policy decision-making.[6, 49, 64, 75, 78, 79] For example, Shiffman (2007)[6] points out the consistent importance of "credible indicators", as one of several factors that shape political priority for reducing maternal mortality in five developing countries. Similarly, Crichton (2008)[80] points to the catalytic effects of a national demographic and health survey, which drew policy makers' attention to a discontinuation in declining fertility rates and reductions in access to and use of contraception, as one in a constellation of factors that led to the re-prioritization of family planning in Kenya.

Yet other studies have illustrated that often evidence is not consistently adhered to and that, even when it is available, it is sometimes ignored altogether.[23, 81, 82] For example, although several analyses of the development of HIV policy in Thailand have pointed to the role and consideration of epidemiological and cost-effectiveness evidence in catalysing the government's response[83, 84], Tantivess and Walt (2006)[82] describe the piecemeal reliance on evidence from CEAs over the course of the history of the epidemic in Thailand. In particular, they suggest that while local evidence that ARVs were not cost effective was critical in explaining the termination of the government's fledgling treatment programme in 1996, this evidence was ignored in 2001 when the Thai government decided to provide

universal coverage of ARVs. They contend that this divergence from the evidence reflected decision-makers' consideration of several other factors, including political and ethical considerations, and note that escalating program costs in a time of financial difficulty (and not necessarily evidence) may also explain the decision to terminate the program in 1996.[82] Also, exploring priority for breast and cervical cancer in Ghana over a 7-year period, Reichenbach (2003)[23] shows that breast cancer received greater attention, in spite of epidemiological and economic evidence that showed that there was a higher burden of disease due to cervical cancer and that this was more cost-effective to screen for and treat. Like Tantivess and Walt[82], she suggests that policy makers stray from prescribed approaches to priority-setting and are influenced by other factors that are not accounted for in rational models.[23]

This variability in the use and influence of evidence has led several scholars to consider the factors that determine the impact or uptake of evidence. In a detailed case study on the factors affecting support for the implementation of the Ghanaian National Health Insurance Scheme, Ageyong and Adei (2008)[85] conclude that:

> "…although [the] availability of evidence is critical, major public social policy and programme content can be heavily influenced by factors other than the availability or non-availability of evidence to inform content decision making….Without an analysis and understanding of the politics of reform and how to work within it, researchers and other technical actors may find their information to support reform is not applied effectively".[85]

Similarly, in a case study of the emergence of priority for mental health in Vietnam, Harpham and Tuan (2006)[86] find that evidence of the severity of mental illness nationally was successful in influencing policy action. They report that the fact that the studies were methodologically sound, there were no conflicting findings and that the results were communicated effectively, underscored this success. However, they conclude that other factors (beyond the nature of the evidence itself) were important as well and state:

> "Nonetheless the policy process was influenced by the evidence from research because key links between organizations and policy-

> makers were established at an early stage, the evidence was regarded as rigorous and the timing was opportune."[86]

2.2.2 Policy champions are essential if priority is to be achieved

Some authors have reported on the central role of policy 'entrepreneurs', 'elites' or 'champions' in accounting for policy change.[6, 63, 80] Others refer to the critical importance of political 'will', 'leadership' or 'commitment' at the highest levels of government.[87-91] The idea that influential individuals, with insider knowledge of the government, are needed in order to successfully elevate a problem or policy to the top of a government's agenda for action, is perhaps one of the most commonly cited factors in explaining macro-level priority setting in LMICs.

According to the literature, policy champions may be elected officials (e.g. Presidents, or Members of Parliament), non-elected officials appointed to positions of leadership by the political directorate (e.g. directors of special government programs and agencies), or civil servants, for whom a policy issue becomes a personal priority and who advocate for its elevation to the agenda for action over a sustained period of time. Although the literature focuses mostly on actors from within the state apparatus, in some cases civil society leaders who come to wield influence over the policy process are also defined in this way. These individuals may talk about a particular health issue publicly and often, stand at the forefront of policy initiation or formulation, or make the case for the allocation of public resources to address the issue, even in the face of opposition from within or outside of government. They are persistent in pushing for change. They are politically savvy and often are able to deliver rousing and passionate speeches on the issue. On a whole, they are thought to play critical roles in navigating a policy proposal or reform through the policy process.[6, 92, 93]

In his article comparing political priority for reducing maternal mortality in Guatemala, Honduras, India, Indonesia and Nigeria, Shiffman cites the existence of high-level political leadership as critical to explaining higher success in Indonesia. The champion in this case was the assistant Minister of Women's Roles, who Shiffman says "single-handedly convinced" the President to take action and who worked to ensure the allocation of additional resources for addressing the issue through the budgetary process.[49]

The definitive role played by President Museveni in leading a sustained and effective government response to HIV/AIDS in Uganda has also been widely acknowledged.[68, 88, 94] President Museveni moved the administration of the Uganda AIDS Commission to the Office of the President, using the visibility and power of the highest office in government to establish priority for HIV and ensure the allocation of resources to this problem. In addition he marshalled awareness campaigns and spoke publically about disease. As a result of his action, Uganda led the African continent (and indeed much of the developing world) in launching an early response to the epidemic. The effect was significant declines in HIV prevalence over the course of a decade.[68] Others have also attributed successful government responses to HIV/AIDS in Thailand and Brazil to the existence of high profile political leadership.[82, 95-97] Similarly, where governments have failed to act decisively to address the epidemic, this is often attributed to the lack of political will or the absence of sustained leadership.[68, 84, 87, 88, 90, 93, 94, 98]

Despite its ubiquitous use in explaining policy change and inertia, attempts to establish evidence for the centrality of political leadership to policy change have been largely based on anecdotal evidence. Indeed, claims of the necessity of policy champions, in the absence of evidence to substantiate them, are quite commonplace. For example, in their paper on priority for malaria in Tanzania, Makundi et al. conclude that "the most fundamental long-term factor in any disease program is political leadership."[92] Missing, however, are any details of how this was true in the case of malaria in Tanzania.

Pointing to the widespread use of anecdotal evidence to substantiate the importance of political leadership in explaining the success of country responses to HIV/AIDS, Nattrass (2008)[98] uses regression analysis to assess whether countries' reputations for having good or bad leadership on HIV is consistent with their performance in terms of coverage in access to ART and mother to child transmission prevention (MTCTP). Looking at 82 countries, she finds that the countries with bad leadership on HIV (such as South Africa, where high-level leaders had denied the connection between HIV and AIDS) have made less progress than warranted, when adjusting for a host of key variables. Nattrass' findings suggest that the opposite was true for countries that had displayed good leadership on HIV. However, notably the variable of interest—political leadership— is not well defined and, although she acknowledges her failure to find a credible operational proxy measure for this, it is not clear what criteria are used to categorize countries as possessing good or bad political leadership with regards to HIV policy.

The difficulty in operationalizing the concept of political/policy leadership has resulted in some questioning its analytical power in explaining the emergence of priority and policy change more generally. Grindle and Thomas call it a "catch-all culprit"[56], while Putzel refers to it as "a type of black box".[94] Reich argues that it (inaccurately) "personalizes policy change" and "ignore[s] the political constraints to policy reform".[99, 100] These critics and others point to several critical questions that remain either inadequately addressed or completely unanswered by those who view policy change through the 'political will' frame. For example: Do individuals really have the power to instigate change? If so, how does such leadership come about? Is a champion more or less likely to emerge in certain political, economic, institutional or socio-cultural contexts, or around issues with certain characteristics as opposed to others? What motivates them to act? And once on the scene, what do they do and how exactly do they do it?[88, 89, 94, 100] Despite such criticism, without a doubt, politicians and other government decision-makers are indispensible to policy change. Given the complexity and bureaucracy that is characteristic

of all activities of government, it seems reasonable that having 'insiders' to shepherd policy proposals through the system could lead to sustained action.

2.2.3 Priorities in health in developing countries are reflections of donor preferences

Between 1990 and 2007 development assistance for health has more than quadrupled, rising from US $5.6 to $21.8 billion. At the same time the actors involved in providing this assistance have expanded to include a host of new private foundations, such as the Bill and Melinda Gates Foundation, and global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, alongside traditional actors, such as the United States Agency for International Development and the World Bank.[101, 102]

Several studies point to the fact that the global distribution of development assistance for health does not generally correspond to country need, as defined by epidemiological evidence[101-103], or to priorities articulated by countries themselves.[104] Not surprisingly, these studies suggest that, like developing country governments, funder decisions are political, not 'rational'.[105] Donors often have their own agendas, or are guided by the pursuit of national security or economic interests in the case of bilateral donors.[106-108]

Scarce resources for health in many low and middle-income countries, means that many countries are highly dependent on foreign funding to meet health needs. Evidence points to the fact that funders often influence choices about national priorities, either through earmarking of aid for specific diseases[75, 109] or by tying the provision of aid to specific conditions[76, 110], but also in less explicit ways, for example through the transfer of ideas via technical capacity building[111] or by displacing government spending on health[112, 113].

In their assessment of the factors including resource allocation and equity in the Ghanaian health system, Asante and Zwi (2009) find that 'earmarked' funds from donors

constrain the ability of local district managers to make decisions about how to allocate scarce resources. This was found to be especially true when faced with public health crises.[114] Looking at the opinions of decision-makers on the allocation of resources within a national HIV/AIDS Program in Pakistan, Husain et al. found that even though most study participants did not see HIV/AIDS as a priority, the program's budget had grown exponentially (increasing by 140% between 1991 and 2004) with much of the increase funded by international donors. They report that the contribution of development assistance for health to the country's foreign exchange reserves, featured strongly in the calculus of federal actors who created the program.[109]

Even in middle-income countries where donor assistance makes up a very small proportion of spending on health, there is some evidence that the impact of donors on government decision-making is not necessarily proportional to the degree to which countries are dependent on aid.[101, 112, 115] In looking at resource allocation for health problems in Brazil, India and Russia (three relatively aid-independent middle-income countries), Sridhar and Gomez find strong evidence of donor influence on health spending in two out of three of the countries.[116] Similarly, Birn (1996)[105] describes the profound impact that the Rockefeller Foundation had on health policy in Mexico, despite providing relatively small amounts of funding. Highlighting the Foundation's influence through the provision of scholarships, she suggests that donors can have significant impacts on domestic health policy via less direct, subtler routes:

> "The Rockefeller Foundation recognised that the dozens of returned fellows were its greatest spokespersons, planners and designers of the public health system. On the federal level, new patterns of government service were cultivated, with US-trained fellows serving in important posts, flashing fancy techniques and following foreign organisational structures. Diseases were attacked one by one, using foreign knowledge and technology. Prevention and cure were separated. International standards, not Mexican needs, began to determine budgeting priorities".[105]

However, Fotlz (1994) cautions against this one-dimensional view of the relationship between donors and governments. Exploring the US government's attempt to

influence the content of health reforms in Niger and Nigeria, she points out that donors are sometimes unsuccessful in influencing the national policy agenda, even in cases where aid is conditional. She concludes that "unless strong constituencies for reform exist within the host government, reforms are unlikely to be adopted".[117] Similarly, looking at pharmaceutical policy reform in Sri Lanka, Bangladesh and the Philippines, Reich (1995) argues that domestic political variables are more consequential in determining the outcome of reform than international variables, including the World Bank.[100] More recently, in case study analyses of priority for addressing mental health in the Solomon Islands, and resource allocation for HIV/AIDS at the provincial level in South Africa, other authors have drawn similar conclusions.[118, 119] For example, Zwi et al. conclude that their work "reveals a nationally driven and internationally supported move towards mental health promotion and wellbeing".[119]

2.2.4 Priority emerges in response to pressure from civil society or transnational advocacy networks

There has been increasing focus on the central role of advocacy by non-state civic actors in accounting for the emergence of political priority. Some accounts of the emergence of priority for health issues suggest that pressure from civil society is pivotal in providing the impetus for authoritative decision-makers to address a previously neglected issue. Referring to Brazil, Thailand and South Africa, Nattrass asserts that: "Although individual leaders might demonstrate different aptitudes and commitment, ultimately they all respond to political incentives: the greater the pressure from civil society, NGOs and activists, the more likely it is that leaders will prioritise a HAART rollout."[120] Others have pointed to the role of civil society activism in catalyzing government action to provide universal access to antiretroviral therapy in Brazil and Thailand.[69, 87, 120] This has also been

identified as playing a pivotal role in the mobilization of priority for cervical cancer in South Africa[121] and breast cancer in Ghana.[23]

Zuniga defines a civil society organization as "any group of individuals that is separate from government and business".[71] In particular, accounts of political priority focus specifically on the subset of civil society groups that attempt to influence the policy process. These groups can include non-governmental organizations, churches, labour unions, professional organizations, groups of people affected by a disease or problem, or groups that advocate on behalf of those affected. Often civil society groups that share interests or values come together in the form of advocacy networks, sharing information and resources in order to promote a cause. The empirical literature suggests that these networks may be national, regional or transnational in scope and membership.

Drawing from the theoretical literature on collective action, health policy analysts have also placed some emphasis on the role of transnational advocacy networks, i.e. webs of domestic and international actors working in tandem to influence the actions of national governments and global institutions.[122] This has been particularly common in explaining political priority for HIV/AIDS. For example, Sridhar and Gomez suggest that transnational advocacy networks are particularly important in explaining the mismatch between burden of disease and priority for HIV in Russia, India and Brazil.[116] In their book on global activism around access to treatment for people living with AIDS globally, Smith and Siplon describe how U.S.-based treatment activists, in the form of the Health Global Access Project (Health GAP) worked together with the Treatment Action Campaign (TAC), a network of local and national civil society groups in South Africa, to generate political priority for universal access to AIDS drugs in South Africa.[123]

Conversely, the absence of civil society pressure or weak transnational advocacy networks have been cited as explanations for why an issue has failed to garner attention from policy makers. For example, comparing policy priority for breast and cervical cancers in Ghana, Reichenbach asserts that the absence of a mobilized constituency around cervical

cancer is reflected in its lower priority status, as compared to breast cancer.[23] Weak transnational advocacy networks, and the absence of domestic mobilized constituencies is also used to explain low priority for preventing chronic non-communicable disease in developing countries[124] and for combating maternal mortality in Nigeria.[63]

This focus on the role of civil society in setting national priorities has prompted some policy analysts to consider the conditions under which such advocacy groups and networks emerge and the factors that make some collective action efforts more effective than others.[9] The scholarship has proposed several such factors, including good leadership, coalition and network building, cohesion between actors, collective issue framing or the ability of actors to recognize and make creative use of 'windows of opportunity'.[6, 9, 121, 123]

While 'networked accounts' of the health policy, do seem to resonate with accounts of a changing health policy context in which policy makers are increasingly vulnerable to an increasingly complex array of global, regional and national processes and actors[69], some evidence suggests that advocacy networks are neither sufficient nor necessary for the emergence of political priority. In comparing the road to treatment access in Brazil and Barbados, Headley and Siplon (2006) note that, even though domestic advocacy seemed to be a salient factor in the case of Brazil, political priority for universal access to treatment emerged in Barbados in the absence of any pressure from advocacy groups.[87] Even though they ultimately assert that non-state actors played a critical role in the Thai government's decision to prioritize access to ART, Tantivess and Walt suggest their influence was limited:

> "…NGOs and PHA [People living with HIV/AIDS] had fewer resources and therefore less influence, although their ability to mobilize others was a strong source of power. In contrast, the government's authority and legitimacy to make final decisions on public policies was its most influential resource. State actors were therefore often able to dominate the policy process. The influence of health officials over civil society members could be observed at every policy stage."[69]

2.3 Moving beyond unidimensional explanations

Why these do not suffice

My review of the published literature reveals that the analysis of how health policy priorities are set in LMICs remains in a fledgling state. The number of articles that explicitly set out to study how political priority emerges is very small and most studies are found to be lacking in both methodological and analytical rigour. These observations are consistent with the findings of the systematic review of the literature analysing health policy processes in developing countries, conducted by Gilson & Raphaely in 2008, who write:

> "Examination of these articles clearly shows that LMIC health policy analysis is still in its infancy. There are only small numbers of such analyses, whilst the diversity of policy areas, topics and analytical issues that have been addressed across a large number of country settings results in a limited depth of coverage within this body of work. In addition, the majority of articles are largely descriptive in nature, limiting understanding of policy change processes within or across countries."[43]

Moreover, although I find some support for the commonly recited propositions that evidence, political champions, donors and advocacy can affect the priority given to health issues by national governments, it is clear that each of these (on their own) offers an inadequate explanation of priority setting at the national level. This is not surprising. Previous work in the field of public health, by Walt, Gilson and others, has shown policy-making in the sector to be characterized by a much more complex amalgamation of factors[54, 125, 126].

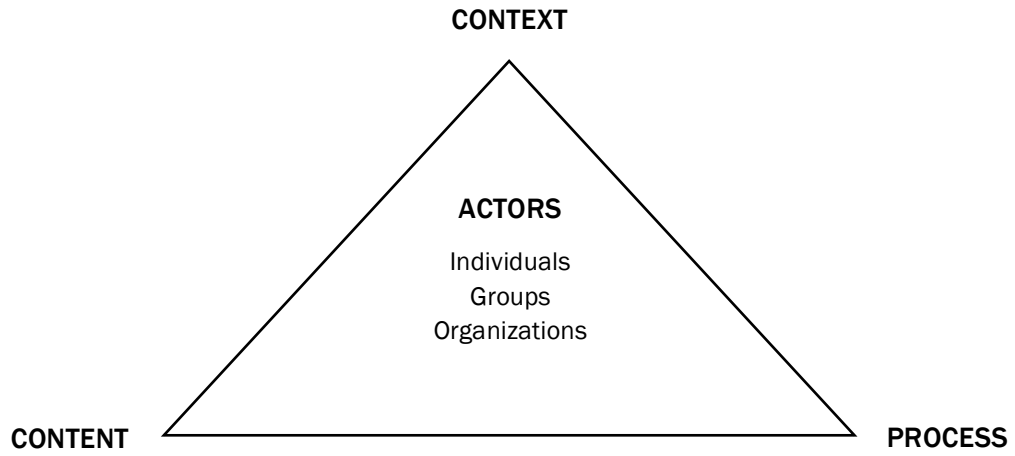
In 1994 Walt & Gilson called health policy analysts to expand the scope of their analysis, beyond the technical aspects of health policy, to include consideration of the actors involved, the processes by which policy is developed and implemented, and the context in which decisions are made. Discouraging attempts to develop 'parsimonious

models', Walt & Gilson first urged 'thick description' of the policy process and suggested that health policy making was characterized by a complex array of interrelationships:

> "In reality actors are influenced by the context within which they live and work…. Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture. The process of policy-making (how issues get on to the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions."[54]

The four categories identified by their framework (see Figure 2.1 below) suggested some initial places to look in order to begin to understand the complexity of health policy in LMICs. Almost two decades later, though it is apparent that some attempts have been made to identify key actors in the policy process, less work has focused on understanding the process by which health policies come to the attention of policy makers and how they decide what they will take authoritative action on (for example, through the allocation of resource or the creation of legislation). Also, while some studies describe the national or global political, economic and social contexts in which priority emerges, few draw links between how contextual factors influence the nature and power of actors involved and the decision-making process.

Figure 2.1: The health policy triangle



Source: Walt & Gilson (1994)[54]

Getting there: the importance of methodological and analytical rigour

A number of methodological and conceptual weaknesses, pervasive in the existing literature, might explain why more robust, empirically grounded explanations of political priority have not surfaced. Firstly, the majority of studies lack definitional and conceptual clarity of priority and attempt to discuss its determinants without addressing how one detects its presence in the first place. Secondly, authors do not explicitly outline their sources and methods of data collection. Consequently, the informed opinion of authors is often offered as fact. Also most articles consist of a single case study of a country or health initiative in which the criteria for case selection is left unclear and episodes of priority emergence (or neglect) are seemingly cherry-picked by the authors. Much of the existing work is descriptive rather than explanatory and many studies fail to set accounts of the emergence of political priority against the contextual and historical backdrops against which they occur. Finally, although a wide array of theories and frameworks (from the policy sciences and beyond) aimed at enhancing our understanding of the policy process exists, the use of such conceptual tools to guide analysis and to help explain findings is not commonplace.

These observations are similar to those made by Gilson and Raphaely[43]. In an article in the same issue, which reflects on the challenge of "doing health policy analysis", Walt et al. (2008)[60] summarize the methodological weaknesses identified in Gilson and Raphaely's systematic literature review as follows:

> "The review notes the absence of explicit conceptual frameworks, little detail on research design and methodology, and a preponderance of single case studies on particular issues. It draws attention to the limited use of relevant theory to underpin analysis and the paucity of attempts to provide an explicit, explanatory focus. As the authors say, the main question is often 'what happened', to the neglect of 'what explains what happened'. Researchers also rarely reflect on how their own positions shape their research interpretations and conclusions."[60]

Indeed Gilson and Raphaely (2008) note that only 35% of all policy analysis articles included in their review made their study design explicit. In addition, they found that less than a quarter of the articles that addressed the agenda-setting and policy formulation phases of the policy process were explanatory in nature.[43]

It is no coincidence that where attention is devoted to methodological and analytical rigour, a few 'thicker' accounts of the generation of priority for health issues in developing countries have emerged. In the best of these studies what constitutes priority status is clearly defined and/or a measure of priority is identified, primary data collection methods are employed, the authors seek to explain (and not just describe) what happened, and theory guides data analysis and grounds findings. The best of these employ a comparative approach, identifying common features of the policy process across multiple case studies, or provide an in depth analysis of a single case in order to elucidate or propose changes to an existing framework. A good example of this work is Shiffman's collection of articles on priority for addressing maternal mortality. His work presents intricate case studies, based on extensive primary data collection, in five countries Cross-country comparison and theoretical grounding, leads to the distillation of key factors and a proposed framework.[6, 61-65] This and several other 'thicker' accounts of the emergence of national (and global) priorities in health are worth discussing separately. I turn to this in the next section.

2.4 'Thicker' accounts of the emergence of priority in developing countries

A global account of the generation of political priority for health problems

Shiffman and Smith have proposed one of the most rigorous explanations of the emergence of priority thus far. Using case studies of global efforts to address maternal mortality and new-born survival, the authors develop an 11-factor framework to explain why some health issues garner more attention and resources than others. According to the

authors, each of these factors is related to one of four central categories: i) the power of actors, ii) the power of ideas, iii) the political context and iv) the technical characteristics of the issue itself. Here the central actors are 'policy communities', which Shiffman defines as "networks of individuals (including researchers, advocates, policy-makers, and technical officials) and organizations (including governments, non-governmental organizations, United Nations agencies, foundations and donor agencies) that share a concern for a particular issue"[73]. See Table 2.1 for the complete framework.

Subsequently, both authors have identified their failure to theoretically ground these factors as a weakness of their framework. In particular, they have drawn upon social construction and collective action theory to explain the empirical reality of how the various categories and factors in the framework interact.[66, 73] This framework has also been used by Shiffman to analyse global priority for new-born survival, and work is currently under way by a research group to apply it to investigating the factors that determine the emergence of priority status for health issues at the national level in Bangladesh, Bolivia, Malawi and Nepal.[66]

Table 2.1: Framework on determinants of political priority for global health initiatives

Category	Description	Factors shaping political priority
Actor power	The strength of the individuals and organizations concerned with the issue	1. *Policy community cohesion:* The degree of coalescence among the network of individuals and organizations centrally involved with the issue 2. *Leadership:* The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause 3. *Guiding institutions:* The effectiveness of organizations or coordinating mechanisms with a mandate to lead the initiative 4. *Civil society mobilization:* The extent to which grassroots organizations have mobilized to press political authorities to address the issue
Ideas	The ways in which actors understand and portray the issue	5. *Internal frame:* The degree to which the policy community agrees on the definition of, causes of and solutions to the problem 6. *External frame:* Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	7. *Policy windows:* Political moments when conditions align favourably for an issue, presenting opportunities for advocates to influence decision makers 8. *Governance structure:* The degree to which norms and institutions operating in a sector provide a platform for effective collective action.
Issue characteristics	Features of the problem	9. *Credible indicators:* Clear measures that demonstrate the severity of the problem and that can be used to monitor progress 10. *Severity:* The size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11. *Effective interventions:* The extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement, and inexpensive.

Source: Shiffman & Smith (2007)[9]

The first published result of this effort has been an article on the emergence of priority for new-born survival in Nepal, beginning in the year 2000, by Smith & Neupane.

Though, Smith & Neupane (2011) [66] acknowledge that the process at the global level is likely to look somewhat different to that at the national level, they conclude that their findings are largely consistent with the key categories of influential factors proposed in Shiffman & Smith's framework. Most notably, however, the authors critique the focus on policy communities as "the central creators and disseminators of ideational messages".[66] In the case of Nepal they find that sometimes ideas that originate outside the policy community can be pivotal in generating priority.

Accounts at the national-level

At the national-level, based on case studies of political priority for safe-motherhood in five developing countries, conducted between 2003 and 2007[61-65], Shiffman proposed a framework of nine factors that influenced (positively or negatively) the priority status of efforts to reduce maternal mortality in Guatemala, Honduras, India, Indonesia and Nigeria. He groups these factors into three main categories: i) transnational influence, ii) domestic advocacy, and iii) national political environment. These are described in more detail in Table 2.2.

Table 2.2: Factors influencing priority for safe motherhood in Guatemala, Honduras, India, Indonesia, and Nigeria

Category	Factor	Description
Transnational influence	Norm promotion	Efforts by international agencies to establish a global norm concerning the unacceptability of maternal death
	Resource provision	The offer of financial and technical resources by international agencies to address maternal mortality
Domestic advocacy	Policy community cohesion	The degree to which national safe motherhood promoters coalesced as a political force pushing the government to act
	Political entrepreneurship	The presence of respected and capable national political champions willing to promote the cause
	Credible indicators	The availability and strategic deployment of evidence to demonstrate the presence of a maternal mortality problem
	Focusing events	The organization of forums to generate national attention for the cause
National political environment	Clear policy alternatives	The availability of clear policy alternatives to demonstrate to political leaders that the problem is surmountable
	Political transitions	Political changes, such as democratization that positively or adversely affect prospects for safe motherhood promotion
	Competing health priorities	Priority for other health causes that divert policymaker attention away from maternal mortality reduction

Source: Shiffman (2007)[6]

Again Shiffman suggests that the protagonists in the story are 'policy communities' and he places great emphasis on the role of international factors, such as donor funding.

However, unlike his explanation of political priority for global health initiatives, this framework lacks theoretical grounding.

Using burden of disease data (in the form of age-standardized DALYs), reports from governments and multilateral organizations, and expert interviews, Sridhar and Gomez suggest that the emergence of political priority for HIV/AIDS in Brazil and India, but not Russia, can be explained by number of factors acting simultaneously from above, below and within the state.[116] 'Above' or 'top-down' factors include the availability of external funding, incentives to act on certain issues fuelled by attention from the media and philanthropic organizations, and the nature of the government's relationship with multilateral health (and other related) institutions. 'Below' factors result from civil society pressure or activism. Factors from 'within' the state include the nature of electoral politics, the relationship between relevant ministries, and the nature of bureaucratic incentives. Gomez and Sridhar also suggest that transnational advocacy networks and the action of private actors such as pharmaceutical companies can play crosscutting roles.[116]

Comparing three cases of pharmaceutical policy reform, in Sri Lanka, Bangladesh and the Philippines, Reich (1995)[100] proposes that political priority for a health initiative is most likely to emerge when policy makers or policy advocates: 1) draw on widely held values to justify the policy or reform, 2) do not threaten to alienate powerful groups in society, 3) are proactive in managing group competition by using bargaining tactics to optimize support and minimize opposition, 4) take advantage of windows of opportunities, such as national elections, economic crises, or natural disasters, and 5) do not propose a policy that poses a threat to the stability of the ruling regime (or is perceived as such by the political elite), recognizing that political leaders will oppose proposals that undermine their political self-interest.

In their review of 28 peer-reviewed articles, providing empirical accounts of changes in national HIV policy in developing countries, Dickinson and Buse (2008)[127] find

support for John's (1998)[128] proposition that institutions, ideas and interests are critical in explaining policy change. In an editorial with Sidibé, they say:

> "Policy emerges through interactions among institutions (the structures and rules which shape how decisions are made), ideas (which include not only evidence by also the way that problems and solutions are framed – often based on underlying values and training) and interests (groups and individuals who stand to win or lose from change)."[129]

According to these authors, the evidence suggests that instructional factors include the nature of the regime, the degree of centralization, the creation and nature of the institutions created to address the issue, the existing structure and capacity of the health care system, as well as religion or professional organizations and societal norms and values. They also find significant support for the importance of evidence, argument and ideas in the development of HIV policies. For example, while epidemiological evidence was often influential, they found that ideas about who was most at risk and moral values about sexual behaviour were also powerful influences on decision-making. Their review also revealed that included among the interests and incentives facing decision-makers, were upcoming elections, other powerful lobbies or stakeholders (e.g. the pharmaceutical industry), perceived threats to the workforce or economy, and their standing in the global arena.[127, 129]

Finally, in an interesting cross-country, qualitative analysis of why there is low priority for mental health in four African countries, Bird et al. (2011)[130] ground their findings in the model put forward by Hall et al. (1975)[131], which stresses legitimacy, feasibility and support as key elements of achieving policy change. Applying this framework, the authors identify nine important factors, including appreciation of the severity and prevalence of the problem, the knowledge of appropriate interventions, competing priorities, the absence of advocacy. Here there is a great deal of overlap with Shiffman's findings presented in Table 2.2 above.[130]

2.5 Minding the gaps

My review of the literature has revealed that policy analysis of macro-level priority setting in LMICs is still in its infancy and thus perhaps the most significant and most obvious observation of all is the need for more robust, empirically-based, theoretically grounded work in this area. However, surveying the small body of work on the factors influencing prioritization decision and policy change at the national level in LMICs reveals three important gaps in our current knowledge to which I hope this thesis will contribute.

First, the literature provides both an empirical and theoretical basis for thinking more seriously about the role of evidence and ideas in public policy decision-making, yet it generally fails to consider how these two factors are related. Secondly, it affirms the importance of global and transnational forces in the health policy processes of LMICs, but reveals the absence of an empirical basis for understanding exactly how these forces interact with domestic factors. And thirdly, while the literature suggests that domestic actors can and do play defining roles in determining national priorities in health, there is a lack of consensus on *who* these central actors are.

2.5.1 The role of ideas, argument and evidence

Thicker accounts of the macro-level priority setting have suggested that ideational factors are critical in explaining why some health issues receive policy makers' attention and government resources and others do not. A few of these scholars have further pointed to the relationship between ideas and evidence in the theoretical literature. For example, Buse et al. define *ideas* as encapsulating both evidence and "the way that problems and solutions are framed".[129] Similarly, drawing on social constructivist theory, Smith and Neupane (2011)[66] challenge the concept of 'issue characteristics' or 'credible indicators' as being

distinct from other ideational factors in Shiffman and Smith's original framework (See Table 2.1), asserting that:

> "We interpret the material conditions of problems, such as mortality and morbidity levels, through lenses of social norms and culture and that this shapes the behaviour of policy actors…. Theoretical grounding in social construction leads us to analyse issue characteristics (focusing on material conditions of problems) in terms of their ideational power to affect priority generation."[66]

These scholars suggest a shift in the way we conceptualize evidence. Yet, several questions remain unanswered by the empirical analyses of macro-level priority setting in health. For example: How is evidence related to ideas about a policy problem or solution? What makes some ideas more powerful than others? How is the constellation of ideational factors that are salient in a policy decision, related to the power of actors, the processes by which decisions are made, the institutional, political or economic context? Indeed if evidence is not distinct from ideas, as Smith and Neupane suggest, then answering such questions should contribute to our understanding of how to improve the use of evidence in health policy decision-making.

Furthermore, in the health policy literature, evidence is often narrowly understood to be 'research evidence'. However, Black (2001)[102] suggests that policy makers might define evidence more broadly to include expert opinion, personal experience, and anecdotal or localized accounts of the effects of problems and solutions. This literature review indicates that little is known about the constellation of evidential sources that influence decision-making in LMICs. Consequently, in my data collection and analysis for this thesis (described in the next chapter) I have paid particular attention to the nature of 'evidence' used in health policy decision-making, the relationship between evidence and the dominant ideas that frame each policy problem and/or solution, and to the factors that shape an ideas power to motivate action.

2.5.2 The nexus between the global and national arenas

While more robust accounts of macro-level priority setting in LMICs do not entirely attribute priorities to the whims of foreign donors, almost all of them do point to the importance of international actors[6, 116, 127]. However, most of these fail to address under what circumstances, to what extent, and how, these actors are able to wield influence over domestic prioritisation decisions. In one of a handful of exceptions to this, Sridhar & Gomez's (2011) identify a number of factors that could explain differences in the effect of donor priorities on resource allocation patterns in Brazil, India and Russia. These include the degree of closeness between the government and relevant multilateral agencies, and domestic political interests in conforming to global agendas to amass "international popularity" or for other diplomatic ends[116]. However, these are presented as hypotheses, in the absence of empirical evidence. Furthermore, several other studies have asserted that domestic factors are more important in accounting for health priorities, even where powerful international actors (such as donors and pharmaceutical companies) seek to influence decision-making[100, 117].

In surveying the literature it is clear how little is known about how international influences interact with domestic factors. Other scholars have acknowledged this gap as well. For example, Sridhar and Gomez (2001) state that:

> "…more attention needs to be paid to the role that the international community plays in shaping domestic policy through identifying the various stakeholders and better understanding how they negotiate and interact."

Similarly, Smith and Neupane state that:

> "[we] need to understand, for instance, how transnational (compared to local) policy communities, donor (versus national) priorities, and shared (or divergent) ideas about health problems matter for political priority generation and impacts."

In each of the case studies presented in this thesis, this is a recurrent question. Detailed historical accounts of macro-level priority setting, based on rich qualitative data,

allow for the analysis of the relative influence of international and domestic factors, and the relationship between them.

2.5.3 Identifying the central domestic actors—Who are they? What are their defining attributes? How do they wield influence?

Most empirical accounts of macro-level priority setting in LMICs identify either individual or groups of domestic policy elites as playing central roles in the process. For example, many scholars place emphasis on the role of individual policy entrepreneurs, political champions, or high-level political leaders in generating priority for health problems. On the other hand, some scholars argue that such accounts unduly personalize policy change and still others point to policy communities or networks instead. Some studies emphasize the importance of authoritative decision-makers, while others present accounts of actors, on the outside of government, as driving policy change (See Section 2.2.2).

However, in general there seems to be a lack of consensus around exactly who these actors are. Furthermore, little is known about their defining attributes (for example, whether they are more likely to be found on the inside or outside of government), the tactics they use to influence resource allocation, and the factors that determine their degree of influence. There is also much debate over to what extent (if at all) they can be said to drive the prioritization process. A number of authors have highlighted this need to better understand domestic policy actors. For example, seeing authoritative decision-makers as the principle actors, Grindle and Thomas (1991)[56] state:

> "We believe decision makers are not simply forced by events, interest group pressures, or external agencies to make particular choices; generally they have a significant range of options in the management of public problems—including at times the option of not address them... [I]f they are not simply forced to act in predetermined ways or have no choice but to accept certain courses of action—then the dilemmas and choices they confront are critical to understanding policy change."

This statement could well apply to the full constellation of domestic protagonists that have been identified in empirical accounts of macro-level priority setting. Indeed, despite the fact that several scholars have suggested that more in depth knowledge about who the central domestic policy actors are is critical to understanding how priorities emerge, very little work has been done to explore the attributes, interests and tactics of these actors.[106, 127] In a conceptual piece on the politics of health reform, Reich (2002) suggests that these 'policy advocates' are marked by "courage, creativity, and a capacity to recognise opportunities for change" and are able "to manage the politics of change, through hard-nosed political analysis and innovative political strategies".[126] Rich empirical characterization of these actors is needed to verify and build on these. The study design employed in this doctoral research, makes it especially suited to contributing to this gap in the literature. A heavy reliance on in-depth interviews with domestic policy elites allows for the construction of intricate character sketches of key policy actors, which can offer insight into how they influence the policy process.

2.6 Concluding thoughts

Research about the emergence of political priority that goes beyond simplistic propositions remains rare. However, the scholarship that does exist suggests that, though complex, the emergence of priority for health and health care issues in developing countries is neither completely random nor beyond explanation. On the contrary, one theme that cuts across all of the studies is that, despite the peculiarity of the national contexts, the varying characteristics of different health problems, and the seemingly unique confluence of factors that seem to converge to explain the emergence of political priority in each case, there are often shared features and processes that characterize the emergence of political priority in the health sector.

The devil is in the detail

Yet, what is certain is that the devil is in the detail. It seems painstakingly obvious to acknowledge, what is generally agreed upon, that a constellation of actors (each with their specific interests), the context (including social, political and economic institutions), the processes of agenda-setting and decision-making, and (more recently) ideas, are important to explaining how and why political priority emerges. While the existing literature has identified a long list of factors, this list is by no means exhaustive and it is likely that other factors (not yet featured in the literature) are important as well. Smith & Neupane's addition of political fragmentation to the list of factors that influence the political environment in Smith & Shiffman's framework, is indicative of this.

However, with the literature marked by the absence of consensus on the factors that are most salient, thicker description and more extensive 'laundry lists' of factors are likely (on their own) to be of little help in opening the black box of macro-level priority setting in LMICs. For example, Sridhar and Gomez (2011) state that "[i]n the absence of additional comparative inquiry, one cannot be certain that the factors identified were the primary forces at work nor of their causal weight."[6] Following this, Shiffman suggests that "[s]ubstantially more research...will be necessary to establish which factors are most and least influential in shaping political priority."[9]

Addressing the gaps

The existing empirical evidence, albeit small in size, suggests that thick description can give way to robust explanation when: i) it is based on comparisons across multiple cases[43, 56, 60, 100, 116]; ii) it is focused on identifying mechanisms (i.e. on answering how and why questions)[66, 106]; and iii) it is grounded in relevant theory[60, 66, 73]. I have drawn from these insights in designing my own empirical research. I clearly define a relative measure of priority, employ a multiple case study approach, use process tracing as a principle method

of data analysis in order to distinguish the relative influence of key factors, focus on what mechanisms explain the influence of these factors, and ground my findings in the wider theoretical literature. These methods are described in greater detail in the following chapter. In this chapter I have identified three areas in which significant questions remain unanswered. Leveraging my access to actors and data in Barbados, I believe that this work is well poised to make a contribution to these gaps in the existing literature.

Chapter 3
Methods & Background

3.1 Introduction

This chapter is divided into two main parts. In the first, I begin by presenting a description of the methodological roots of my approach to this study. In particular, I provide a rationale for my use of case study research methods and my reliance on process tracing, in order to make inferences about the mechanisms by which priorities in health are set in Barbados. I then detail the methods of case selection, data collection and analysis. Finally, I describe my efforts to ensure the validity and reliability of my data and findings, the limitations of this study, and discuss a few ethical considerations.

Central to the case study approach and successful process tracing is the need to understand the context in which the phenomenon being studied takes place.[4] In the second half of the chapter, I turn my attention to this task by introducing the country in which the cases presented in Chapters 4-6 unfurled. In this section I focus specifically on the health policy context, describing the population health status, the structure of the health care system, how it is administered/governed, how it is financed, and the non-state actors generally involved in health policy-making in Barbados.

[4] For example, Falleti and Lynch (2009) suggest that "credible causal social scientific explanation can occur if and only if researchers are attentive to the interaction between causal mechanisms and the context in which they operate".[110]

3.2 Methods

3.2.1 Overarching methodological approach

As Bennett and Elman (2006) state: "[m]ethodological choices must take into account the characteristics of the phenomena we seek to understand."[132] My review of the health policy analysis literature revealed that how LMICs set national priorities in health is generally not well understood and highlighted a need to move beyond the current laundry list of factors towards more explanatory accounts of macro-level priority setting. Notwithstanding, it is clear that researchers face several challenges in attempting to study how governments choose to allocate scarce resources for health. For example, it can be difficult to distinguish between the relative salience of a large number of variables that seem to be at play. Also, government decision-making is seldom instantaneous and often takes place over considerable periods of time, while researchers have short time horizons over which to conduct research. The importance of the context in which policy is made can make it difficult to distinguish between the boundaries of context and the process(es) under consideration and imposes limits on the generalizability of findings.

Investigating public policy decision-making does not readily lend itself to randomized control trials—the gold standard in epidemiology. This is especially so where analysts are concerned with understanding the real-world context in which public policy emerges, or when they are primarily concerned—as I am here—in capturing the relationship between the context and the political phenomenon of interest.[110, 133] Within the field of public health, there has been increasing acknowledgement of the potential of qualitative methods, and case studies in particular, to contribute to answering important questions.[134, 135] Fitzpatrick and Bolton have noted that qualitative research methods are "particularly useful when investigators are 'opening up' a new field of interest".[134] Given the limited scholarship on macro-level priority setting in LMICs, and my aim to study macro-level

priority setting in the real world, I have chosen to use a case study approach to explore how national health priorities are set in Barbados.

A case study approach

In the most general sense, case studies involve the in-depth investigation of a phenomenon or event, in its real-world context, using qualitative methods of inquiry[5]. According to George and Bennett (2005), the case study approach "aspires to cumulative progressive generalizations about social life and seeks to develop and apply clear standards for judging whether some generalizations of the social world are better than others".[138 (p.19)] Several features of this approach make it particularly well suited for this doctoral research. Firstly, as stated by Yin, it allows for the investigation of "a contemporary phenomenon in a real world context, especially when the boundaries between phenomenon and context are not clearly evident".[133 (p.18)] Secondly, case study research is appropriate for work that is exploratory in nature. Well-executed case studies can therefore be especially useful when the scholarship on a given phenomenon is in its infancy, as they can provide opportunities for the development of new hypotheses based on unexpected findings.[132, 133, 138, 139]

However, and perhaps most importantly, the case study approach is acknowledged for its utility in answering 'how' and 'why' questions and identifying/verifying causal mechanisms in complex processes.[132, 133, 140] One potential weakness of this approach is that it generally only allows for the study of a small number of cases, which potentially imposes limits to the generalizability of findings. Still, I believe that the power case studies lack in representativeness is compensated for by their potential for 'fine-grained' analysis to identify and/or test hypotheses about causal mechanisms.

[5] Even though case studies may involve the use of quantitative data or methods of analysis, they are generally associated with qualitative methods of inquiry[133, 136, 137]

Using case studies to move from laundry lists to identifying causal mechanisms

In case study research providing robust evidence to establish the salience of a given independent variable, requires the identification of plausible "causal mechanisms"[6] that link it to observed occurrences of the dependent variable of interest[7]. To achieve this I have i) used process tracing to make causal inferences within cases; ii) employed a multiple case study design; and iii) taken a historical approach to investigating priorities in health.

Since its emergence as a well-articulated method of within-case analysis more than three decades ago, many scholars across the policy sciences have highlighted the fundamental role of process tracing in identifying and/or testing causal mechanisms in case study research.[132, 138, 141-143] Bennett and Checkel (2012)[142] describe process tracing as "the analysis of evidence on processes, sequences, and conjunctures of events within a case for the purposes of either developing or testing hypotheses about causal mechanisms that might causally explain the case".[142 (p.10)]

Clearly illustrating this method, Bennett (2010)[144] adds that:

> "This mode of analysis is closely analogous to a detective attempting to solve a crime by looking at clues and suspects and piecing together a convincing explanation, based on fine-grained evidence that bears on potential suspects' means, motives, and opportunity to have committed the crime in question".[144 (p.208)]

Indeed, like good detective work, process tracing relies on both a careful reconstruction of events/processes (thick description), and careful attention to the order in which events or variables occur (sequence). I have therefore chosen to focus on only three cases thereby allowing me to achieve a greater level of depth and detail. Also, I have not used process tracing to test the explanatory power of hypotheses derived from a particular theory. Instead I take an exploratory approach, starting from various hypotheses that were

[6] Falleti and Lynch (2009) define mechanisms as "relatively abstract concepts or patterns of action that can travel from one specific instance, or 'episode', of causation to another and that explain how a hypothesized cause creates a particular outcome in a given context".[110] This definition is similar to that of Tilly (2001)[141] and George and Bennett (2005)[138]

[7] This is analogous to the emphasis on the identification of plausible causal pathways/mechanisms, as an important criterion in establishing that a causal relationship exists between two correlated variables.

common in the literature, and using process tracing inductively to capture mechanisms in action and to generate hypotheses that explain the observed chain of events.[8]

I chose to compliment this within-case analysis with cross-case analysis by exploring macro-level priority in three case studies. While several authors have noted the power of process tracing to making causal inferences or refuting hypotheses, even when using a single case, there is growing agreement that the credibility of causal inferences can be bolstered further through cross-case comparison.[145, 146] For example, George and Bennett (2005)[138 (p.124)] highlight the fact that, while within-case analysis can allow us to make inferences about the causal mechanisms at play, cross-case comparisons allow us to determine just how portable these mechanisms are in an explanatory sense.

Lastly, I chose to take a historical approach, tracing the evolution of priority over several decades in each of the three cases explored, as opposed to narrowing the emergence of priority to particular episodes or moments. Indeed, several public policy scholars have demonstrated that studying policy change over longer time horizons can give rise to the identification of key mechanisms that would not otherwise be apparent.[132, 147, 148] For example, Pierson has argued that the tendency of many policy analysts to focus on "snapshots" of policy choice or change is inherently problematic:

> "A wide range of processes cannot be understood unless analysts remain attentive to extended periods of time. Snapshot analyses of moments of choice will often miss important elements of the real story, or even make drastically inaccurate interpretations of the parts of the story that do attract their attention."[149]

A historical approach was also taken because it allowed for the exploration of what happened after priority had reached a climax publicly, for example if priority is sustained and why or why not. Together this overarching methodological approach, aimed at opening the black box of macro-level priority setting in health in Barbados, informed the particular

[8] For example if priorities are driven by donors, then one would expect donor funds to have been offered before priority emerged, or other convincing evidence that policy makers were mainly motivated by the prospect of donor financing and not by other factors. This hypothesis may be called into question if the evidence shows that donor funds were not available or sought at all, or if there is sufficient evidence to suggest that this was not a motivating factor among decision-makers.

procedures used in case selection, data collection, and data analysis (both within and across cases). These will be detailed in Sections 3.2.2 to 3.2.5.

3.2.2 Case selection: the role of budgetary analysis

Purposive non-probability sampling based on the presence of the dependent variable is appropriate in this case as this ensures the presence of the dependent variable of interest in each case. As stated in Section 1.3, since the presence of priority is marked by an increase in resource allocation, budgetary analysis of public health expenditure was used to inform case selection.[1] Using paper records, I compiled a database of public expenditure on health in Barbados between 1960 and 2010, based on annual Accountant General Reports[2] and Estimates (or Budgets)[1, 150]. During the case selection phase data had not been adjusted for inflation. However, this was eventually done in order to ensure that major changes in expenditure could not be attributed to this factor.[9]

Case selection was limited to choices among the various program areas delineated in the budget[10]. Analysis of these budgets revealed that year-to-year changes in resources allocated to each area were generally small (incremental) and trending upwards over time. However, at several points, significant (non-incremental) increases in financial resources allocated were evident in some program areas—indicating shifts in priorities. Three cases were selected from among these pre-defined areas based on:

1. Its distinction by one or more period(s) of marked, non-incremental change in the amount of financial resources allocated.
2. The substantial nature, in absolute and/or proportional terms, of this change. For example, spending had increased by more than 100%.

[9] Adjustment for inflation was done using GDP deflator values to convert spending to 2005 dollars.
[10] Generally the major program heads that were identified under the Ministry of Health in the yearly Estimates between 1960 and 2010 were: Health Policy & Formation, Primary Health Care, Queen Elizabeth Hospital/General hospital-based services, Mental Health, Care of the Elderly, Care of the Disabled, the Pharmaceutical Program, Environmental Health and HIV/AIDS.

3. Whether this change could be attributed to a specific policy proposal or program (as confirmed by preliminary investigations of media sources and grey literature).

Given the noted criteria, three cases—the evolution of primary health care (PHC), sanitation, and HIV/AIDS respectively— were identified for further study. See Table 3.1 below and Appendix 3.1 showing the rationale for case selection based on budgetary analysis.

Table 3.1—Policy significance of cases selected based on budgetary analysis

Issue	Period(s) of budgetary increase	Policy/Program
Primary health care	Early-1980s to early-1990s	The introduction of a network of primary health care centres, known as polyclinics, to the public health sector.
Sanitation	Mid 1970s-early 1980s, and 1990-2004	The construction of sewerage systems to cover major portions of the island.
HIV/AIDS	2001-present	The introduction of free universal access to antiretroviral drugs for people living with HIV and a multi-sectoral HIV treatment, care and prevention initiative.

3.2.3 Data collection: Methods & Sources

Over a three-year period, a total of eleven months was spent conducting fieldwork in Barbados. Throughout the data collection process I kept detailed field notes regarding any questions or insights that came to mind post-interview and likewise on the significance of documents reviewed or collected. I also engaged in on-going reflection about what I thought was going on in each case. Data collected was drawn from five main sources: newspaper archives, interviews, non-participant and participant observation of related activities, other documentation and archival records. Data collection from each of these sources is described in detail below.

Newspaper archives

Only one of the two local daily newspapers—the Nation Newspaper—had archival records that were open to the public, indexed and that dated back to the early 1970s. Though electronic records were not available for the first two decades, the Nation Newspaper's collection of clippings were indexed according to key search terms, including "health", "sewage", "polyclinics" and "AIDS". Prior to beginning any other form of data collection, I searched the archives for these terms. This allowed me to sketch a rough timeline of events surrounding each case. The analysis of newspaper archives assisted in identifying an initial list of key policy actors, contentious issues (that may not have otherwise been mentioned by some of the actors interviewed) and critical national and global events that surrounded the emergence of priority for each health initiative. Newspaper archives were also used to corroborate events, dates and other findings from key informant interviews.

Documents and reports

Another important source of data was relevant documents and reports. These included five-year national development plans from 1960 to present, Ministry of Health development plans from 1977 to present, project proposals and reports from the Ministry of Health's Planning Unit, and relevant consultancy reports, among others. Many of these documents were obtained via libraries in the ministries of Health and Finance, the Library of Parliament, the Pan American Health Organization's (PAHO) library and the National Archives. In addition several interviewees loaned me personal copies of relevant documents, which I could not access elsewhere. A former Prime Minister and the current Cabinet Secretary also facilitated my access to key Cabinet papers. Other documents, such as World Bank loan contracts and reports from Barbados submitted to the United Nations General Assembly Special Session on HIV/AIDS meetings, were found through internet

searches. I obtained copies of relevant documents, and where possible had these scanned for portability. I also included details about the significance of documents reviewed in my field notes. These documents were crucial in helping to reconstruct major events and corroborate information provided by key informant interviews.

Archival Records

Yearly records of government Estimates from 1974 to 2010 were used to extract budgetary allocations to the health sector, as well as overall estimated government expenditure and revenue. This data was checked against the Accountant General's Reports for corresponding years[11]. Since electronic records of budgetary data were not available, this data was retrieved by hand and checked three times for accuracy. Basic health indicators including infant mortality, maternal mortality, major causes of death, death rate, birth rate, and relevant epidemiological data, as well as various health systems capacity and delivery indicators, were also obtained from the Chief Medical Officer Reports and the Barbados Statistical Service, for the time period under study.

In-depth interviews

Personal interviews with key policy actors—many of whom could give first-hand accounts of various events or processes—were a central source of data. In total, 64 interviews were conducted with government officials, politicians, health professionals, civil society actors, academics, and representatives from international/regional organizations (See Appendix 3.2 List of interviewees). Initially, these key informants were purposively selected based on my knowledge of the policy actors and context, and information contained in policy documents and reports. Then a snowball method was used to identify

[11] The Accountant General Reports provide an audited account of the government's estimated and actual expenditures. Unlike the yearly Estimates, their format has mostly gone unchanged over the last three decades.

other interviewees.[12] At the end of each interview, informants were asked who they felt were the most influential actors in that particular case and to suggest other key actors that should be interviewed. Only in four cases were people recommended to me as key informants either unavailable or unwilling to be interviewed.

In-depth interviews were found to be most appropriate, as my aim was to carefully reconstruct the process of events that led to the emergence (and in some cases decline) of priority in each case, and not all actors had knowledge of the same stages or aspects of the prioritisation process. While the set of questions asked in each interview was unique, Walt and Gilson's (1994)[54] framework—which suggests that health policy analysts pay attention to the content of policies, the context in which they are made, the process by which they are derived, and the actors who wield power over policy-making processes health—was used to help guide questioning. In addition to questions regarding context, process and actors, informants were also asked specifically about the role of evidence and ideas. Where appropriate, actors were also asked about the methods, process and timing of financing. During my post-interview reflections, new questions often emerged, which I then posed to subsequent informants. Successive interviews also played a corroborative function—allowing me to judge whether or not there was consensus around one actor's construction of a particular event or chain of events.

After informants had verbally agreed to be interviewed, they were advised in person (and in a formal letter) of the interview format and expected length of the interview. They were also forewarned that I would request permission to record our conversation. Most interviews lasted between 1-2 hours, and a few informants were interviewed twice. At times informants did not want portions of their interview to be recorded. In such cases, I complied with the request. All audio recordings were later transcribed, with help from a professional

[12] Tansy has suggested that this type of sample is appropriate when studying public policy, and policy elites in particular, *"where most influential political actors are not always those whose identity is publicly known"*.[151]

transcriptionist. In the HIV/AIDS case study (Chapter 6), I also draw on ten interviews that were conducted in 2004[13].

Observation

Between 2008 and 2010, I was granted access to attend the Ministry of Health's yearly internal budgetary meetings, as well as their yearly Estimates meeting with the Ministry of Finance at which the budget is negotiated and finalized. These meetings provided me with an opportunity to gain insight into the institutional and bureaucratic processes by which resources are allocated. I also attended a series of public health sector consultation meetings in 2008 and participated in a "High-level Symposium on HIV and Human Rights in the Caribbean" in 2010. Non-participant and participant observation proved quintessential to enhancing my understanding of the national context and facilitating my access to a range of policy actors.

3.2.4 Data analysis

Data analysis was an iterative process involving a mixture of inductive and deductive approaches, characteristic of process tracing. The approach taken here can roughly be divided into five stages:

1. Getting to know the evidence
2. Reconstruction of processes and events, including preparation of timelines and descriptive case study narratives;
3. Move from description to explanation—deductive and inductive within-case analysis
4. Search for and consideration of alternative explanations for each case

[13] These interviews were conducted in 2004 for a project comparing the path to universal access to HIV treatment in Barbados and Brazil, conducted with Patricia Siplon.[87]

5. Cross-case analysis and incorporation of relevant theory to ground any cross-cutting mechanisms that emerged

During the first stage, a considerable amount of time was spent getting to know the evidence and immersing myself in the details of each case. Then drawing on the variety of data sources described above, I began to reconstruct the sequence of events and processes that led to the emergence of priority in each case, paying attention to the highest level of detail possible.

This data was then used to stitch together a detailed descriptive narrative and timeline of events for each case, paying careful attention to temporal sequencing and triangulating accounts from interviews with policy documents, news reports and other grey literature.[14] The first writing of each case study chapter therefore took the form of a descriptive narrative of the trajectory of priority for the issue in focus over several decades, with very little focus on overarching explanatory mechanisms. During this stage, I noted that in all three cases priority did not follow a simple linear progression over time, but that it was dynamic—increasing, decreasing or stagnating over discrete periods of time. These various 'episodes' formed within-in case units of analysis that were useful in distilling key factors and mechanisms that had influenced the emergence of priority for that particular issue over time.

Then, looking across episodes, I began to distill factors that seemed to influence the prioritization process, to make inferences about how these factors were at work and their relative salience. During this stage the descriptive narrative was analyzed both deductively and inductively to develop an explanatory account. Hypotheses that were prevalent in the empirical literature were used deductively to interrogate my findings, for example I considered the role of external funding in influencing priorities. However, while an initial look at each of the cases indicated that this factor might play an important explanatory role,

[14] Collier (2011)[143] argues that *"careful description is a foundation of process tracing."*Mahoney (2010)[145] makes a similar assertion.

fine-grained analysis of episodes within the cases, revealed that within the cases priority had often preceded knowledge of available resources or external resources and pressure had been present for some time without resulting in domestic change. My inquiry then proceeded inductively as I sought to explain this empirical reality, generating new hypotheses about the relationship between external financial assistance and domestic health priorities and then in-turn seeing if these held across other episodes in the case.

Throughout this process care was taken to identify (via the literature, documents, or my interviews with key informants) and consider alternative or rival explanations for each observed sequence of events. In particular, discussing preliminary findings with key informants and my supervisors was useful in this regard. Attention was then paid to identifying pieces of evidence that could discriminate between alternative explanations and establishing the authority/reliability of such evidence.

Finally, once explanatory accounts of each case had been written, a similar process was then taken in comparing the findings across the three cases. This stage of analysis, focused on identifying systematic factors and mechanisms that were shared across the case. Where appropriate, I drew on relevant theoretical literature to further refine and ground the hypothesized factors and causal mechanisms that had emerged from the empirical data. Qualitative data analysis software was not used in this case, as the researcher was more interested in reconstructing a set of historical processes than in analyzing these according to specific themes.

3.2.5 Addressing the quality of data and study findings

Addressing the issue of quality in qualitative research requires that attention be paid to ensuring the trustworthiness of data, enhancing the likelihood that research findings could be corroborated/confirmed by another researcher, and improving the potential generalizability of findings.[135, 140, 152] In particular, my reliance on key informant interviews

and my role as the primary research instrument, posed challenges to these aims and introduced potential sources of bias.

In particular, my heavy reliance on in-depth interviews, though well suited to my methodological approach, posed notable threats to both validity and reliability. Informants may not accurately remember past events, may exaggerate their role in the process, or may toe particular party lines.[133] Noting these pitfalls of elite interviews, Berry (2002)[153] cautions that "[i]nterviewers must always keep in mind that it is not the obligation of a subject to be objective and to tell us the truth".[153] My own rich background knowledge of the Barbadian context and of the various (sometimes lesser known) affiliations of many of the actors interviewed, assisted in my weighing up the credibility of their accounts. Factors considered included how close the actor was to the decision-making process, possible personal bias and any potential motives for exaggerating or misrepresenting roles and events. However, the most important measure adopted to mitigate potential bias based on key informant interviews was triangulation—both between informants, as well as, between alternative sources of data. Key 'facts', events or processes recounted in interviews were verified using evidence from government documents and archival records, or by checking with other informants in subsequent interviews. Also, rather than relying solely on my own field notes, I chose to record and transcribe interviews to make sure that informants could be accurately quoted.

The interpretive function that qualitative researchers must exert in their roles as primary research instruments poses a threat to the validity and reliability of findings. Moreover, my function as the primary research instrument was complicated by the fact that as a local researcher, I was deeply embedded in social and professional networks in Barbados and often was connected (either personally or through relatives) to key informants. This certain had its advantages. For example, based on our familial ties, a former Prime Minister trusted me with personal documents and records that I would not have otherwise had access to. However, this was also a potential source of bias.

To address this, as described in Section 3.2.4, I made a special effort to identify and rigorously weigh up rival hypotheses against the detailed evidence of each case. Finally, within-case analysis was complemented by cross-case analysis in order to enhance the inferential leverage (or potential generalizability) of my findings. Careful consideration of the extent to which causal mechanisms were consistent across the cases—why and why not—was applied to enhance inferential leverage.

3.2.6 Ethical issues

In May 2008, I received official clearance from the Government of Barbados to conduct this research, including approval of my request to attend internal budgetary negotiations within the Ministry of Health and to conduct key informant interviews with policy actors. Also, all informants were given details of the research project and overarching research design and verbal permission was obtained to record interviews. Also no significant risks to participants could be identified. However, several important ethical issues arose, due to my personal (and familial) connections to several of the key informants. While this ensured good access to actors, documents and other data, this did not come without some cost.

Most interviewees wanted to know my thoughts about health policy issues and resource allocation in Barbados and to hear about what I was finding across the cases, during my data collection phase. Also, actors often asked about my post-doctoral plans and were eager to hear what I felt I could contribute to the development of health policy domestically. Balancing the rules of good qualitative research, which stress researcher neutrality, against what I felt was a moral obligation to give genuine responses to questions from respondents, was by no means formulaic. At times, at the end of the interview, I spoke openly with informants about my own opinions regarding the emergence of priority in health and other local policy issues. This kind of two-way conversation often proved helpful

in identifying "rival explanations"[136]. On submission of this thesis, I also plan to produce a policy-relevant brief for local actors, which expresses my key findings and potential implications.

3.3 The Barbadian health policy context

With a population of only 284,000 and a landmass of only 166 square miles, Barbados is a tiny middle income country with an estimated per capita GDP of US$13,181(2009). [154] Despite major challenges due to its small size and geographical location—including problems caused by a small tax-base and the absence of economies of scale[47, 155] Barbados has made significant strides in terms of health outcomes and the provision of public health services over the last half century.

3.3.1 Population health status

Between 1960 and 2009, the average life expectancy has increased from 66 to 74.3 years. Over the same time period the infant mortality rate has decreased from 73 per 1,000 live births to 10.9[15] and in 2009 only 3 maternal deaths were reported. Due to an aggressive immunization program, there have been no cases of polio since the 1960s and no reported cases of diphtheria or whooping cough for almost two decades[16].[158] Other conditions, such as typhoid fever, tuberculosis, and under-nutrition, which plagued the island in the first half of the 20th century, have largely become things of the past.

Also, all Barbadians have access to free (at point-of-service) public health care and there is 100% coverage in antenatal care. Also, despite being one of the most water scarce

[15] According to Schneider et al (2002), of all the countries of the Americas, between 1955 and 1995 Barbados achieved the highest percentage reduction in infant mortality rate.[156, 157]

[16] In 2005 immunization coverage for polio was 91%, for DPT/HIB, 92%; and for MMR, 93%.

countries in the world, there is universal access to potable-water and 99% of households have piped water in their homes, while the remaining 1% has access via the many public standpipes dotted across the island. The number of physicians per 10,000 population has increased from 4.8 (1968) to 11.5 (1991), and nurses from 17 to 32.4 per 10,000 population.

In short, Barbados' health profile now looks very much like a 'highly-developed' country—characterized by increasing rates of chronic non-communicable diseases accompanied by decreasing rates of communicable diseases. Chronic diseases now pose a significant challenge to the health care system. In 2000, the Barbados Food Consumption and Anthropometric Surveys reported an obesity prevalence of 55.8% and 63.8% in adult men and women respectively. Also, more than 24.2% of men and 37.5% of women stated that they had been diagnosed with one or more chronic diseases.[159] In 2009, malignant neoplasms, heart disease, cerebrovascular disease and diabetes were the top four causes of mortality.[160] While communicable diseases have generally decreased, HIV/AIDS arose as a significant problem in the 1990s. Recently, the number of AIDS related deaths has declined significantly with the introduction of universal access to treatment, although in 2009 Barbados' HIV prevalence still stood at 1.4%.

3.3.2 Structure of the health care system

Historical roots

For the first half of the 20th century, health care services in Barbados were mainly available privately, as up until the transition to independence, the Colonial authorities paid very little attention to the provision of health services. Moreover, under the vestry system—an archaic form of local government—what little there was that existed in the way of publicly financed health services was delivered via a bifurcated system, over which the central authorities had very little control.

Under the vestry system, health and welfare were administrated and financed by autonomous boards of "Poor Law Guardians" in each of the island's 11 parishes, and delivered via alms-houses. These boards functioned like mini-empires and were characterized by varying levels of political will and financial capacity to respond to the poor health status of their populations across the vestries.[45, 161-165] Some centrally financed care was available on the general wards of the Barbados General Hospital, though such care would be of poorer quality than that afforded to wealthier patients on the hospital's paying words. As a result, up until the transition to independence, there was very little in the way of publicly financed health services.

Today however, public health services have been fully centralized. The Government of Barbados now provides a comprehensive array of services at the primary, secondary and tertiary levels. Moreover, it is now the main financier and provider of health care services on the island.

Public sector

The government provides a comprehensive health care, free at the point of delivery, at three main levels—primary, secondary and tertiary—in addition to an extensive drug service. Services at the primary level consist of both individual health care and population-wide public health services. Primary health care is provided through a national network of eight polyclinics and four satellite clinics, strategically located around the island to ensure easy access via public transportation. These clinics provide comprehensive preventative and health promotion services, alongside some basic curative or secondary-level services. The service-areas offered in the polyclinics include maternal and child health, family planning, nutrition, community mental health, prevention and treatment of sexually transmitted diseases, environmental health, and specialist clinics for people suffering with diabetes and hypertension. Dental and ophthalmologic services are also provided for children under the

age of 18. Each polyclinic is staffed with a multidisciplinary team of health professionals, including medical doctors, dentists, and public health nurses. In addition, the Ministry of Health also oversees the provision of key public health services and plays a leading role in mosquito and vector control, regulating food safety and environmental pollution, and providing sanitation services. [46, 47, 166] With regard to the provision of potable water, sewage disposal and the disposal of solid waste, the Ministry of Health collaborates with the Barbados Water Authority and the Sanitation Services Authority—both of which are statutory organizations.[167]

Secondary-level care is provided in part via the polyclinics, in the form of some acute care and outpatient specialist services, and by the Queen Elizabeth Hospital, the Psychiatric Hospital and via five district/geriatric hospitals. Services at this level include acute/emergency care, an array of modern specialized diagnostic services (including CAT scan, ultrasound and MRI's), and some access to outpatient urology, cardiology, psychiatry and other specialized medical services.

At the tertiary level, care is provided predominantly through the island's sole public general hospital—the Queen Elizabeth Hospital (QEH). This 664-bed institution is a medical teaching hospital of the University of the West Indies and an important regional referral centre. Services offered at this level include 24-hour accident and emergency care, and in-patient services in general medicine, surgery, paediatrics, obstetrics and gynaecology, pathology, neurology among other areas. In addition, there are specialized asthma, dialysis, cardiac catheterization, intensive care and neonatal intensive care units. Care is also provided at the island's 627-bed Psychiatric Hospital—where tertiary-level in-patient mental health care is provided. At this level, the public sector is the main provider, accounting for well over 90% of all acute care beds on the island.[168]

The Barbados Drug Service (BDS) is charged with the responsibility of importing, distributing and ensuring the quality of essential medicines. Through the Drug Service's Special Benefit Program, medicines listed on the government's formulary are available free

of cost (at both public and private dispensaries) to citizens over the age of 65. This benefit is also extended to children under 16 years of age, and persons receiving treatment for hypertension, diabetes, cancer, asthma, epilepsy and HIV (including treatments for the prevention of mother to child transmission).[159]

Private sector

The private sector plays a significant role in financing care at the primary-level, a lesser role at the secondary-level, and a very minimal role in the provision of tertiary-level care. In terms of primary-level care, there are over 100 private general practitioners on the island who operate on a fee-for-service basis, and who receive approximately half of all primary-level visits.[158] At the secondary level, the private sector role is much more limited, and is mainly provided by a small number of specialist consultants who provide outpatient secondary-level services—many of whom who also work in the public sector. There is also a growing number of private diagnostic, laboratory, geriatric, ophthalmologic, dental and rehabilitative service providers on the island. At the tertiary level, there is presently only one private in-patient hospital on the island—the Bayview Hospital. This only has 30 beds and is not equipped to deal with certain medical emergencies and consequently often refers patients to the public facility.

3.3.3 Governance and administration

Throughout the 1960s and 70s, Barbados passed a number of health-related legislative acts, which have formed the basis of the country's modern health care system. The Ministry of Health (MoH) is the primary executing agency responsible for the delivery and regulation of health care services on the island. Decision-making authority is centralized within the MoH, which plays a pivotal "steering role", for example, by articulating plans for the health sector in regular multi-year development plans.[159, 167, 169]

The Health Services Act Cap. 44 of 1969 gives the Minister of Health ultimate authority "for the promotion and preservation of the health of the inhabitants of Barbados".[170] The minister is directly accountable to Cabinet and the Prime Minister, and is responsible generally for defining policy and preparing key health care legislation to be brought to Parliament; regulating the public and private health sectors and stipulating minimum standards[17]. The Minister is supported in this work by the Permanent Secretary—who functions as the Chief Executive Officer and is responsible for all fiduciary matters—and the Chief Medical Officer—who provides leadership in technical matters (See Appendix 3.3 Institutional structure of the Ministry of Health). The Health Policy & Planning Unit, established in 1975, is charged with the tasks of providing technical support to the administration, drafting policy proposals and monitoring and evaluating existing policy and programs.[159] The administration of the island's primary health care centres (or polyclinics) falls directly under the responsibility of the Chief Medical Officer and Senior Medical Officers appointed to oversee care at this level. While publicly financed, an autonomous Board of Directors runs the hospital, which reports directly to the Minister of Health.[171, 172]

3.3.4 Financing

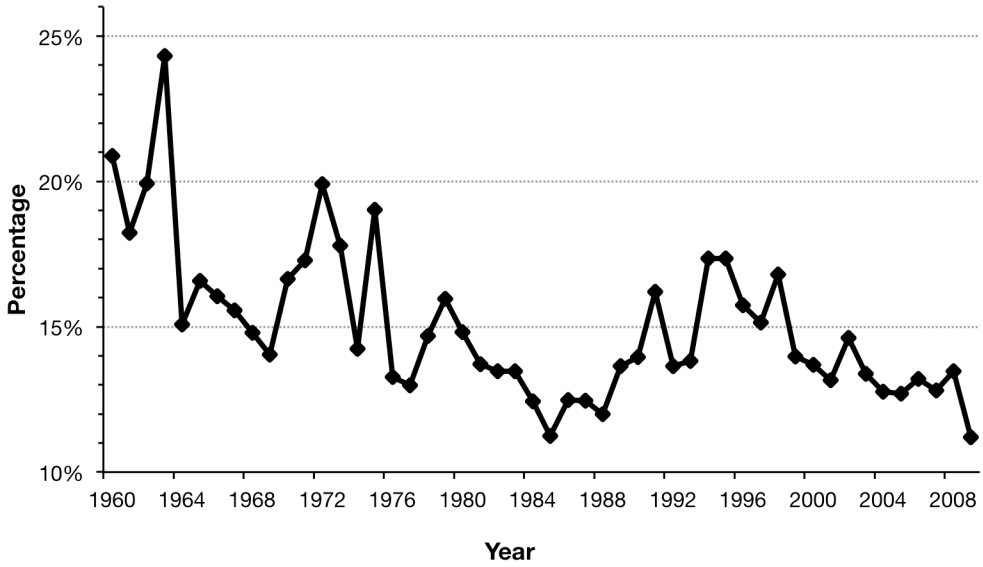
Health services in Barbados are financed in two main ways: i) publicly, through general taxation; and ii) privately via private, employment-based health insurance and out-of-pocket payments. The share of private expenditure on health (28.8% of total expenditure on health in 2009) has been generally increasing since 1995 and is mostly concentrated on primary and secondary level services. For example, in 2002 the Ministry of Health

[17] The Act provides for extensive powers to be held by the Minister of Health, including authority to regulate and monitor impacts of commercial and industrial development on the public's health (especially in terms of their impacts on drinking water quality, near-shore water quality, hazardous waste and air pollution). The minister also monitors food safety and regulates the inspection and licensing of restaurants and vendors in this regard.[167]

estimated that 50% of all primary health care services were being provided by the private sector and financed privately.[158] Despite this, the government is still the principle provider and financier of health care services in Barbados.[167] According to the World Bank, in 2009 public expenditure made up 64.3% of the total expenditure on health. In particular, the government is the financier of almost all tertiary-level care.

The overall level of resources available to the Ministry of Health, as well as for each of the main program heads, is determined through the yearly public budgetary process and is ratified by both houses of Parliament. Since the 1950s, the Government of Barbados has generally placed a high premium on health and has therefore invested substantially in the health sector, allocating up to 20% of its budget to health between 1972 and 1973 (See Figure 3.3 below). Although there has been a general decline in the share of public resources allocated to health since 1995, between 2005 and 2010 an average of 11.8% of the budget was spent on health each year.

Figure 3.1: Percentage of total government expenditure allocated to health, 1960-2009

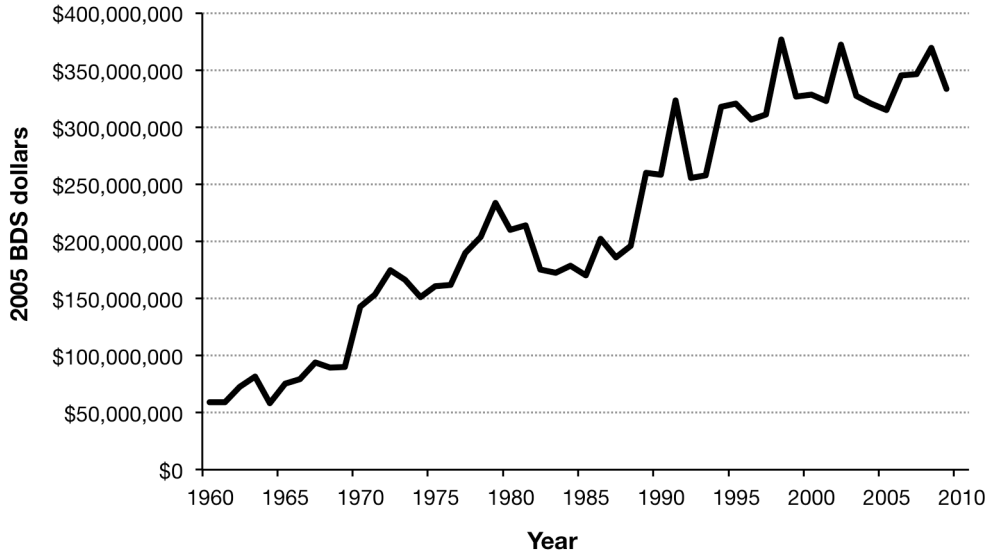


Source: Barbados Estimates, 1960-2009

However, due to the pro-cyclical nature of government expenditure, periods of macroeconomic decline often have profound impacts on the overall amount of resources

available for health. For example, for the fiscal year 2010-2011, the budgetary allocation was US$187 million—some 7.7% lower than the previous year, reflecting the impact of the current financial crisis.[1] Similar declines in the allocations to the health sector have occurred in response to economic recessions in the early 1980s and 1990s.

Figure 3.2: Total government expenditure on health, 1960



Source: Barbados Estimates, 1960-2009

Official development assistance (ODA) has generally made up a very small proportion of expenditure on health care in Barbados. For example, between 1995 and 2009, external resources comprised between 0.03-5.4% of total expenditure on health. ODA, has been mainly comprised of concessionary loans, is generally project-based and focused on capital projects. The island's main sources of external resources for the health sector have been the Inter-American Development Bank (IDB), the World Bank, and the European Development Fund (EDF). The Pan American Health Organization (PAHO) has also historically played a significant role in providing technical (and some financial) assistance to the public health sector.[159]

3.3.5 Non-state actors in health policy

Civil society participation in policy making in Barbados has been described as both weak and tokenistic.[156] That said, there are a growing number of domestic non-state actors involved either in the health policy process or in the delivery of health services in Barbados. These include associations of medical professionals, such as the Barbados Association of Medical Practitioners (BAMP)[18] and the Barbados Nurses Association. Several non-governmental organizations—such as the Barbados Family Planning Association, the Barbados Diabetes Foundation, the Heart and Stroke Foundation of Barbados and the Barbados Cancer Society—also provide vital resources in health promotion, prevention, management, care and support. However, many of these organizations receive substantial subventions from the government. Several research institutions based in Barbados and elsewhere in the region—namely the Caribbean Epidemiology Centre (CAREC), the Chronic Disease Research Centre and the Health Economic Unit of the University of the West Indies—also play a substantial role in producing policy-relevant information and often actively seek to influence the public agenda. Finally, the Caribbean Community (CARICOM)—a regional multilateral institution—has also been increasingly influential.[159]

3.4 Concluding thoughts

In this chapter I have outlined my overarching methodological approach and detailed the methods I have used to explore macro-level priority setting. Then in the second half of the chapter, I have introduced the reader to the Barbadian context and provided the backdrop against which the rest of the thesis is set. I believe that a case study approach—and in particular, using process tracing techniques—can help me to explore the stories behind these shifts, and to gain insight into how national health priorities are set in

[18] These two associations have shown themselves to be particularly powerful; and BAMP in particular has taken on the characteristics of a labour union over time.

Barbados. Focusing on priority for primary health care, sanitation and HIV, at various points over the past 60 years, this is the task of the next three chapters.

Chapter 4
Primary health care on the national policy agenda

4.1 Introduction

In 1978, over 3,000 delegates met in Alma Ata (then the capital of what is known today as Kazakhstan) for the *International Conference on Primary Health Care* hosted by the WHO and UNICEF.[173, 174] At that time, Alma Ata (as it is commonly referred) was an international gathering in the name of public health that was unprecedented in scale, both in attendance and political impact.[175] Counted among its outcomes was an ambitious commitment by the 134 nations present to work towards the achievement of "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."[176] It was at this landmark event that the concept of primary health care (PHC) rose to international prominence as the principal mechanism through which 'health for all' could (and indeed, according to its organizers, should) be achieved.[174, 177] It is perhaps for this reason that Alma Ata is often regarded as the birthplace of PHC.[177-179]

In this chapter, I trace priority for PHC in Barbados over the course of more than five decades. What is perhaps most striking about this account is that Alma Ata is not the beginning of this story. Instead, the story begins several decades before this historic gathering[xix].[156, 182] In my interviews several key informants pointed to the fact that Nita Barrow, a Barbadian nurse who had championed a focus on preventative and community-based approaches to health care across the region in the 1950s, is widely recognised for her

[xix] Several informants also pointed to the fact that Nita Barrow, a Barbadian Nurse who had championed a focus on preventative and community-based approaches to health care across the region in the 1950s, was the president of the Christian Medical Committee at the time and had been very influential in influencing Halfdan Mahler and placing PHC on the agenda of WHO.[178, 180, 181]

role for helping to place PHC on the agenda of WHO as Director of the World Council of Churches' Christian Medical Committee between 1975-1981.[178, 180, 181, 183, 184]

In a personal interview, Sir George Alleyne, the former director of PAHO stated:

> "Even before primary health care became fashionable, the Caribbean health ministers in 1975 I think had passed a resolution and discussed what they conceived to be primary care – even before Alma Ata.… Also, one of the major influences on the whole concept of primary care was Nita Barrow."[180]

Indeed by 1975, the year that WHO formally dedicated a program to this area in the lead-up to Alma Ata, Barbados was on the cusp of a second phase of increased priority for what was only then becoming more widely known as PHC. Moreover, the country was already well on the path to achieving many of the goals set out in the declaration.

Defining Primary Health Care

Tarimo and Webster (1994)[185] have suggested that Alma Ata offered two main definitions of PHC—as a level of care and as an overarching approach. As service level PHC is often used to refer to an array of services that constitute the first point of contact between health professionals and health consumers. According to the WHO:

> It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work.[186]

However, the Alma Ata declaration also defined PHC as an overarching conceptual approach to the development of health—a set of underlying values and principles that drive the particulars of PHC strategies.[185, 187 (p.6)]

While many aspects of this broader understanding of PHC as an approach are evident in the dependent variable being explored here, in this chapter I have subscribed to the (admittedly more limited) understanding of PHC as an array of first-line health services. In particular, this chapter focuses on the emergence of priority for the creation and subsequent expansion of PHC centres or polyclinics (as they were later called)—the

principal arms through which many government-funded PHC services were delivered in Barbados (See Appendix 4.1 for a description of manifestations of PHC in Barbados over time and comparison with Alma Ata's broader approach).

Although domestic policy actors did not use the term 'primary health care' until 1976, I believe that this concept appropriately captures the dependent variable being traced in this case. The term primary health care, as I use it here, is distinguished fundamentally by: i) its designation as a main point of entry to other levels of the health care system; ii) an emphasis on decentralization or bringing health care services closer to where people live; iii) and, its main focus on health promotion and preventative (as opposed to curative) activities/services.[187, 188]

A gradual move from laggard to leader

In 1923, a formal complaint by Barbados' Public Health Inspector[xx] regarding the state of health conditions in Barbados prompted the Colonial Office to send a dispatch to the Governor of Barbados stating that:

> "We regard it as a matter for regret that the colony of Barbados, which from its natural advantages might be the most healthy of the West Indian colonies, should as far as we are able to judge, be one of the most unhealthy."[189]

Across the British West Indies, the health of the people had not featured as a priority during the time of slavery and little had changed after emancipation[xxi]. However, Barbados still stood out among its regional counterparts with regards to the sheer extent to which the provision of basic PHC services had been neglected.[45]

In 1945, the island's infant mortality rate was the highest among the British West Indies and the death rate was 30.1, with only St. Kitts & Nevis recording a higher rate (See

[xx] The role of the Chief Medical Officer is the modern-day equivalent of the Poor Law or Public Health Inspector.

[xxi] In 1928, the death and infant mortality rates across the British West Indies ranged from 16.5 to 39.8 and 110 to 331 deaths per 1,000 live births, respectively.[190]

Appendix 4.2).[190] Under the 'vestry system'[xxii] the closest thing to PHC was provided by 11 alms-houses (located in each of the island's parishes), which provided very primitive services to the poor and indigent. However, not all of these were staffed with trained health care professionals due to different levels of political will and varying financial capacity across these local authorities.[45, 161-163] Moreover, despite several attempts to place the issue on the agenda during first half of the 20th century[xxiii], up until the early 1950s, there was still virtually nothing in the way of publicly provided PHC services[xxiv].[45, 161-163, 189, 191]

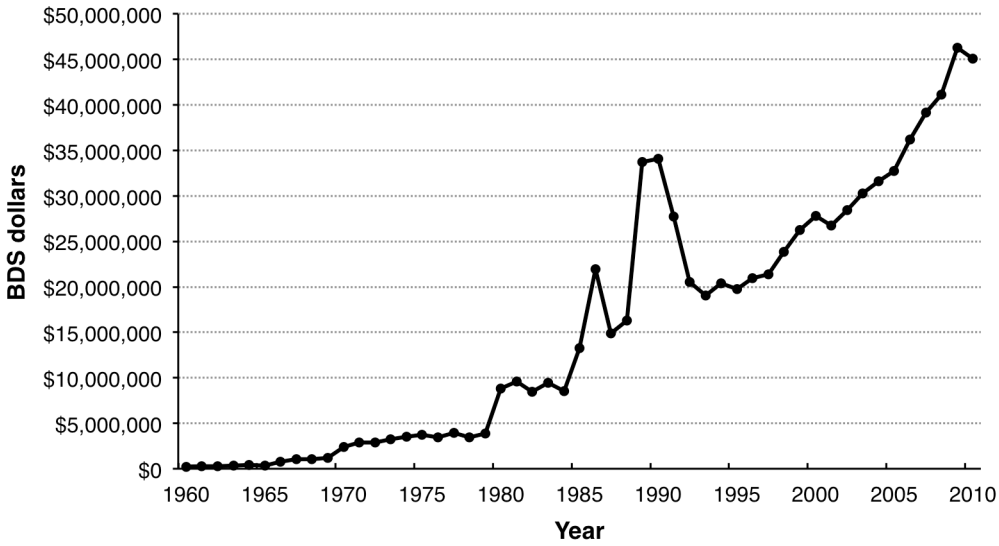
Finally, in 1953, the government established its first health centre and PHC received earmarked budgetary resources for the first time (See Appendix 4.3). By the end of the decade, two more health centres were established and the foundation of Barbados' PHC system was laid. Building on this effort, in 1976 decision-makers voiced their commitment to ensuring universal access to PHC sparking substantial further public investment (see Figure 4.1) and resulting in the establishment of the polyclinic system between 1976 and 1990 (Appendix 4.1). By the year 2000 (the proposed deadline by which 'Health for All' was set to be reached) the Pan American Health Organization reported that Barbados had one of the best public PHC systems in the English-speaking Caribbean.[192] The country's infant mortality rate stood at 15.1 deaths per 1,000 lives births, and diseases like typhoid, cholera, childhood malnutrition and tuberculosis—key indicators of an effective PHC system—had largely become things of the past.[154, 193]

Figure 4.1: Public expenditure on primary health care, 1960-2010

[xxii] See Chapter 3 Section 3.3.2

[xxiii] For example, in his testimony to the Royal West India Commission in 1938 John Hutson reported that in 1919 the local government in Barbados had failed to take up an offer of financial assistance from the Rockefeller Foundation for improving preventive health services on the island.[163]

[xxiv] Secondary and tertiary care was provided by the central government at the Barbados General Hospital. However, it is important to note that even at these levels, the care available was limited and the best quality care was generally reserved for paying patients.[162]



Source: Barbados Estimates, 1960-2010[1]

Today Barbados has an island-wide network of eight well-equipped polyclinics and four satellite clinics, which provide comprehensive preventative, health promotion, primary-level curative services, and some rehabilitative services. The services offered at this level now include maternal and child health, family planning, nutrition, mental health, the prevention and treatment of sexually transmitted diseases, environmental health, and specialist clinics for diabetes and hypertension. Dental and ophthalmologic services are also provided for children under the age of 18.[1, 46, 47, 166, 192] Furthermore, between 1953 (when the island's first health centre opened its doors) and 1990, spending on PHC increased from 7.2 to 13.1% of public expenditure on health and the government became the principal provider of services at this level.[1, 192]

Explaining the evolution of PHC in Barbados

In this chapter I chronicle priority for PHC in Barbados over the latter half of the 20th century. I begin by considering why PHC priority generation efforts during the 1930s and 1940s failed to mobilize domestic resources, despite successfully placing the issue on the agenda of the Colonial authorities. I then explore the key factors that led to the first signs of priority for PHC (and the establishment of health centres) beginning in the early

1950s. I go on by explaining why access to these essential services failed to grow, and why budgetary allocation for this area was in flux, during the first decade after independence. Finally, looking at the renewed emphasis on PHC starting in 1976, I explain why priority for PHC increased in Barbados at this time (even before the historic Alma Ata conference). I consider how substantial financial investment to expand access to these services was mobilized despite some opposition for the medical establishment during the late 1970s and 1980s (See Figure 4.1 and Appendix 4.3).

4.2 A period of increasing attention but no action

Despite yearly reports from the island's Chief Public Health Inspector, detailing the poor health conditions on the island[194, 195], it was not until there was widespread social and political upheaval across the region in the late 1930s that PHC truly found its way onto the domestic and colonial agendas.[45, 161] In Barbados, riots broke out in the capital city in 1937 after the authorities announced the deportation of a Trinidadian-born political activist, Clement Payne, whose message and demands for political and economic reform and social justice were seen as a threat to the local colonial establishment.[196] Four days of island-wide demonstrations, awakened the local authorities to the fact that "there was a large accumulation of explosive matter in the island, to which the Payne incident only served as a detonator".[197] In response, the Colonial government appointed the West India Royal Commission (or Moyne Commission) to determine the causes of the riots or, as stated in the Commission's report, "to investigate the social and economic conditions"[190] in the region. This, along with the local Deane Commission (which was conducted in 1937)[197], served as an important vehicle for placing PHC on the Colonial agenda.[161, 198]

4.2.1. Local doctors link socio-political upheaval with the need for investment in PHC

A number of doctors used the commissions as an opportunity to place health on the agenda of the Colonial authorities by drawing links between the poor state of health and health care services in Barbados and political and economic stability, with which the Colonial government was principally concerned.[163-165, 199-201] These medical practitioners pointed out the island's high infant mortality rate, high incidence of worm infestation, and onerous burdens of malnutrition among children and venereal diseases among adults. Moreover, they demonstrated that these illnesses all disproportionately affected the island's (majority) black population and was one of the sources of the dissatisfaction that led to the riots. They also pointed out that the island's system of governance often resulted in responses to communicable disease epidemics that were either delayed or detrimental to public health.[163, 164] Among all their concerns, the need to focus on preventing morbidity and mortality in the first place was a consistent message from each of the doctors who submitted evidence to or were interviewed by the Commission.[46, 162-165, 197, 199, 200]

In a particularly candid memorandum, the then-Chief Medical Officer (CMO) of Barbados described the existing health care system as "wasteful and antiquated"[165] and expressed concern about the lack of resources for primary care. He wrote:

> "It is emphatically true that by far the major portion of available medical funds has in the past been devoted to the cure and amelioration of the sick, and proportionally little to the preventive aspect of medicine."[165]

Indeed, of all the islands of the British West Indies, the Moyne Commission report revealed that Barbados allocated the least percentage of their total health expenditure to preventive activities, that is 8% versus 92% on curative services (See Appendix 4.4).[190]

The result of these efforts to place health on the agenda was that health and medical services featured prominently in the Moyne Commission Report and its recommendations.

In the final report it was clear that the message delivered by the CMO and others from Barbados and around the region had been heard:

> "It ought to be recognized in the West Indies that expenditure on curative work can never effect a permanent improvement in the health conditions of a country. The whole revenues of a colony might be spent on the alleviation of disease and the cure of the sick and the most up-to-date and costly methods might be used, without much evidence of improvement in the general health conditions…. It is significant that Directors of Medical Service, most members of the medical profession who gave evidence before us, and the parent body of the British Medical Association, all stressed strongly the very great need for an increase in preventive medicine."[190 (p.142)]

4.2.2 The Colonial Office fails to mobilize domestic priority

In response to the concerns expressed during the commission, the Colonial authorities set out to generate priority PHC in each of the Caribbean countries by: i) articulating and promoting a vision for the expansion of PHC in the region; ii) providing financial assistance; iii) and, investing in educating necessary health care professionals.[161, 190, 202] In 1940, the Colonial Welfare and Development Organization—the principal arm through which the commission's proposals would be advanced—presented a blue print for how the development of a more preventative approach to addressing health in the region could be achieved.[202] The proposed 'health unit system', which was based on the experience of the Rockefeller Foundation's experience in delivering basic health services to rural communities in South and Central America, would influence ideas of PHC in the region for years to come.[202] Moreover, it bore striking resemblance to the version of PHC that was later articulated at Alma Ata more than three decades later (See Appendix 4.1 and 4.5).[203, 204]

To aid the advancement of this and other policy proposals, a fund to the tune of £5.5 million was earmarked for development and welfare in the British West Indies[xxv].[202, 205, 206] However, the Moyne Commission made explicit that the disbursement of this fund should be conditional:

> "We may content ourselves with observing that in the allocation of money from the British West Indian Welfare Fund, the Comptroller of that fund may well be influenced by the extent to which the Barbados system of government provides for the efficient and controlled execution of schemes financed by him".[190]

Finally, the Moyne Commission had identified the lack of health care workers, and specifically those with public health training, as a major impediment to expanding access to preventative care[xxvi].[190] As a result, the Colonial Office helped establish the West Indies School of Public Health in 1945 in hopes that this would contribute to generating priority for PHC throughout the region.[45, 162]

No local action without domestic political support

By 1942, the development of health units (or health centres) was well underway in several islands, including Jamaica, British Guiana[xxvii], Antigua, and St. Kitts & Nevis.[202, 204] However, despite concerted efforts by the Colonial Office, Barbados remained woefully behind the rest of the region in terms of its advancement towards the expansion of primary care services. For example, even though a proposal for the establishment of three health centres in Barbados was technically approved by the central government in 1945, this was stalled due to the failure of the House of Assembly to pass legislation to centralize the necessary functions.[207] In 1950, the Colonial Office's Development and Welfare's comptroller reported:

[xxv] It should be noted that development and welfare assistance had been promised to all the colonies in the British Empire, yet the West Indies were the only ones to receive any funding before the end of World War II. Conceivably, this was because it was here that the threat of civil unrest was most imminent.[205, 206]

[xxvi] In 1938, in a hearing before the Commission, the acting Chief Medical Officer of Barbados had reported that there was only one public health nurse working on the island in 1938.[164]

[xxvii] Now Guyana

> "In all but four Colonies, the infant mortality rates are now below 100, the lowest being in Trinidad (75) and British Guiana (77) and the highest in Barbados (147), where least progress has been made in developing these services which are regarded as a hallmark of an enlightened community".[208 (p.52)]

Between 1937 and 1950, despite pressure from the Colonial Office, there was no action in Barbados. While domestic advocates succeeded in influencing the Colonial authorities, they found it much more difficult to mobilize the support of their own political leaders.[45, 162] Under the vestry system, power for the administration of health services was split across 11 local boards, which reflected the interests of the wealthy (predominantly white) elites.[45, 162] Local advocates had very little influence over those who wielded power under this system. As a result, the government remained impervious (or at least indifferent) to their demands, even failing to take advantage of external assistance from the Colonial authorities.[161]

4.3 The emergence of domestic priority for PHC

A decade after the recommendations had been made the first signs of priority for PHC in Barbados began to be apparent. In July 1953 Barbados' first health centre was opened in the north of the island.[209] The Speightstown Health Centre heralded a major breakthrough in the provision of primary-level services in Barbados. Moreover, with its creation came the establishment of a dedicated budgetary stream for PHC by the central government (See Appendix 4.3). Over the next seven years two more health centres—Enmore in the capital (1955) and one in the southern parish of St. Phillip (1957)—would be established.[191, 210] Between 1953 and 1963, expenditure on primary care grew almost ten-fold from just over BBD$37,000 to BBD$330,000.[1] The services provided by these centres reflected the needs that had been identified by the Moyne Commission[190], and were almost exclusively focused on preventive care and health promotion (See Table 4.1 below). By

1960, with three health centres and five out-post clinics dotted across the island, it could now be said that Barbados had the makings of a PHC service.

Table 4.1: Comparison of key problems identified by the Moyne Commission to stated priorities of Barbados' primary care response 1953-1975

Key problems identified by the Moyne Commission	Services provided by health centres in Barbados, 1953-1975
Over-population	Family Planning
High infant mortality High maternal mortality rate	Maternal and Child Health Services, including antenatal clinics, and childhood immunization programs
Venereal Disease Control	Venereal disease control, available at the Enmore Health Centre
Basic sanitation and consequently rampant enteric diseases and worm infestation	Basic education in household sanitation
Treatment and control of other communicable diseases	Control of communicable diseases
Tuberculosis	Treatment and control of tuberculosis, available primarily at Enmore
Malnutrition	Services to address childhood malnutrition (though this appeared later, from 1968 and onwards)

Sources: Royal West India Commission Report (1945)[190], Byer (1975)[210], Byer (1957)[209]

A number of factors came together to facilitate the emergence of priority for PHC, after years of no-progress even in the face of domestic advocacy during the 1930s and 40s. First, universal suffrage and the move towards a ministerial system of government helped open up opportunities for political engagement of non-white Barbadian intellectuals, who were more socially-oriented in their political outlook and allowed for the centralization of health policy decision-making powers. Most importantly, unlike years gone by, these advocates were now extremely well connected with powerful authoritative decision-makers. It is this new power that seems most poignant in explaining government action on PHC during this period. In particular, one of these doctors, Dr. Maurice Byer—a public health doctor, originally from Grenada—assumed the position of Medical Officer (later, Director of Medical Services) and together with a small group of public health professionals, began to leverage his connections to powerful actors to drive priority for PHC from within the Ministry of Health.[161, 180, 211, 212]

4.3.1 Political reform creates fertile ground for domestic priority to emerge

Over the course of the 1940s in spite of the fact that the political and social reforms were slow in coming, it seemed that "the political dyke had been broken".[46] The 1937 riots had given rise to the emergence of charismatic political leaders from among the island's small black and coloured middle class and a new party—the Barbados Progressive League (renamed the Barbados Labour Party or BLP in 1944)—came to embody many of the ideals of the masses.[213] Over the course of the 1940s, the Colonial government found itself under mounting pressure to meet popular demands for political and constitutional reform. Two of these reforms, were particularly important in paving the way for this first phase of priority for PHC by enhancing the likelihood that policy advocates' demands would fall on fertile ground.[161, 191, 212, 214]

Universal Suffrage improves representation of the majority

Firstly, in 1950 after more than a decade of struggle within the legislature, universal adult suffrage was finally introduced and the property requirement for becoming a member of the House of Assembly was removed.[196] This resulted in irrevocable change to the national political landscape. For the first time, the aspirations of the masses could be realized via the ballot box. In the 1951 general election, fought under universal franchise, the BLP swept to power with 15 of the then-24 seats in the House of Assembly. This was in contrast with the election in 1946, when they had garnered only 9 out of the 24 available seats and had been unable to command a majority in Parliament. [213] The party had won the election on a platform of political and social reforms. And in their Manifesto, they had promised to ensure that Parliament pass new public health legislation "especially [with regards to] the field of preventive medicine" as a matter of priority.[215] The extension of voting rights had effectively catapulted the BLP into a position of power, providing them an opportunity to advance their social welfare agenda. Indeed, in their 1956 manifesto, the

Barbados Labour Party lauded the establishment of health centres as "a boon to the community" and the "foundations for a good health service throughout the Island".[216]

The abolition of the vestry system empowers the central government to effect change

In a memorandum to the Moyne Commission in 1939, then-Chief Medical Officer of Barbados had surmised in relation to a call for a shift towards providing preventive care:

> "There is, I fear, easy reason to be pessimistic about the result of this appeal [to reform the health services], as Barbadians are very attracted to their antiquated system of parochial government, of which the health administration is but one aspect." [201]

A second major change therefore occurred when the vestry system, which was identified by both the Colonial Office and local advocates as the single greatest impediment to expanding the provision of PHC services, began to be dismantled (and was ultimately abolished).[45, 161-164, 212] Beginning in 1946 under the 'Bushe Experiment' the island began a gradual shift towards a ministerial system of governance, with the intention of increasing the ability of elected members of the house to have a genuine effect on policy.[196] Although ministerial government was not fully adopted until 1954, beginning in 1946 several major constitutional and legislative changes under the Bushe Experiment, had direct effects on the organization of health services on the island.[161, 162]

Foremost among these changes, was that a Minister of Social Services was given ultimate responsibility for health services (in 1946) and a new Public Health Bill was finally passed in 1948. This bill established several senior health posts within the central government and delegated the responsibility for "all matters affecting the public health and medical services of the island"[217(p.16)] to the Director of Medical Services. While this stopped short of dismantling the vestry system, the bill also established the post of Medical Officer of health, to supervise the development of health services at the parochial level.[217] This stood in stark contrast to the organization of health services for the first half of the

century, in which the central government had little political control over local health policy and local government had little or no expertise in dealing with health matters.[45, 162]

In the period between 1946 and 1958, when the vestry system was finally abolished, these organizational changes opened up new opportunities for PHC advocates to influence policy from inside government.[161, 162] Indeed, PHC advocates soon assumed the posts of Medical Officer and Director of Medical Services, from which they could much more effectively mobilize attention and resources.[161, 209, 211] Generally, the inertia and vested interests that formerly characterized health policy decision-making under the vestry system of government gradually dissipated, allowing for more coherent (island-wide) health planning.

Political reform proves important but not sufficient

It seems unlikely that increased investment in PHC for all Barbadians would have emerged in the absence of these reforms. Universal suffrage (in the context of fair elections) served to make government more responsive to the desires of the majority poor, black population who had been demanding access to health and other social services for some time. The dismantling of the local system of government gave the political directorate the power it needed to meet these demands and provided new opportunities for PHC advocates to influence policy development directly. However, although the legislative and administrative structures necessary for the implementation of the health unit system were in place by 1948, PHC did not receive a dedicated budgetary stream until 1952 and the first health centre was not established until five years after this.[150, 162]

In the context of vast social needs and scarce resources in the years immediately preceding independence[161, 196], it is unlikely that political reforms alone would have necessarily led to priority for PHC. Evidence suggests that the timing of the establishment of the health centres was driven by the presence of PHC advocates who began to wield

influence in the domestic policy arena beginning in the early 1950s and were therefore able to seize the opportunity of political reform to mobilize public resources for their cause.

4.3.2 Domestic PHC advocates acquire new power to drive priority generation

In accounting for the drastic change that took place with regards to priority for primary care and the provision of preventative health services in Barbados after 1950, Walrond has suggested that this shift was due to "a combination of political will working in conjunction with doctors largely bred in the Caribbean".[46, 214] Many of the policy actors interviewed reiterated this view and pointed specifically to the role played by Dr. Maurine Byer, in spearheading the response.[171, 191, 212, 218-220] For example, a former director of PAHO stated: "The whole public health and primary care system, I think, is a tribute to the genius and organising capacity of Maurice Byer."[180] One former politician and Minister of Health explained:

> "In those early years under black self-government, beginning in the early 1950s, health and education were the top-most priorities. But the investment in public health was not only due to far seeing political operatives, but also to the work of a committed cadre of public health doctors…. I remember, in particular, Maurice Byer."[191]

Notably, these efforts were built on those that went before them. For example, PHC advocates had all been beneficiaries of the increased public health training opportunities that were made available to doctors and nurses in the region[xxviii], as recommended by the Moyne Commission.[161, 162] However, these medical professionals differed from those who had been at the helm of priority generation efforts during the 1930s and 40s in two key ways. First, they were all *"born and bred in the Caribbean"*[222] among whom, beyond improving the health of their fellow citizens, there was a broad sense of wanting to

[xxviii] The public health training opportunities were mostly financed by the Colonial Office and PAHO.[162, 221]

contribute to the nation's social development[161, 212, 223]. One such medical professional, Sir Frank Ramsey, wrote in his biography:

> "In young Barbados…we felt we could assist in contributing to making Barbados a better place by…trying in the spirit of Omar Khayyam[xxix] to refashion 'Little England'[xxx] closer to our hearts desire."[224]

Secondly, and perhaps most importantly, these policy actors wielded a great deal of influence within the changing political landscape, unlike those who had failed to mobilize domestic priority for PHC before them.[211, 224]

Power and proximity to authoritative decision-makers

The ability of these local actors to influence policy can only be understood against the fundamental changes to the national political context that were taking place in the 1950s. Prior to this time, the social hierarchy in Barbados was such that almost all of the top government officials and most influential professionals were white, with members of a small coloured middle class working as lower-level professionals and government works, and a large black lower-class that wielded little or no influence over public decision-affairs. [221, 225] However, with the dawn of black self-government in 1951 and the change to the ministerial system in 1954, PHC advocates found themselves closer than ever to the locus of power.[161, 191, 211]

Unlike the circumstances faced earlier by black middle class social activists who had campaigned for improved social conditions in the 1920s and 30s, the 'powers that be' were no longer the white planter class with vested interests in maintaining the status quo. Instead, many of the most powerful political actors were now their contemporaries—other members of a small but strong social network that linked members of the black and

[xxix] Ramsey was paying reference to a stanza in 'The Rubaiyat' by Omar Khayamm's : "Ah love! could you and I with Him conspire To grasp this sorry scheme of things entire, Would not we shatter it to bits - and then Re-mold it nearer to the heart's desire!"

[xxx] Even after independence, Barbados was often affectionately referred to as "Little England".

'coloured' middle class of that time.[161, 191] For example, those from Barbados had almost always been educated at either of the two top secondary schools for boys and others from elsewhere in the region had often studied with key local actors while completing their medical training in England.[191, 211, 213]

In his biography, Dr. Frank Ramsey, one such PHC advocate, describes close friendships with Dr. Hugh Gordon Cummins[xxxi] who was appointed as the Minister responsible for Social Services, including health, in 1954.[224] He also describes visits from Errol Barrow—the man who would ultimately lead the country to independence and become the first Prime Minister of Barbados—while on a Colonial Development & Welfare scholarship in the early 1950s.[213, 224] Also, describing Byer's Barbadian connections, a senior medical professional and historian said:

> "Sir Maurice Byer was a Grenadian educated in Edinburgh, where most of the Eastern Caribbean people went to study medicine in those days. Sir Maurice Byer's connection to Barbados would have been because he was a classmate of Dr. Lionel Stuart."[211]

Byer and other PHC advocates of this era, formed part of a region-wide 'old boys network', which enjoyed close connections with the political directorate of that time. This was a crucial factor in determining their effectiveness as advocates. Moreover, these actors had in depth knowledge of the national and regional socio-political context, which they applied in their efforts to mobilize support for PHC.

'The Barbadian way'—Local knowledge and political savvy

Two informants pointed to the failed efforts of British doctor, Graham Humby (superintendent of the Barbados General Hospital at the time), in trying to mobilize increased resources for addressing malnutrition, as a counter example of the successful effort led by Byer and other public health doctors in placing PHC on the agenda.[161, 180] According to Ramsey[224], in 1956, determined to mobilize the government to act, Humby

[xxxi] For example, Dr. Ramsey and his wife honeymoon at the residence of Dr. Cummins in 1953.

placed six severely malnourished infants in a cot and called the media. In the article that accompanied these photos in the Advocate newspaper, he said:

> "Some time ago I made a sincere plea from the bottom of my heart that too many of our children were being neglected…. You talk, talk, and talk and you spend thousands dressing your children beautifully on Sundays but for heaven's sake first things must come first…. This primitive inhumanity must be stopped…".

Just around election time, at the height of his powers, Grantley Adams (the island's first black Premier) famously replied by saying: "there is not enough room in Barbados for Dr. Humby and me. I was born here and I don't intend to go anywhere". In a few days Humby had left the island. It was clear just how much power was shifting away from the Colonial dominance that had pervaded social and political relations for more than three centuries.

This contrasted starkly with an account from Sir George Alleyne of Byer's effort to place family planning and PHC on the national agenda:

> "When Barbados had high levels of maternal mortality and high levels of female fertility, Maurice Byer invited Grantley Adams one day to visit six young women who had had multiple pregnancies, and when Grantley Adams interviewed those women, one of them showed him her varicose veins and pointed out that she did not really want to have all those children. Right after that the Barbados Family Planning act was passed by politicians."[180]

As a result, family planning was added to the slate of services offered in the health centres. According to Sir Carlilse Burton, Humby "oversold his case, when in actual fact Adams [then Premier of Barbados] was looking to see what he could do to get things in order in Barbados".[161] Indeed, both Humby and Byer had tried to use similar forms of evidence to generate priority among the political directorate for various aspects of primary-level care. Humby's use of the media to target decision-makers, stood in contrast with Byer's use of his social and professional influence to court support away from the spotlight. Ramsey (2006)[224] suggests that this difference in approach had more to do with Humby's lack of knowledge on how to do things "the Barbadian way". In his biography[224] he

contrasts his own efforts to generate attention for nutrition a decade later with Humby's, saying:

> "I had decided not to continue along the 'Humby Road' like a bull in a china shop, but rather to travel the Barbadian way…with a low medical profile because I was dealing at that time with a politically sensitive subject and a great determination to succeed on my part where Dr. Humby had failed a decade earlier."[224]

Although Byer was not Barbadian, which suggests that effective action does not necessarily hinge on one's nationality), he was able to draw on an in-depth knowledge of the nuances of the domestic socio-political context in his effort to generate priority for PHC.[161, 211]

4.4 The in-between years—a lull in attention for PHC

After a vibrant start in establishing the island's PHC services, during the latter half of the 1960s and the early 1970s current public expenditure on PHC was generally stagnant, although there appears to have been modest growth when this is adjusted for inflation (See Appendix 4.3). Also despite the fact that extremely high public demand had posed a challenge to the capacity of the health centres from the very beginning, between 1958 and 1976 no public funds were allocated to expanding access to these facilities.[209, 212, 218] Perhaps due to this high demand, the parochial alms-houses (renamed 'district hospitals') of the Colonial era persisted, and along with the QEH's Casualty (or A&E) department, formed the only other source of publicly-financed PHC.

Although the vestry system had been abolished in 1958, and despite a change in name, little had changed regarding how these institutions functioned. At each of the old alms-houses (by then referred to as 'district hospitals'), there was a single medical practitioner who was charged with the responsibility of providing primary-level curative services. Free (government-financed) services were limited to the elderly and indigent, and as a result there was a strong stigma associated with district hospitals as places for the

poorest of the poor (as had been the case in the past).[161, 191, 212, 220] One former Minister of Health, Keith Simmons, recalled that stark inequalities in the quality of and access to care at this level were still visible:

> "In each parish there were still parochial doctors, and he had two sets of patients—self-paying patients and government patients. And it was true that they were seated in separate areas and of course self-paying patients were seen before the government patients, even though the government was paying similar fees for them to be seen."[220]

Despite, the persistence of what would later be identified as major barriers in access to PHC and evidence of the need for even further investment in this area, this failed to materialize in the first decade of independence. Indeed, recalling her years as an administrator in the Ministry of Health beginning in 1971, one key informant said:

> "At that time we were not looking really critically at primary health care…. Yes, we had these clinics that started in the 1950s, but there was not as strong of an emphasis as there was years later."[212]

Two main factors seem to have contributed to this lull in priority for PHC. First, there was a great deal of competition for resources and attention from other priority issues/areas both within and outside of the health sector. Secondly, and perhaps more importantly, several of the key PHC advocates (who had successfully mobilized priority during the 1950s) were no longer present to ensure that this attention was sustained. In the absence of advocates to articulate the inadequacies of the existing system and amidst vastly improved health outcomes (perhaps also due in part to improvements in education and standard of living), decision-makers had the impression that the primary care needs of the population were being adequately provided for. [211]

4.4.1 Competing priorities

By 1960 poor conditions at the Barbados General Hospital—including inadequate staff and overcrowding, began to capture the attention of policy makers. According to

Hunte, the hospital had been subject to a great deal of criticisms, and the issue "had been discussed on the floor of the House of Assembly, on political platforms, and in all sections of the community".[162] To remedy these ills, a committee of inquiry recommended that a new, state-of-the-art hospital be built, and between 1960-1964 Government embarked on a major capital project to build the Queen Elizabeth Hospital. The total cost of the new hospital was BDS $9.4 million, a third of which was financed by the Colonial Welfare and Development Fund and two-thirds of which came from Government.[161, 162] Government also planned to increase the number of staff at the new hospital from 697 to 1072.[162] Over this period (1960-64), government expenditure on the QEH grew by 57.4% (from BDS$3.8 to $6 million), while PHC increased more modestly by 39% (from approximately BDS$237,000 to $329,000).[1] Between 1960 and 1970, hospital based services consumed the lion's share of the health budget, comprising an average of 75% of public expenditure on health.[1]

In addition to competing priorities within the health sector, other areas of national concern detracted attention (and resources) away from PHC. In 1961, led by the charismatic Errol Barrow, the recently formed Democratic Labour Party (DLP) swept to victory promising economic growth through diversification of the economy. The effects of centuries of neglect by the Colonial authorities had not been confined to the health sector, but were visible across all other social and economic sectors. According to one informant:

> "The reason why, between independence and 1976, Mr. Barrow's government didn't do a great deal about primary health care is because there were so many 'bigger' issues, bigger priorities."[211]

To be sure, as Barrow led the country towards independence several great challenges laid ahead. Up to that point the main source of national income, employment and foreign exchange had been sugar, but with growing competition in the world market this was increasingly being sold at a loss.[44] It was clear that if Barbados wanted to realize economic growth, diversification of the country's economic base would be critical.

Between 1961-1976 the Barrow government invested heavily in education, based on the belief that the intellect of Barbados' people was now its greatest natural resource. In 1962 the government introduced free secondary education for all and, over the course of their 15 years in office five new secondary schools were built, and the Barbados Community College, the Barbados Hotel School, and the Barbados Institute of Management and Productivity were established.[226, 227] During this period, public expenditure on education alone accounted for 21% of total government expenditure.[228]

The government also chose to invest heavily in kick-starting the manufacturing and tourism industries to diversify the economy and generate employment.[191] Examples of projects undertaken included the establishment of the Pine Hill Dairy (1966) and the construction of the Hilton Hotel, both in which the government was the principle financier and shareholder. These often large scale capital projects demanded heavy investment on the part of the government, for example BDS$7.63 million in the case of the Hilton.[219, 226, 227]

4.4.2 The departure of key PHC advocates

Although, these competing priorities undoubtedly played some role in declining priority for PHC, perhaps a more powerful explanatory factor is the fact that two of the actors who had played pivotal roles in advocating for attention and resources for PHC left Barbados to take up posts elsewhere in the region. In 1961 Dr. Kenneth Standard, founding medical officer of the St. Philip Health Centre left Barbados to take up the post of Lecturer in Social and Preventive Medicine at the University of the West Indies campus in Kingston, Jamaica.[229] Under the mentorship of Dr. Maurice Byer, Standard had become a vocal advocate for increased resources for PHC and had been at the forefront of research efforts to document the success of this work.[161, 211, 222]

It was an unfortunate coincidence that in 1962 Dr. Byer then also left the island, relinquishing his position as Director of Medical Services (in which he had served for

almost a decade) to take up the post of Principal Medical Officer for the Ministry of Health in Jamaica[xxxii].[161, 211, 236] Several informants pointed to Dr. Byer's pivotal role in generating and then sustaining priority for PHC between 1951 and 1962. Describing Byer, one informant suggested that Byer was not easily replaceable as the de facto ringleader of PHC priority generation efforts in Barbados:

> "Byer was able to achieve what he achieved because he was a man of great vision, he was a highly ethical, dedicated, committed man. He worked for the people, he had oodles of old world charm, persuasive power and an ability as a teacher to get people to do what they should do; and he just never gave up. He just kept on, and so he got the government of Barbados in the old colonial days to approve his vision of improving public health."[211]

No push = No priority

Other committed health professionals, such as Edgar Cochrane and Vaughn Wells, assumed the role of Director of Medical Services (later, Chief Medical Officer), after Byer left. However, although each of these actors made significant contributions to health in Barbados in their own right[xxxiii], neither of them emerged as particularly vocal advocates for the expansion of the existing PHC infrastructure and services. The reasons for this are not certain. Key informants have suggested that these actors felt that the system was adequate and were convinced that there were other equally (or more) pressing priorities.[161, 191, 211] Indeed, in a personal interview, Sir Carlisle Burton[xxxiv] (who was serving as the Permanent

[xxxii] During this period, PHC in Jamaica had flourished, with Byer overseeing the expansion of Jamaica's health unit system and an emphasis on maternal and child health and Standard pioneering the island's community health aide program.[230-234] Standard went on to dedicate a lifetime to advancing community health and public health education in Jamaica (and the Caribbean writ-large). Byer left Jamaica in 1970 but went on to advocate for investments in PHC elsewhere in the region before returning to Barbados in 1975.[191, 235]

[xxxiii] Cochrane is recognized for his pivotal role in leading in the elimination of tuberculosis, and Wells is recalled, along with Sir Carlisle Burton, for their contribution to introducing more coherent planning and administration in the public health sector and for championing investments in educating health professionals.

[xxxiv] Sir Carlisle was one of a handful of key informants who could provide a first-hand insider's testimony of health policy decision-making in Barbados in the 1950s and 60s, as one of the most highly

Secretary in the Ministry of Health at the time) corroborated this, saying that during the 1960s "the hospital was virtually collapsing"[161] and was therefore their top priority.

Some informants suggested that the fact that major reductions in the prevalence of tuberculosis, typhoid, gastroenteritis, infant mortality and childhood malnutrition[xxxv] were achieved, was seen by some as an indicator that investments in PHC were adequate and explains why policy-makers gave less attention to the issue (See Appendix 4.6, showing life expectancy at birth and infant mortality rates in Barbados between 1950-1974).[171, 191, 211, 237] In a personal interview, referring to this lull in efforts to address PHC, a local public health doctor and historian stated:

> "By 1970, what had been a political crisis, a political tragedy and a political scandal in the early fifties, no longer existed, between Independence and 1976 that Government felt that something was in place and perhaps did not recognise how much needed to be done".[211]

It is perhaps important to note that these reductions in disease were also likely in part due to a general rise in the standard of living of ordinary Barbadians, driven by economic growth as well as major gains in the areas of education and housing.[47] Also, although epidemiological evidence may have suggested that all was well, the stark inequalities in access to quality PHC were clearly apparent on a visit to any of the island's district hospitals. [191, 211, 218, 220, 238] The fact that no advocates emerged to link these problems to a call for action, and not necessarily the fact that epidemiological evidence indicated that progress had been made, appears to be critical in explaining the lack of attention for PHC during this time.

Although investments were maintained, especially in the lead-up to the independence in 1966 and the elections between 1970-71, this did not translate to any additions to the existing network of health centres. Moreover, between 1970 and 1976,

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ranked health bureaucrats of that time. Unfortunately he passed away on September 18, 2012 (prior to the submission of this thesis).

[xxxv] Notably, advances in combatting childhood malnutrition during this period were mostly enabled by funding the Macy Foundation.[224 (p.115)]

resources for PHC declined by just over 30% in real terms[xxxvi], from approximately BDS$21 million to just over BDS$14 million 2005 dollars (See Appendix 4.3).[1] In 1975, Byer returned to the island to take up the post of CMO once again, and voiced his concerns about the decreasing focus on PHC, saying:

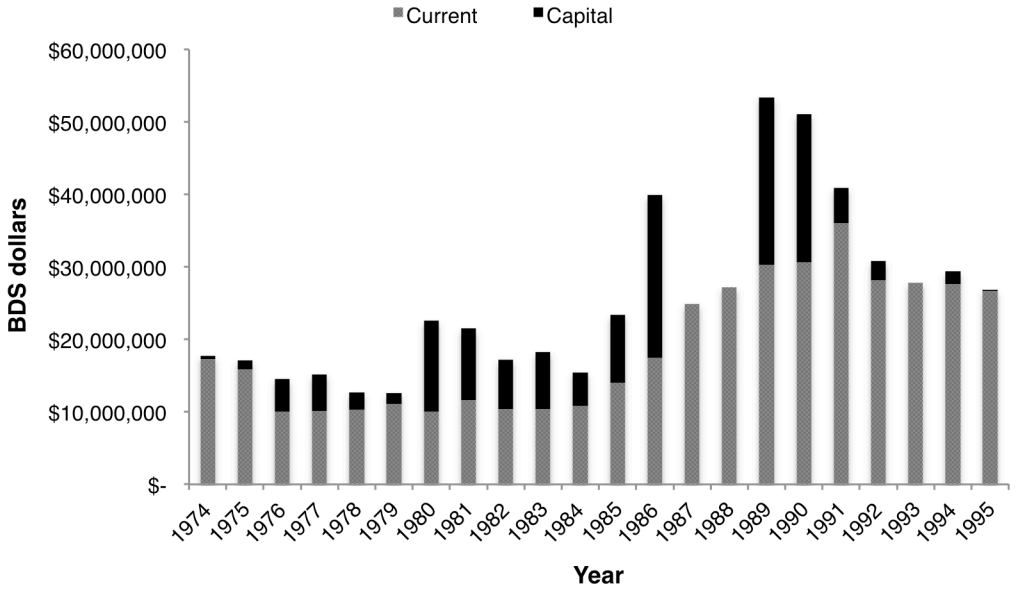
> "The fact that a given community, through its most loudly vocal organs, demands more and more hospitals, and more and more curative services, does not necessarily mean, that that community's most urgent health needs are going to be met, by the supply of more hospital beds, and larger hospital out-patient departments."[210]

4.5 A second phase of priority for PHC

In July 1976 the Minister of Health presided over the opening of the island's first 'multipurpose clinic' (later called 'polyclinics')—a facility he promised would herald the provision of an enhanced package of PHC in Barbados.[162, 211] Though under the guise of a different name, these polyclinics mostly built on the pre-existing health centres, integrating a wider array of curative and diagnostic services with preventative care. Still, this heralded a period of renewed emphasis on PHC in Barbados. In 1978, the Speightstown Health Centre was expanded and transformed into the Maurice Byer Polyclinic and a third polyclinic was established at Black Rock in the environs of Bridgetown. By 1990, a total of eight polyclinics and four smaller outpatient clinics had been established. Accordingly, public expenditure on PHC peaked at BDS$31.6 million 2005 dollars that year, in part due to heavy capital expenditure on the further expansion of several of these clinics (See Figure. This was some three times the amount of current and capital government expenditure allocated to this area in 1976.[xxxvii]

[xxxvi] The percentage change in resource allocated over this period in current terms was just under 25%.
[xxxvii] Spending on PHC dropped to BDS$21.4 million 2005 dollars in 1993 once the construction and expansion of all polyclinics had been completed and has grown incrementally since.

Figure 4.2: Share of capital vs. current expenditure on PHC, 1974-1995



Notes: Polyclinic project implementation took place between 1976-1990 No capital expenditure data available for 1987-1988 and 1993.

Source: Accountant General Reports, 1972-2009[2]

In accounting for the re-emergence of priority in this case, technocrats from the Ministry of Health (in particular the Chief Health Planner), feature as prominent drivers. They played key roles in framing the issue in socially and politically salient ways, in identifying and seizing the opportunity presented by a general election to advance priority for PHC, and in mobilizing authoritative decision-makers to act, once they had successful placed PHC on the agenda. In the face of heavy opposition to a package of reforms to health care delivery, which included a heavy emphasis on PHC, the Minister of Health's efforts in advocating for resources for PHC appears to be critical as well.

4.5.1 A technocrat uses the opportunity of a election to put PHC on the agenda again

A technocrat in the driving seat

In accounting for the re-emergence of attention for PHC in 1976, the current Senior Medical Officer with responsibility for PHC services said:

> Health was a concern to people—the long amount of waiting time, and also we were going through a recession around that time as well, so people could not afford to go to the private doctors. But really, government was pushed by the technical people in the Ministry of Health. We had a very progressive health planner and project manager at the time, Cortez Nurse."[171]

Similarly, several other actors have pointed to the decisive role of Nurse—his political savvy and persuasive power in placing PHC on the agenda again[171, 191, 211, 212]. The appointment of Cortez Nurse as the chief planning officer in 1975 was significant for two reasons. Firstly, prior to this there was no one office within the Ministry of Health responsible for the overall planning with regards to health care and health care services on the island. Staffed only by himself and a secretary, Nurse's appointment thus signalled the start of the Health Planning Unit, as we know it today. It was also significant because since independence, the top-most technocrats within the Ministry of Health had been a stable cohort of actors.[161, 191, 239] A former health inspector, Nurse had recently completed postgraduate training in Health Planning and Socioeconomic Development in Canada, where he had focused on socio-political factors influencing access to basic health services among immigrant communities in Toronto.[218] Although he brought a high level of expertise to the role, he differed from most of the other technocrats in terms of his lack of medical training.[191]

> "[T]here was some difficulty at first because up to that point any semblance of planning, was done by medical professionals, by doctors. And here, for the first time, a non-doctor was setting a sense of direction for health care… It was a paradigm shift."[218]

However, whatever Nurse lacked in terms of recognized authority early on in his role as Chief Health Planner, he made up for in terms of political savvy and in-depth knowledge of the local political and social context.

Seizing the opportunity of an election

Nurse recognised that an upcoming general election could provide an important vehicle to leverage his efforts to generate attention for PHC among authoritative decision-makers. Unlike in 1971, the party in power was not coming into the 1976 elections from a position of strength and bitter debates over constitutional reform and economic hardship brought on by a global recession had become sources of popular dissatisfaction.[xxxviii] For three terms, the DLP had campaigned successfully on a commitment to ensuring access to social services and included among its accolades the introduction of free universal access to primary and secondary education. However, in the lead up to the 1976 elections, the BLP sought to capitalize on the general desire for change.[44]

In an interview, Nurse described his efforts at capitalizing on the window of opportunity that he felt the election had presented:

> "Around elections, early o'clock, it is necessary to go around whoring.... Both parties have to write manifestos. You are there to advise them about what the people would like them to do. When the BLP saw the proposal I had written [about eliminating means-testing and the provision of primary care through community health centres], they incorporated it into their manifesto. I think their manifesto came out before the DLP, so it looked like the DLP was copying them rather than the other way…. Really they were both copying civil servants."[218]

Eager to juxtapose themselves against the incumbents, the BLP instead promised free National Health Service (NHS), of which the expansion of free access to PHC services was to be an integral part.[240] One politician recalled:

> "In the 1976 election, the thing that I found myself speaking about most on the platform was health and we put this thing in our manifesto and I was just articulating it as I went along. It wasn't spelt out in any detail."[191]

On the campaign trail, a spotlight was now on the health sector, and the existence of means-testing at the district level quickly became a political sore. With a sense of rivalry

[xxxviii] Barbados was experiencing a general economic slow-down in the wake of the 1974 energy crisis, which had notably resulted in rising unemployment.

emerging between the two parties on their plans to improve PHC, and the general increase in social expenditure known to accompany elections in Barbados, Nurse knew it would be easier to mobilize financial resources for piloting the multi-purpose clinics:

> "Government had been constructing a crematorium at Warrens but the project had stalled. We then agreed to make some adjustments and turn it into a multipurpose clinic at Warren…. Because it was around election time we got some money quickly to do something (sic)."[218]

In spite of the fact that the clinic did not actually open its doors to patients until after the election, struggling to muster grassroots support then-Minister of Health Erskine Sandiford presided over an official opening ceremony in May of that year.

Political savvy helps place the spotlight on PHC

Displaying a great deal of political acumen, Nurse effectively managed to generate attention for PHC among actors from both sides of the political divide. By the time that the BLP came to power in 1976—having won the election decisively[xxxix]—PHC was firmly on the public agenda. In an unpublished article entitled 'An Approach to Planning for Health in the Caribbean'[239] referring to priority setting in the Caribbean, Nurse states:

> "Very often political expediency or simple 'pressure groups' needs become the allocating mechanism, rather than some rational socio-economic evaluation of needs and capabilities."[239]

Reflecting on the rise of access to primary care on the political agenda in 1976, Nurse expressed the view that a good planner should be able to capitalize on what is politically expedient in order to advance a cause or programme saying: "You see, a health planner doesn't have to play politics, but he does have to understand it."[218] In addition to this key role of seizing the brief moment of opportunity presented by the election, Nurse and other technical officials from the Ministry of Health also played a key role in helping to develop two core ideas that helped to motivate action by authoritative decision-makers.

[xxxix] The DLP took came out of the 1976 elections with 17 out of the 25 seats in the House of Assembly.

4.5.2 Two core ideas help to motivate action

Between 1978 and 1990, two core ideas proved powerful in mobilizing authoritative decision-makers to devote increased resources to PHC. Nurse played a key role in linking PHC to highly salient issues—namely, memories of health care under the vestry system and the need for cost containment in the face of declining economy growth. He and other technocrats within the Ministry of Health first made the claim that the persistence of means testing as a method of rationing limited primary level care was a relic of the colonial past and a driver of inequity in access to health services. Secondly, they worked to gather evidence to support the assertion that cost-savings could be realized, and the burden on secondary and tertiary services would be reduced, if greater investments were made in PHC.

No more' pauper medicine'

Some health policy actors interviewed cited widespread public dissatisfaction with the primary-level curative services delivered at the district level, in accounting for the emergence of PHC as a priority issue in the mid-1970s.[171, 241] However, there is no evidence to indicate just how big a concern this was for regular citizens and whether there was indeed widespread demand for expanded access to PHC. Moreover, means testing had persisted without any notable outcry from the public or from powerful policy actors, for an entire decade since independence.[45, 191, 211, 224] Instead, efforts to frame the need for PHC in this way seem to have been led by Nurse and other technocrats, from within Ministry of Health. In a personal interview, Nurse admitted that the lay population had not translated their dissatisfaction into specific demands:

> "There was a demand for care, but people did not understand what the [policy] demands were as such. For example, they knew that if they did not have money they had to go and stand up in the casualty for a long time, and the QEH Casualty did not have a very good reputation."[218]

In his initial assessments of the health care system, he found that there were several non-medical barriers to accessing care. He was particularly incensed by the use of what was a crude form of means testing by welfare officers to ration care at the primary-level. He also noted that, like the alms-houses of colonial times, there was a high degree of social stigma associated with receiving care at the district level:

> "I had gone out to see how the welfare officers worked… and I found that we were still basically in a slave society, in a 'massa-type' situation. I remember one that really infuriated me was a girl whose face was really swollen and who really was in pain. Just to get a tooth extraction, the questions that the officer was asking about her personal life—for example, 'if she didn't have a man to help pay the doctor?'. I swore that this must stop (sic)."[218]

Aware that increased investment in PHC had been achieved in the 1950s, when this need was situated within the wider struggle to address the social injustices that had been perpetuated under the vestry system, Nurse built on the collective memory of this transition to help generate priority for PHC once again. Within the context of a hotly contested election, and high unemployment and economic hardship due to the 1973 oil crisis, the idea that the persistence of means testing at the primary-level was a vestige of the island's colonial past proved to be incredibly powerful in motivating political actors.[191, 211] Aware of the pending elections, Nurse used this argument to encourage the Minister of Health to agree to establish the first 'multipurpose health clinic':

> "[In 1975] I worked with Erskine Sandiford, who was then Minister of Health, and convinced him that what we were doing with health was still behind God's back, in terms of the acceptance of having to go through the welfare officer for health care and that kind of thing."[218]

However, this powerful idea fit well into the election rhetoric of the opposition party at the time—namely their accusations that the DLP had been neglecting its welfare role during its last term in power.[240] As a result, in the lead-up to the election the persistence of means-testing or what the leader of the then-opposition party, Tom Adams, referred to as "pauper medicine" became a central talking point.[191, 218] Though there was no evidence to show that this reported unequal access to primary care services was resulting in

higher mortality and morbidity among those less able to pay, defending a bill to establish the NHS in parliament Prime Minister, Tom Adams, addressed Parliament saying:

> "In Barbados, we want to…merely ensure that the best medical care at primary level, is available to everybody whether they can pay for it or not. This is what the National Health Service is about. For those many people who go to the ordinary clinic run in connection with the Casualty, known as the walk-in clinic, there will be no more walk in clinic eventually. For people who go to what used to be called parochial medical officers and then district medical officers, there will be no more district medical officers. The idea of pauper medicine will be abolished."[242]

This prevailed as the dominant rationale presented to the general public to justify investment in the polyclinics and implementation of the National Health Service throughout the BLP's ten-year tenure. Moreover, this idea was successful in mobilizing broad-based support for the polyclinics and undergirded sustained investment in PHC even after a change in government in 1986.[171, 191, 220, 243] As a result, even though there was much disagreement surrounding the proposed NHS, the one aspect on which there seemed to be consensus was the need to abolish the district level means-testing and to expand free access to PHC services.

A study reveals potential cost-savings with increased investment in PHC

Also, in 1975 the Ministry of Health requested technical assistance from the Inter-American Development Bank (IDB) to conduct a comprehensive study of the existing health care system.[xl] The final report identified several inadequacies and inefficiencies in the delivery of health services on the island. [245] Among these was the fact that, with the exception of some basic services for the 'elderly and indigent', for the majority of Barbadians access to primary-level curative care was largely determined by ability to pay. Also, the existing PHC facilities were over-burdened, with each of the three health centres

[xl] The study was conducted Peat, Marwick, Mitchell & Co. Management Consultants, a Trinidad-based firm, and drew on mortality and morbidity statistics and other records from the Ministry of Health, in-depth interviews and discussions with Ministry of Health officials and health care personnel from both the public and private sectors, and visits to the island's health care facilities.[244]

serving populations of between 70,000 and 94,000 people. Consequently, the study revealed that many patients were entering the health care system at the secondary or tertiary level—60% of all cases seen by the Accident & Emergency (A&E) department at the QEH were in fact non-emergency cases, which could have been addressed at the primary level. The authors cited this as the root cause of overcrowding and long wait times in the hospital's A&E department—both major sources of public dissatisfaction.[245]

Based on this study, technocrats in the Ministry of Health became convinced that expanding access to PHC was critical, and Nurse began to compile evidence to support the assertion that greater investment in PHC would lead to a more efficient use of limited public resources.[218, 244-246] In their 1977-1982 development plan, the Ministry of Health recognized the need "to reduce wastage of economic, human and other health resources".[247] Similarly, in outlining the rationale for the polyclinic project[248], technocrats illustrated that the cost per patient visit at the proposed polyclinics would be half that of seeing the same patient as an emergency outpatient at the QEH. In addition, while PHC services only accounted for 51% of all outpatient attendances by public health care institutions in 1978, the plan proposed to increase this share to 81.8%.[248]

These analyses proved critical in mobilizing support among key authoritative decision-makers (in particular, the Ministers of Health and Finance[xli] at the time), as they became convinced that significant savings could be made by relieving the specialized (and more costly) services offered at the QEH from what were demands for basic primary-level care. This was particularly salient for decision-makers at the time in the context of poor economic performance, due to the 1973 and 1979 oil crises. Moreover, by connecting the problem of the long wait times in A&E to the need for expanded access to PHC, policy makers could assure the public that they were working to address what was becoming an increasingly controversial issue. [243, 249-251]

[xli] The Minister of Finance was Prime Minister, Tom Adams.

Challenges to the credibility of these claims

It is unclear to what extent evidence informed these core ideas or PHC advocates' ideas about the problems and solutions drove the evidence. However, the idea that means testing should be abolished went unchallenged.[191, 212, 218, 220] Conversely, there was not consensus regarding the veracity of the claim that investment in PHC would lead to greater efficiency, or around the particular policy solution that was proposed by the BLP-administration.[218] Opponents argued that far from being less costly (as technocrats were claiming) that experience in Great Britain, Canada and elsewhere in Europe suggested that the contrary would be true.[211, 214, 252] Representatives from the Barbados Association of Medical Practitioners (BAMP) argued that there was no definitive way of showing that restructuring the system of health care delivery in Barbados would actually yield health gains:

> "In the past 30 years our health indices in the form of infant mortality rates, birth rates and life expectancy have improved and demonstrated unequivocally that we are among the healthier people in the world. There is no study nor any authority on health care that can recommend that the proposed NHS [policy] will further improve the health status of Barbadians as defined by these indices."[237]

In the face of fierce opposition from BAMP, the fact that powerful decision-makers emerged to help champion these claims was a critical factor in accounting for the emergence of priority for PHC. In particular, the Minister of Health, Billie Miller, and Prime Minister, Tom Adams, became key supporters of the call to ensure universal access to PHC services.

4.5.3 Powerful decision-makers support increasing priority for PHC

The National Health Service Proposal and its opponents

While technical officials within the Ministry of Health played a key role in placing PHC on the agenda, they did not have a monopoly over the policy development. Once the issue had been placed on the political agenda, in their manifestos and in campaign speeches, politicians developed their own policy proposals to address the gaps in the provision of PHC services that technocrats had identified, often drawing on their own personal/professional experiences to do so.[191, 218, 220]

Given that the Leader of the Opposition at the time, had recently returned from studying in London, it is not surprising that he drew on his experience of England's NHS in proposing that a similar concept be employed to ensure universal access to PHC services in Barbados.[191, 211, 214] However, as one informant noted, "[n]ow the pity was that the decision to go with a NHS concept was a fairly last minute decision leading up to the 1976 election and the manifesto was therefore written rather hurriedly".[211] A political candidate at the time and Minister of Health under the BLP administration corroborated this:

> "Soon after I became the Minister [of Health], both he [Tom Adams] and I had to be in New York. I was invited by the Association of Barbadian Nurses in New York to come and speak to them about the National Health Service. He wanted to come and I remember he said to me: 'It will give me an opportunity to go and hear what the National Health Service is'…. It was in the manifesto but it wasn't fully fleshed out."[191]

After the BLP won the elections later that year, technocrats and other international experts worked with political leaders to fully articulate the proposal to establish a NHS in Barbados.[191, 218] Although PHC remained a central focus, the resultant proposal—as articulated in the 1977-1982 national health plan and consultant reports—was both considerably wider in scope, and much more controversial, than what technocrats had originally envisioned (See Table 4.2 below).[247]

Table 4.2: The National Health Service Proposal

	Key features of policy proposals		Implemented?
I. Barbados Drug Service:	• The establishment of a public agency to oversee the procurement and regulation of pharmaceutical products on the island. • A publicly funded service to provide citizens with quality pharmaceutical drugs at the most affordable cost. • A special benefit service through which drugs would be provided free of cost to citizens under 6 and over, 65 years of age, as well as to those requiring medications for hypertension, diabetes, cancer, epilepsy and asthma.		Yes
II. Primary Health Care Phase:	a) The Polyclinic Project	• The development of a nation-wide network of 8 community-based primary-level facilities (or polyclinics) • The project aimed to build on the preventative focus of the pre-existing health centres, by providing a wide range of primary-level curative, diagnostic and rehabilitative services. • The plan proposed the construction of eight polyclinics.	Yes
	b) General Practice Service	• A universal primary-level GP service available free of cost at point-of-service operated out of the polyclinics and group practices located around the island • Each citizen would be registered with a general practitioner of his/her choice and would receive primary-level GP services free of cost at the point of service • GPs would be responsible for a panel of patients and would be remunerated on a capitation basis • An after-hours emergency service	No

Notes: Shaded area indicates original proposal to expand PHC services.

Sources: Ministry of Health and National Insurance (1978)[248]; Kaiser Foundational International (1979)[253]; Roemer (1979)[254]

Members of the Barbados Association of Medical Practitioners soon took issue with key aspects of the proposal. In particular with regards to the PHC phase, they voiced disagreement with the idea of a government-funded and regulated GP service. According to one former president of BAMP, "they [the doctors] felt that the government was trying to control them"[241], by requiring them to work longer hours in order to run the after-hours emergency service. They also feared that the government would exert control by placing restrictions on the number of patients a GP was allowed on his/her panel.[214, 237, 252] Another informant—and active member of BAMP at the time—indicated that at the time they were concerned about the proposed methods and levels of remuneration under the proposed service:

> "[T]he concept was so naïve that unfortunately it got the government and the doctors into battle. You couldn't expect doctors to work 24/7 to be on call all night, every night of the year and to be paid at the salary of a teacher with a first degree…well maybe it was at a salary of a head teacher, but it was clearly a ridiculous suggestion. And so, BAMP became a trade union as a result of this proposal and fought this rather bitterly."[211]

Medical doctors often constitute powerful lobbies because of their monopoly on medical expertise. In the context of a small island, where there is often only one or two specialists in a particular discipline at any given time, BAMP was an especially powerful force to contend with.[241, 252] In the face of such strong opposition, the role of authoritative decision-makers in supporting priority generation efforts was pivotal.[218, 241]

Technocrats help mobilize the Minister of Health to champion PHC

After the excitement of the elections had subsided, continued efforts by Nurse and other technocrats behind-the-scenes ensured that PHC remained an issue of concern among powerful decision-makers. The new Minister of Health, Billie Miller, soon emerged as a champion for increased investment in PHC.[171, 218] Miller's father had served as Minister of Health between 1958 and 1961, and had demonstrated a strong commitment to PHC during his tenure.[161, 191, 218] According to Nurse, this provided fertile soil for his efforts to garner her support:

> "Basically, Billie Miller came out of a political family. Her father before her was very community oriented and so was she. So selling an idea like that to her was like pushing an open door."[218]

In an interview, Miller acknowledged that an added sense of drive came from the fact that she saw her work in this area as honouring her father's legacy:

> "What I really did was to upgrade the centres that my father had built in his time. It was incredible that all those years later, I was building on my father's foundation."[191]

However, she also pointed to the importance of Nurse's ideas (expressed in planning documents and proposals) in shaping her views early on:

> "[Mr. Nurse] was on leave when I first came to the Ministry of Health but…I asked for old files and read everything I could get my hands on to get up to speed. When he came back from leave and I met him for the first time, I told him that I had read his work and I was greatly impressed."[191]

In the 1977-1982 Ministry of Health Development Plan asserted that the administration considered the development of the PHC sector to be its foremost priority.[247, 248, 255] Before long, even in the face of heavy opposition, Miller had joined technical personnel in their efforts to ensure on-going priority for expanding public coverage at this level.

Leveraging power to unleash resources

Despite being relatively new to the political arena, Miller punched above her weight in terms of social and political capital. She was a close friend of the Prime Minister, Tom Adams, and therefore enjoyed easy access to him. Their connection went back several decades, with Miller's father serving as Minister of Health when Adams' father was premier of the island.[191] As a result, Miller had the willing ear of the country's highest office whenever she required it. As a result even in the midst of difficult economic times—due to a global oil crisis in 1981—domestic resources were allocated to begin the establishment of the polyclinics network.[218, 256] Accounting for her success at mobilizing resources for PHC, she said:

> "Tom was a fantastic Prime Minister. He never blinked when I went to him with requests. For example, there was money left over from the EDF [European Development Fund] and he said that I could have it. So we used European funds to build the polyclinic in Speightstown."[191]

In 1977 the Prime Minister also established a steering committee at the level of the Cabinet, to provide strategic direction to planning the establishment of the National Health Service.[191, 218, 248] Under the leadership of Miller and Nurse, this committee became the focal point of efforts to mobilize support and resources for PHC over the next eight years.[191, 218]

Adams took special interest in its work, often stepping into the fray when the committee's plans came under attack by the island's powerful medical association. For example, speaking to the press after reporting to parliament that negotiations with the medical association had been unproductive, Adams stated: "We are prepared for the struggle. There will be a battle."[242] And, in another sitting of Parliament he asserted:

> "…[I]t is usual as countries develop to have a free health service, it is usual, it is normal, and what we are going through in Barbados with the doctors has been gone through in virtually every English-speaking country in the developed world. In America, the doctors won. In Britain, the Government won, if you want to oversimplify it. In Barbados, the Government will win."[257 (p.1158)]

The role of political support in the face of strong opposition

Referring to renewed priority for PHC during this period, one Senior Medical Officer with responsibility for PHC said: "[T]he whole thing came about because between the political and technical people, we knew that there had to be a change."[171] This was perhaps made most evident in 1981 when Miller was moved from the Ministry of Health. Although she continued to agitate for resources for PHC from within Cabinet in her new position as Minister of Education, frequent changes to the Minister of Health (four in total by 1986) and the death of Prime Minister Adams in 1985, had significant consequences for efforts to generate priority for the implementation of the National Health Service.[191, 252, 258]

> "Some unfortunate things happened that I believe cut the crop off early…. I think that Tom had moved Billie [from the Ministry of Health] because the doctors were getting on him and saying that they wouldn't support it. The Minister who came after Billie took it off the rails."[218]

Nurse was convinced that in addition to their advocacy, Miller's persistence in securing support at the highest level of government was of critical importance:

> "I found it very easy [to work] with a woman that I found to be very upright, a woman up to this day I have very high esteem for. She did not care about your political persuasion. She was interested in concepts…. One thing about Billie is that once she understood

> and agreed with a proposal, she would fight for it. I'm sure that if Billie Miller had stayed, we could have won."[218]

In the face of strong opposition, they ultimately failed at their efforts to fully implement the NHS. However, they were successful in mobilizing (and sustaining) public resources for the polyclinic project. The fact that the Ministry of Health had secured external financing to assist with the establishment of five additional polyclinics in 1979, appears to form part of the explanation of why priority for PHC was sustained (even after a change in government).[259]

4.5.4 External financing for PHC helps sustain priority for PHC

Several key informants pointed to the importance of external financial assistance in helping to ensure that priority for PHC was maintained, in the midst of strong opposition to the NHS proposal and throughout the economic turmoil of the 1970s and 80s.[191, 218, 220]. A look at public expenditure seems to corroborate this. Even though it was announced that the government was committed to establishing a network of polyclinics in 1976, Barbados was in the midst of an economic recession sparked by the 1974 oil crisis and resources failed to materialize. Public expenditure on PHC was only significantly increased after 1979, when a US$3.3 million dollar loan was finally secured from the IDB. Similarly, public expenditure on health fell by almost 20% between 1980 and 1984, spending on PHC fell accordingly by almost 30%, in the wake of another global economic recession. However, despite a continued decline in overall government expenditure in 1985, spending on PHC was boosted by another IDB loan for ensuring the continuation of the polyclinic project.

In a personal interview, Nurse indicated that external financial assistance proved crucial because of the high upfront costs of constructing the clinics:

> "The investment required for the physical infrastructure was too high and then we also had to look at the current costs—manpower, supplies and so forth. But getting the loan took longer than I

> thought it would and really it ended up pushing the building [of the polyclinics] into the 1980s."[218]

Working together with Miller and Adams, Nurse sought to leverage the supportive global environment that existed for PHC efforts in the wake of Alma Ata to mobilize development assistance for the project:

> "I would say that the Alma Ata declaration helped encourage IDB to fund primary health care efforts and I think it might have helped us to get the funds from them at a concessionary rate. Alma Ata declaration also helped to give more impetus to what we were doing within the Ministry of Health."[218]

However, acknowledging that the polyclinic project differed (and in some ways fundamentally so) from WHO's PHC approach, Nurse admitted that this required framing domestic efforts using the language that was being using by global actors, saying: "All we did was change what we called it and called it primary health care."[218] These efforts proved successful. In 1979 the Inter-American Development Bank approved a US$3.3 million (1979 dollars) loan for the construction of four polyclinics. Then in 1985, another loan was approved for the construction of a fifth polyclinic (See Appendix 4.3).

4.6 Concluding thoughts

Technical personnel within the Ministry of Health—in the first instance a small group of medical professionals and in the second the Chief Health Planner—working in close alliance with key authoritative decision-makers, seem to be key drivers of priority for PHC in Barbados. These actors influenced the prioritisation process by: i) developing and propagating understandings of an issue that prove powerful in motivating politicians to act, in each case drawing on a variety of evidential sources to make their claims; and ii) successfully identifying and seizing specific (and sometimes time-sensitive) events or periods, when they feel that their likelihood of success is enhanced, in order to mobilize attention or resources.

Across these episodes, the technocrats who were most successful at these activities shared a number of characteristics—they were closely connected to powerful domestic authoritative decision-makers, they displayed an intuitive knowledge of the local context and drew on this to think strategically about how and when to catalyse change, and in each case they are described by a range of key informants as being extraordinarily committed to expanding access to PHC and persistent in their calls for government resources and attention. However, this chapter also illustrates that, even for policy advocates best poised to generate priority in these ways, success can be constrained (or in some cases, enabled) by factors beyond their control. Among these, were changes to the power wielded by their political allies (either due to party changes or shifts in political appointments) and the presence of a powerful opposition lobby. The latter was especially influential, as while PHC advocates still managed to generate resources for PHC between 1976 and 1990, heavy opposition from the island's medical association meant that they were unable to realize their proposal in its entirety.

External financial assistance was relied on (albeit to varying extents) and international ideas and experiences influenced policy content, in both phases of increased priority for PHC. However, on their own, international actors were not found to be major drivers of priority for PHC. This was perhaps most clearly illustrated by the failed attempts of the Colonial government to mobilize the domestic administration to invest in PHC between 1937 and 1951.

Between 1953 and 1990, domestic actors successfully mobilized the domestic political system to invest considerable resources in expanding access to primary-level preventative and curative services on the island, transforming Barbados from laggard to leader with regards to PHC when compared to other islands in the English-speaking Caribbean. However, perhaps due to the reliance on large upfront investments in physical infrastructure in this case, the unique power of the medical profession as a lobby, and/or the small close-knit network of principal actors that comprise Barbados' health policy arena—

over time, the prioritisation process was such that past priority generation efforts and policies informed subsequent ones.

Chapter 5
Challenges in generating and sustaining priority for sanitation

5.1 Introduction

In 1854 a cholera epidemic swept through the Caribbean, wreaking havoc everywhere it went. To refer to its toll on Barbados as tragic would be a gross understatement. Within three months the epidemic was responsible for the deaths of between 20-25,000 people or 15% of the island's population.[260-262] Describing the epidemic's impact on the city of Bridgetown in an eyewitness' account, Rev. Thomas Butcher remarked that streets that were once distinguished by the hustle and bustle of carts filled with goods for commerce, had ground to a halt:

> "[T]he unmistakable rumbling of the dead carts, carrying empty coffins…and returning with them filled—five or six coffins in a load—to the place of interment. Intense excitement agitated every heart…and the land was wrapped in solemn gloom. When the mind thought, it thought of cholera; when the tongue spake, it spake of cholera; when the hand wrote, it wrote of cholera."[263 (p.12)]

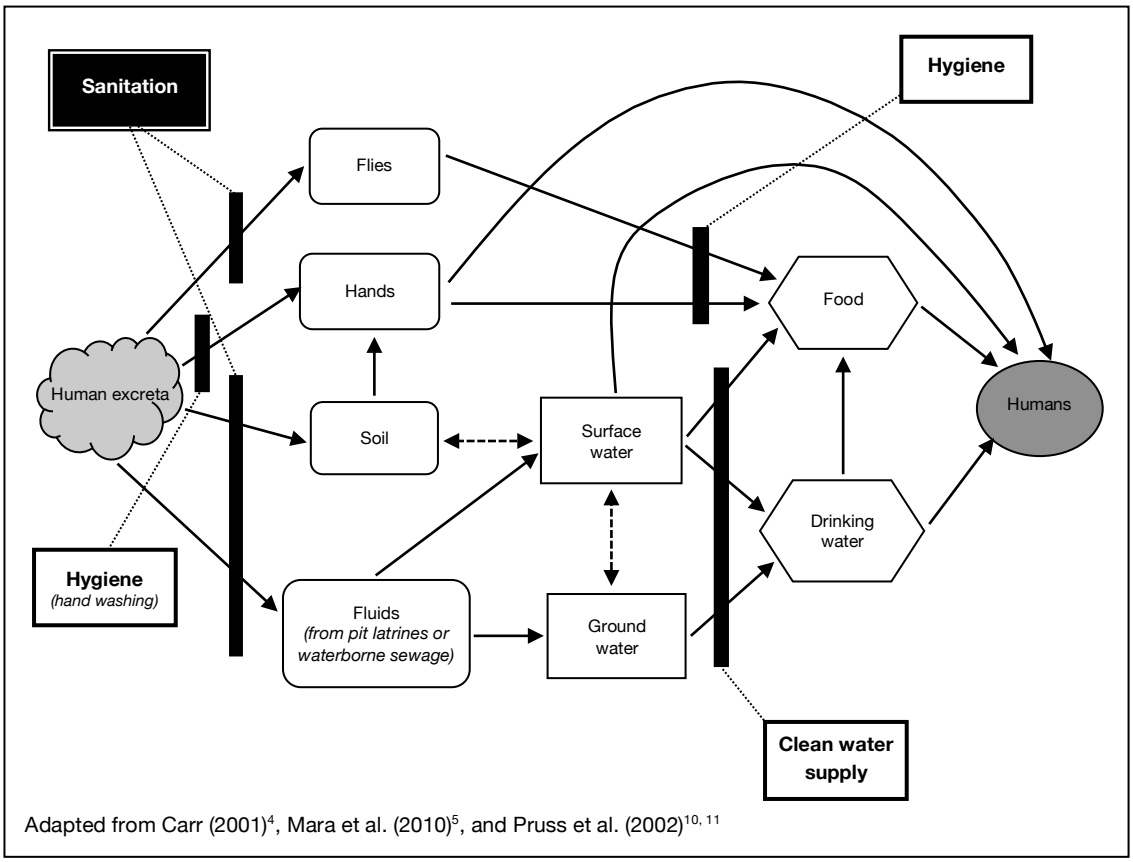
Cholera is a bacterial infection of the small intestine spread primarily via human faeces[xlii], which flows in the form of large volumes of watery diarrhoea (in the order of 10-20L per infected person a day).[260, 264] Where there is inadequate treatment of drinking water and/or where water supplies are not kept clearly separate from contamination from the disposal of human excreta, this allows for efficient and speedy propagation of the infection through an otherwise healthy population. In 19th century Barbados both poor sanitation and limited access to clean water for the majority poor, black masses—a status quo that was maintained by the Colonial leadership—provided a fool proof vehicle for the disease.

[xlii] Cholera is can also be spread via contaminated seafood (shellfish and plankton).

Defining sanitation

Like cholera, several of the world's most deadly and debilitating infectious diseases are transmitted when pathogens in one person's excreta (generally their faeces) travel to the mouths of others.[xliii] In general, faecal-oral diseases are transmitted either directly via the hands of the infected or (most often) indirectly, when human excreta come into contact with the water supply or food chain (See Figure 5.1, below, showing the transmission pathways of faecal-oral disease). Figure 5.1 also illustrates the mutually reinforcing roles that access to clean water, hygiene and sanitation play in mitigating the potentially devastating effects of faecal pathogens on human health. In particular, sanitation acts as a first-line of defence by reducing the likelihood that disease-causing pathogens will be able to get into the potable water or food supplies in the first place.[4, 266, 267]

Figure 5.1: Routes of faecal-oral disease transmission and role of sanitation



Adapted from Carr (2001)[4], Mara et al. (2010)[5], and Pruss et al. (2002)[10, 11]

[xliii] Among the oral-faecal diseases, diarrheal diseases such as cholera, typhoid, gastroenteritis, and dysentery, account for the majority of deaths. However, other related diseases such as poliomyelitis, schistosomiasis, trachoma, and hookworm infection can have severe life-long debilitating effects.[265](p.3)

In its narrowest sense, (environmental) sanitation refers to measures for the safe disposal of human excreta[xliv]. As Mara et al. (2010) point out, the emphasis here is on 'safe disposal', which "implies not only that people must excrete hygienically but also that their excreta must be contained or treated to avoid adversely affecting their health or that of other people."[5] There is widespread acknowledgment that the collection, transport, treatment and disposal of human excreta or sewage is foundational to public health.[5, 269, 270]

Broadly speaking, there are two main types of technologies for the management of human excreta (See Appendix 5.1). On-site systems, such as pit latrines, treat and store excreta at its point of origin. Off-site technologies involve taking the waste to another location for treatment and disposal. On-site sanitation is still widely used on the island; however due to the country's dependence on groundwater and high water table, these technologies do not necessarily provide adequate protection, especially in lower lying coastal areas (see Appendix 5.1 and 5.2). As a result, sanitation policy in Barbados has generally taken the form of public investment in sewage systems and treatment plants.[xlv] Budgetary allocation for such projects is therefore used as a primary indicator of the presence of priority in this case.

Challenges in generating and sustaining priority for sanitation in Barbados

At the time of Barbados' deadly epidemic, the aetiology of cholera was not well understood. However, by the turn of the 19th century (largely due to the work of British doctor and public health pioneer John Snow), it was well-known that a clean water supply and adequate sanitation went hand in hand and were vital to the prevention of cholera and

[xliv] Environmental sanitation may sometimes be used to refer to a wider set of activities including the management of solid (rubbish), industrial or hazardous wastes, and the drainage of storm water.[268]

[xlv] These are considered by some to be the 'gold standard' of sanitation systems. However, it is important to note that there is some debate over this. For example, Carr (2001)[4] and Cairncross (1989)[271] have identified the high cost of such systems, their dependence on large amounts of water, and environmental implications of (untreated/treated) discharges on recreational waters and aquatic environments, as reasons for the inappropriateness of sewage systems in some contexts.

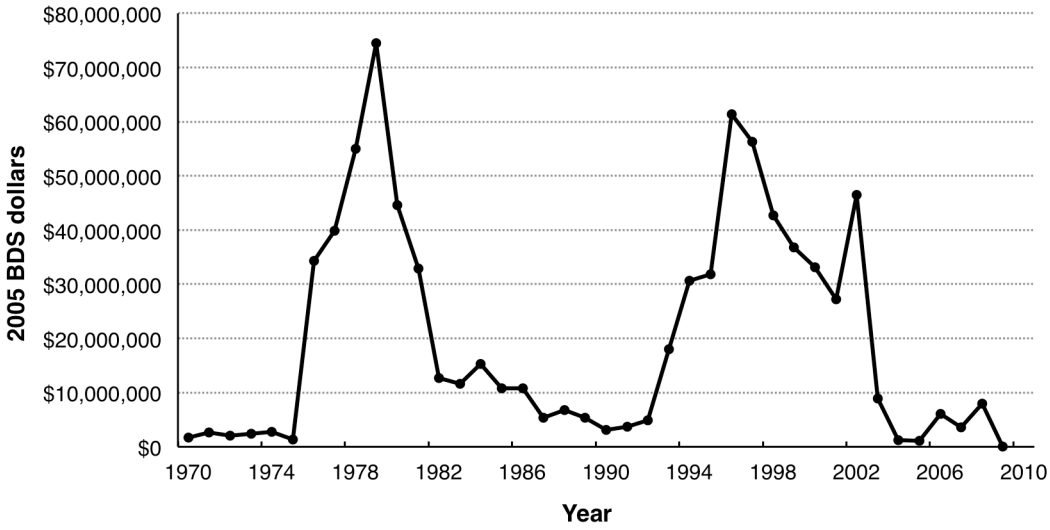
other deadly diseases.[272] In England, this evidence sparked the institutionalization of public investment in systems for the treatment and disposal of sewage. However, in Barbados, while the authorities emphasized expanding access to clean water, sanitation continued to be neglected for more than a century afterwards. As a result, by 1960 75% of all Barbadians had access to clean piped water in their homes—an achievement of which the government was quite proud.[45] However, almost nothing had been done in the area of sanitation.

Beginning in 1959, financed by WHO/PAHO, the first efforts towards improving sanitation in Barbados began and throughout the 1960s health officials became increasingly concerned about sewage disposal and the safety of the island's water supply. Yet there were still no earmarked public resources for sanitation until health officials took action by creating a senior post within the Ministry of Health and hiring the island's first ever sanitary engineer. In 1970, environmental sanitation appeared as a dedicated line item in the Ministry of Health's budget for the first time and that year, the government began to make plans for the construction of a multi-million dollar sewage system and treatment plant for the city of Bridgetown. In 1976, the government allocated more than BDS$35 million (2005 dollars) to sanitation in its yearly budget, and by 1979 sanitation comprised more than 30% of all public health expenditure.

Even before this system was completed, it was clear that it would only address the tip of the iceberg, and that further investment in sanitation—especially in sewering densely populated low-lying areas on the south and west coasts on the island—would be needed. However, since the early 1980s, sustaining priority for sanitation has been fraught with difficulty. Although plans to invest in improving sanitation on the island's south and west coasts were announced in 1979, between 1982 and 1992 resources for sanitation declined significantly, almost returning to 1974 levels. While spending grew exponentially beginning in 1992 with the construction of a sewerage system for the South Coast, this was more than a decade after plans for this project had been announced (See Figure 5.2, below). Moreover, since 2003 sanitation appears to have fallen off government's agenda altogether and the

impetus for continued investment in this area (particularly for improving sanitation on the island's west coast) has been lost.[273-276] Accordingly, public expenditure has fallen significantly, dropping to zero in 2009 (See Figure 5.2).[1]

Figure 5.2: Government expenditure on sanitation, 1970-2010 (in 2005 BDS dollars)



Notes: The data in this graph includes spending on sewage disposal/management only.
Source: Barbados Estimates, 1960-2010[1]

Explaining fluctuating resource allocation for sanitation in Barbados

This chapter begins by describing the absence of priority for sanitation for more than a century after the cholera epidemic of 1854, setting the backdrop against which subsequent efforts to generate priority for sanitation were set. I then explain how the work of international organizations, along with fetid conditions in the capital city, contributed to mounting attention for sanitation during the 1960s and led to the appointment of a sanitation technocrat within the Ministry of Health. I go on to explain how this technocrat leveraged his position within the administration to move sanitation up on the agenda, successfully mobilizing substantial resources for sanitation between 1975 and 1982. Finally I explain why efforts to generate priority since the early 1980s have been so fraught with difficulty. In these final sections, I chart the role of technocrats in their battle to ensure that resources

were mobilized for improving sanitation on the South Coast and suggest reasons for the current absence of priority and stalled efforts to sewer the West Coast.

5.2 A brief background on priority for sanitation in Barbados—a century after cholera

For much of the 20th century, there continued to be little or no public investment in improving sanitation facilities in Barbados. It was therefore the result of a combination of improvement in access to potable water, natural advantages—namely the island's reliance on underground water sources, the natural filtration properties of limestone (of which 85% of Barbados' landmass is comprised), its climate and location—and sheer luck, that Barbados was spared devastation of the order that had been experienced during the 1854 cholera epidemic. In particular, excreta-related disease continued to plague the majority poor, black masses. Yet, despite several attempts to place sanitation on the public agenda between 1919-1945, priority for sanitation failed to take root.

Failed attempts at generating priority for sanitation

During this period, several external actors made attempts to place sanitation on the domestic agenda. For example, according to Hunte, in 1919, the authorities failed to take advantage of financial assistance to improve sanitation:

> "The [Rockefeller] Foundation had offered staff and funds to treat hookworm infestation in specified districts in Barbados, on the condition that an organized system of excreta disposal be implemented. This offer was refused or ignored by local authorities."[162] (p.258)

Again in 1921, when an engineering firm recommended a sewage system for the city of Bridgetown and pointed out that current practices of excreta disposal could negatively affect tourism, according to Ramsey, the government's response was "that tourists would not be afraid to visit Barbados, because typhoid fever was killing only black

people."[45] In 1945, following the 1937 riots, local health officials brought the island's poor sanitary conditions to the attention of the colonial authorities as one of the many social factors that was a source of discontent among the majority poor black masses. In a Moyne Commission Memorandum on Health Services, the authors made special mention of what they felt were deplorable conditions in the island's capital, saying: "As the city of Bridgetown has grown, it is obvious that no proper town planning or proper sanitary provisions were enforced."[164] Subsequent efforts by the Colonial Office to influence the provision of basic sanitation through the provision of financial assistance (in response to the Moyne Commission) also proved futile, as authoritative decision-makers remained uninterested in sanitation.

(Un)sanitary conditions and disease point to inadequate excreta disposal

As a result, up to the middle of the 20th century, more than 50% of households in Barbados were lacking what was considered to be the most basic form of adequate sanitation—the pit latrine. In poor households 'sanitary' facilities often consisted of a privy with a cesspit or a pail (bucket) closet and, according to Ramsey, "those without a 'pit hole' were encouraged to use and consequently pollute the cane fields."[45] For the wealthy minority, who generally had access to piped water on their premises, water closets that emptied into closed cesspits, and later modern waterborne toilets, were common. While the difference in bathroom facilities contributed to individual levels of hygiene, there was very little difference in terms of what happened to the waste once it had been discharged.

In the central areas of the island, disposal of human and other liquid waste was mostly by means of on-site 'suck wells'—deep pits that allow for filtration of liquid waste through fissures in the coral limestone.[277, 278] The incredible filtering capacity of limestone, had allowed the integrity of the groundwater supply to be preserved.[238, 279] However, along the island's southern and western coasts and across the low-lying city of Bridgetown, where

there is a high water table, suck-wells were often not feasible (See again, Appendix 5.1). As a result, in these areas excreta was often dumped in the nearest gully, watercourse, or gutter, and when cesspits or septic tanks were full 'night soil operators' collected the waste and deposited it to designated coastal littoral zones or in public drains.[45, 238, 280]

As such, sanitary conditions in Barbados throughout the late 19th and 20th centuries were considerably poor, reflecting the generally low standard of living endured by the majority poor black population on one hand and the indifference of the island's colonial government on the other. Periodic outbreaks of typhoid fever (between 1920-1922 and in 1956) and generally endemic gastroenteritis, which was leading cause of child mortality up to the mid-1950s, served as evidence of this neglect.[224, 281]

In response, for the first half of the 20th century public action to ensure the safe disposal of human waste was feeble, at best. Though the legislature did pass a number of acts that made reference to sanitation[xlvi], these emphasized the responsibility of individual landowners and households. Sanitary conditions were therefore mostly a function of individual discretion and financial well-being. In his article on the development of public health in Barbados, Byer wrote:

> "According to local Sanitary law every householder had to provide sanitary facilities, the minimum acceptable accommodation being what was called a "pit-hole". This was a small hole, 2 to 3 feet deep, covered with a sheet of galvanized iron or an old barrel top. Most of the people in the lower-income bracket, however, lived on very hard out-crops of lime-stone, with little or no soil over the limestone… The use of tax-payers money for digging earth pits for latrines on private property was not to be considered".[238]

The wisdom of ecological interconnectedness, suggests that there is no such thing as 'away', when it comes to the issue of waste disposal. Moreover, the experience of Great Britain's battle with waterborne disease and subsequent sanitary revolution, which took

[xlvi] In 1868 an Act was passed for the prevention of contagious diseases, this was revised in 1880 and allowed for the inspection of all ships and cargo before docking. Also, another act passed in 1892 made several contagious diseases, including cholera, notifiable. And there was the Public Health Act of 1928 and its many amendments, which addressed the minimum sanitary conditions to be enforced by inspectors, among other sanitary matters.

place towards the end of the 19th century, had served as a reminder of this.[268, 282] However, in Barbados, little thought was given—either by individuals or the colonial authorities in Barbados—to what became of their faeces once it was emptied into suck-wells or dumped into the sea. Public officials did not express concerns about this, until after more than a century of neglect.

5.3 Increasing concerns about sanitation

By the 1960s, due to better access to potable water and primary health care services, excreta-related diseases like typhoid and poliomyelitis, were beginning to disappear. [210, 236, 238] Yet, ironically it was during this period that the first signs of government attention for sanitation began to emerge. Two factors seem pertinent in accounting for this shift. First, within a global and regional context of increasing attention for sanitation, beginning in the late 1950s, domestic health officials were repeatedly exposed to the need for investing in proper excreta disposal. Pushed by international actors, they soon began to question the sustainability of maintaining the status quo. Also, in the 1960s, as access to piped water expanded rapidly and the amount of waterborne waste grew, the problem of excreta disposal literally began to spill over into public life. As a result, during this decade, public health officials and authoritative decision-makers became increasingly concerned about sanitation.

5.3.1 Interactions between local and global actors lead to increasing domestic concern about sanitation

Though regional cooperation on water and sanitation began in 1902, with the establishment of the Pan American Sanitary Bureau (the pre-cursor to the Pan American Health Organization), for much of the century water and sanitation remained low on the

international health agenda. However, in 1948, the creation of the World Health Organization gave new energy to the cause, when its member states listed sanitation among their top six priorities.[272] Over the next two decades, in response to this leadership by WHO, decades of inertia where water and sanitation were concerned began to give way in the global arena.

Table 5.1: Effects of international/regional organizations on attention for sanitation in Barbados in the 1960s

International Agency	Activities	Domestic effects
WHO/UNICEF	Rural Environmental Sanitation Program, launched in 1954, to provided direct assistance for projects in approximately 27 countries.[272]	Aid provided for the construction of fly-proof pit latrines and the drilling of suck-wells in hard limestone areas, starting in 1959.[45, 47, 238] This project formed the underpinnings of a division within the Ministry of Health dedicated to environmental sanitation (eventually, the Environmental Engineering Division).
PAHO	The provision of technical assistance to governments in the region.	Technical assistance from PAHO facilitated a study on the impact of sewage disposal on groundwater quality in 1961, which prompted Cabinet to adopt the Groundwater Protection Zoning Policy in 1963.
	Training of sanitary engineers and other environmental sanitation personnel, through WHO/PAHO postgraduate fellowships.[283, 284]	Several local public health inspectors benefited from the training opportunities provided via PAHO.[211, 238] Among these was the island's first Environmental Engineer who joined the Ministry of Health in 1969.[280, 285]
Organization of American States	Latin American and Caribbean Governments sign the Charter of Punta del Este, a commitment to providing access to potable water and sewage disposal to 70% of the urban population and 50% of the rural population in the next ten years.[286, 287]	Exact scope of impact unknown

In Barbados and the Caribbean, much of this work was advanced under the aegis of the Pan American Health Organization, which had become WHO's regional arm (See Box 5.1 above). These international agencies sought to place sanitation on the agendas of governments in the region through the provision of financing and technical assistance and high-profile political conferences. [283, 287 (p.297-299) 284 (p.261-262)] For example, in response to PAHO's efforts to generate priority for water and sanitation in the region, in 1961 Latin American and Caribbean governments set themselves a target of providing access to potable

water and sewage disposal to 70% of the urban population and 50% of the rural population in the next ten years in the Charter of Punta del Este. [286, 287]

According to Wolman et al. (1972)[287] this charter had significant agenda-setting power in the region, as it "focused attention on the need, gave visibility to the problem, and provided a yard-stick against which progress could be measured."[287] However, where previous efforts by external actors to place sanitation on the domestic agenda had failed during the first half of the 20th century, these efforts were largely successful because of the collaborative and amicable relationships that emerged between domestic health officials and international actors. These exchanges proved critical, in causing domestic officials to question the safety of the water supply and to challenge the status quo regarding methods of excreta disposal on the island. For example, in 1959, a Harvard-based sanitation expert voiced his concern about the widespread use of suck-wells as a method of sewage disposal on the island[xlvii]:

> "For more than 300 years, Barbados has been emptying its wastes into one set of holes in its coralline base and drawing its water from another set…and the island is rather proud of the quality of its water. However, both the rate of draft of water and the rate at which wastes are disposed of in the so-called 'suck-wells' are increasing rapidly. No one knows how long such practices can safely continue."[279]

This view was rooted in the paradigm that, due to the interconnected nature of the water system, this method of excreta disposal was bound to have a negative effect on the groundwater supply even if there was not yet evidence to suggest that this was already the case (Appendix 5.2). Domestic actors soon echoed similar concerns[xlviii]. For example, in 1961 Barbados' Director of Medical Services sought technical assistance from PAHO to

[xlvii] This concern about Barbados's excreta-disposal practices, was based on Moore's observations and conversations with regional actors, while he was conducting training for waterworks engineers in the British West Indies on behalf of PAHO from March 17 to June 6, 1958. This training was conducted in association with the Government of Trinidad & Tobago.[279]

[xlviii] Though highly likely, it is uncertain whether or tot Byer (or any other actors from Barbados) would have benefitted directly from the training provided by Moore and others as described in the footnote above.

conduct research on ways of reducing the impact of excreta-disposal on the island's groundwater sources stating that:

> "These fissures and solution passages in the limestone [suck-wells] set me to thinking…[that] 'where water supplies are concerned, innocence must always be preferred to repentance.' I considered that it was necessary that the innocence of the Barbados water supply be preserved."[238]

5.3.2 Malodorous conditions in Bridgetown generates some attention

With the 1960s came a significant increase in commercial development in and around the city of Bridgetown. An industrial park had been established near the city's main port, and this sector was beginning to grow. Also, by 1960, 75% of all households had access to piped water. While access to clean water helps to mitigate the transmission of faecal-oral diseases, it also means a larger volume of waterborne waste. These changes together, resulted in a rapidly growing amount of sewage. Moreover, this continued to be disposed of in the same way it had been for more than a century—either emptied into storm drains or dumped into the sea.

The result was increasingly malodorous conditions in the capital city. A newspaper article recalling the origins of the Bridgetown Sewage Project, noted that:

> "Back then, Bridgetown was smelly with effluent being discharged into the gutters from two package plants, one in Lower Broad Street and the other in Roebuck Street. Sometimes the gutters choked and the stench rose. Sewage was also dumped into the Careenage[xlix] and into the sea at Bay Street leading to a very polluted Carlisle Bay and smelly Careenage."[288]

To combat the problem, beginning in 1965, the Ministry of Health encouraged the use of septic tanks in areas where suck-wells were not feasible, and stipulated that hotels, commercial entities and the island's two largest medical establishments, located in the Bridgetown area, install package treatment plants on-site. However, these measure only

[xlix] A major estuary in the city of Bridgetown.

made things worse—as the city's high water table meant that septic tanks could not adequately absorb liquid waste, resulting in frequent overflows (often into public storm drains).[280]

Several actors, including a number of journalists, pointed to the fact that such concerns were influential in generating support for the sewerage project among decision-makers.[191, 273, 275, 289-291] According to one journalist:

> "Numerous complaints reaching the Ministry of Health about offensive odours from septic tanks, sewage wells, and cess-pool emptiers… demonstrated the urgent need for the development of a sewerage system."[291]

Indeed recalling how the issue of sanitation had first captured the attention of members of the political directorate, then-Minister of Health recalled that "[i]t was much talk about the noxious odours emanating from the drains down on the Princess-Alice Highway and the President Kennedy Drive (sic)."[292]

5.3.3 Outcomes

During the 1960s two important gains were made. First, the findings of studies conducted with assistance from PAHO between 1961 and 1963, on reducing the impact of sewage disposal on groundwater quality, prompted Cabinet to adopt a Groundwater Protection Zoning Policy. This divided the island into five geographical zones and outlined minimum standards for sewage disposal according to the potential threat posed to the groundwater supply. It was also the first sign of recognition on the part of public authorities of their responsibility to ensure the safe management and disposal of excreta. Secondly, in 1969, the Ministry of Health hired its first sanitary engineer—a former public health inspector by the name of Arthur Archer, who had received this training while on a PAHO scholarship.

During this period there was some improvement in the provision of sanitary facilities due to the construction of pit latrines for poor households through PAHO/WHO's Environmental Sanitation Program, for example between 1959 and 1963 the number of people without basic sanitation dropped from 50% to 25% of the population.[236] Although, according to Reid (1981), across the Caribbean island states "most [PAHO/WHO] rural sanitation programs were inoperative due to lack of funds as soon as the original sponsors of the program withdrew their assistance".[293]

In response to complaints about the odorous conditions in Bridgetown, the government gave lip service to the public health importance of environmental sanitation and the need to introduce "a proper sewage scheme for Bridgetown" in both the 1962-1965 and 1965-68 National Development Plans .[294, 295] Thus, the promised funding for conducting feasibility studies for this project—a meagre sum of BDS$36,000—was still not forthcoming as the decade came to a close. [295]

5.4 Resource priority emerges for sanitation—the Bridgetown Sewage Project

In my key informant interviews, policy actors attributed the absence of domestic resources for sanitation during the 1960s, even in the midst of signs of increasing attention, to the substantial capital investment required for the construction of sewage systems or to the fact that sanitation is a generally unappealing subject and not something authoritative decision-makers are eager to include in political speeches. However, why public resources were not released during this period is not certain. [191, 273, 275, 296] Yet, whatever the cause of this inertia, in the decade that followed, it was overcome. In 1970, the MoH requested financial assistance from the IDB to begin feasibility studies for, what later became known as, the 'Bridgetown Sewage Project'. Then in 1975 the Government of Barbados signed a BDS$19.4 million loan agreement with the IDB to finance the project. By the time the

project was completed in 1982, the government had spent over BDS $95 million, or the equivalent of approximately BDS $300 million (2005 dollars), on sanitation in general.[1, 45, 280, 285, 297-300]

The presence of sanitation experts in the MoH—a result of the gains made during the 1960s—appears to be a critical factor in accounting for this change. Between 1969 and 1975, Archer and a growing team of public health engineers managed to shift the political calculus of action/inaction on sanitation, by generating broad-based political support for a costly policy intervention. They did this firstly by capitalizing on new evidence that sewage was causing damage to the marine environment to develop a powerful new understanding of sanitation as being linked to environmental degradation and the viability of the tourism industry. Secondly, these actors also proved successful in attracting external financing, without which it seems unlikely that priority would have emerged at this time.

5.4.1 A new sanitation expert in the Ministry of Health drives efforts to push sanitation higher up on the public agenda

While the Director of Medical Services (Maurice Byer) and the Senior Medical Officer (Frank Grannum), had dedicated some attention to the issue of sanitation during the early 1960s, these actors did not possess expertise in sanitary engineering.[238] The addition of a public health engineer to the ministry's staff in 1969 served as a catalyst in the prioritisation process. A former public health inspector, Archer had for some time seen the need for government to address sewage disposal in the city and its environs. On taking up his post as Senior Public Health Engineer, he considered making this a reality a matter of priority.[273, 288] As the island's only public health engineer at the time, with his expert knowledge and close links to the international environmental sanitation community, he emerged as a powerful actor in the development of sanitation policy in Barbados.

In 1971, spearheaded by Archer, the Environmental Engineering Division (EED) was established within the MoH and by the mid-1970s it was staffed by a team of eight technical personnel.[255, 273] According to several informants, it was these technocrats who were most influential in moving the government from tacit attention to actual action with regards to improving sanitation in Barbados[191, 273, 275, 290]. In addressing Parliament, the Minister of Health (Billie Miller) stated:

> "He [Arthur Archer] is the person who had to persuade the Government of the day of the high priority that a sewage project deserved in this country. He is a man who today is an authority in the Caribbean on environmental matters and will very soon become an international authority on environmental matters (sic)."[292]

In a personal interview, she corroborate this view, saying:

> "The impetus to sewer Bridgetown goes back a long, long way and I would think that Mr. Archer was aware of it all during his years as a public health inspector…. But it was senior civil servants, particularly those in the Ministry of Health, who eventually encouraged successive governments to make it a top priority. Mr. Archer was very supportive and influential [in that process]."[301]

Power in expert knowledge

At the time, expertise, where environmental sanitation was concerned, was concentrated exclusively within the EED. As a result, technocrats wielded significant power over the policy process—from defining the problems to outlining the policy solution and later throughout the implementation phase. In particular, the fact that Archer was well respected regionally as an expert, helped in winning the confidence of decision-makers:

> "We had a public health practitioner who had international and regional recognition and was respected by the politicians. When Arthur Archer spoke, they listened to him."[273]

Decision-makers trusted Archer to the extent that, even when they had doubts about aspects of the plan, they were prone to giving way to his expert opinion. For example, in a personal interview, Billie Miller (who served as Minister of Health during the construction

of the project) said: "I questioned them persistently but was constantly over-ruled by their superior advice, including that of Mr. Archer in whom I had confidence."[301]

Archer and his staff leveraged their expertise to drive the prioritisation process. Speaking about their central role one informant said:

> "They were influential because they laid out a road map for the politicians. They said to the politicians, here is the problem, here is what is going to happen if we don't fix it, here is what we need to do and here is the cost for doing it…and then they were able to find the funding as well."[273]

In particular, Archer played pivotal roles in reframing sanitation to generate broad-based political support, and in securing external financial assistance—two factors that were critical in generating and sustaining priority for sanitation for more than a decade.

5.4.2 A new understanding of sanitation's role helps mobilize support

By the early 1960s, locally, within public health circles, the wisdom of investing in sanitation as a pre-emptive public health measure was generally accepted. Yet, perhaps with the rates of waterborne disease in decline, it was perhaps difficult to convince policy makers to take action on what seemed to be a mostly invisible problem. Indeed, even when complaints about terrible odours of sewage in Bridgetown surfaced, these had not been sufficient to mobilize domestic resources for sanitation. However, in the early 1970s increased financial resources for sanitation were finally secured when decision-makers came to see sanitation as being inextricably linked to the bread and butter of the economy—the island's tourism industry.

A study conducted by marine biologists was pivotal in providing the evidence on which this new understanding of sanitation's role was built. Realizing that the findings of these environmental studies offered a more politically salient rationale for investing in sanitation, Archer and his team in the EED played pivotal roles in articulating these new ideas and using evidence of bacteriological contamination of the coastal areas of

Bridgetown to link them to the pre-existing proposal to sewer the city of Bridgetown.[273, 275, 296, 302] It is ironic that in generating political support for sanitation, very little emphasis was placed on its public health merits—even though this was the primary source of motivation for technocrats in the health ministry.

Marine biologists link sewage to marine degradation

Between 1967-1969, studies conducted by the Bellairs' Research Institute (an environmental research station of McGill University, Canada located in Barbados) showed evidence of damage to coral reefs off the island's west coast, which they suggested might be due to elevated nutrient levels caused by increasing amounts of waterborne waste entering the coastal marine environment as a result of burgeoning coastal development[1].[304, 305] Also, marine biologists argued that, in addition to fostering marine biodiversity, the island's reefs also acted as protective barriers and suggested that signs of beach erosion on the island's western and southern coasts might be also be attributable to the impact of increasing volumes of unregulated and untreated sewage on the marine environment.[273, 305, 306]

Even though there was not strong scientific evidence to link pollution from sewage directly to coral reef health, in Barbados these reports proved extremely successful in capturing the attention of decision-makers. [307] The concerns voiced by scientists were also buttressed by lay reports from "fishermen, scuba divers, yachtsmen and pleasure boat operators"[299] who also felt that increased pollution of coastal waters (which they attributed to the often visible streams of sewage flowing from land to sea) was responsible for the

[1] High nutrient levels are known to enhance algal growth, which can in turn damage or ultimately kill coral reefs. According to DeGeorges, Goreau & Reilly (2010) [303], Barbados was one of the first countries to recognize this effect that increased coastal development could have on the marine environment.

destruction of the coral reef offshore and visible erosion at Rockley Beach[li] and declining populations of lobsters, sea-eggs and other species of fish.[299]

Scientific evidence establishing this causal relationship did not become available until the mid-1980s[lii]. However, by the early 1970s, this claim had become widely accepted in Barbados.[191, 296, 302] For example, in 1976, voicing his support for the Marine Areas Preservation and Enhancement Bill in Parliament, the Leader of the Opposition stated:

> "I have had the benefit of a lot of discussions with persons, mainly from Canada, who know about marine pollution, and I have been quite assured [that]… the reef at Worthing, from St. Lawrence going North is dead…. We, in our lifetime, have seen that reef killed.... It is not through oil leakage or anything like that. It is from the pouring of sewage, road wash, fish market wash, and the general effluence of Bridgetown.(sic)". [313]

Technocrats connect the dots to link sanitation to the vital tourism industry

These studies seemed to have more to do with the health of coral reefs than they did with public health.[liii] However, technocrats from EED felt that they offered an opportunity to generate attention for sanitation at the highest levels of government, given that tourism had become of increasing importance to the national economy during the 1960s.[273, 275, 296] Understanding that "[t]he protection of the marine environment assume[d] major importance as it is the island's major tourist attraction"[299], technocrats deliberatively sought to reinforce emerging ideas about the links between excreta disposal, the environment, and the tourism sector. Most importantly, they offered that a sewerage system and treatment plant for the city of Bridgetown—the site of the most notorious coastal dumping sites for sewage—was urgently needed to arrest this devastating impact on the marine environment.[218, 273, 275, 290, 299, 302]

[li] A popular south coast beach.

[lii] More rigorous studies conducted in the 1980s and early 90s confirmed both the existence and extent of the problem.[306-312]

[liii] Sanitation experts did suggest that this could post a threat to the health of sea bathers, although there was no epidemiological evidence to support these claims.[273, 290]

In 1969 the Ministry of Health collaborated with the Bellairs' Institute to conduct marine water quality monitoring to assess the level of bacteriological pollution in the Bridgetown area. According to Archer(1994)[280], major point sources of discharge of untreated sewage into the sea, were mostly centred around Bridgetown's Carlilse Bay[liv]. Night soil operators also routinely emptied the contents of privy pits and septic tanks into the sea at Bay Street and Lewis Alley (also located in the city). Not surprisingly, the results of bacteriological studies conducted in these areas showed high levels of pollution in these areas, with coliform counts reaching dangerously high levels at peak disposal times.[280]

Wielding this evidence of bacteriological pollution of the Bridgetown marine environs, Archer and his team were able to fuel the dissemination and acceptance of powerful ideas regarding the links between sewage disposal and continued growth of the tourism sector. For example, Archer reflected on the rationale for the Bridgetown Sewage Project in newspaper article, saying:

> "Tourism is our major foreign exchange earner and employment resource. Our beaches, marine areas with the remaining coral reefs, clean air and seawater are major attractions to visitors…. Damage and destruction of these natural gifts, particularly the coral reefs with their colourful variety of fish and other marine species, and their ability to dissipate the force of waves and protect our beaches and beach property, will drastically reduce our tourism appeal. This will have adverse economic consequences, which will be severely felt by those in the mercantile and commercial sectors in Bridgetown and the coastal tourism industry…. [The Bridgetown Sewerage System] is a means of preserving the health, environment and economic heritage of this and future generations." [302]

This frame, was repeatedly articulated by technocrats in articles, proposals and by several policy actors in key informant interviews.[191, 218, 273, 275, 290, 314] For example, the current director of the Bridgetown Sewage Plant said:

> "I think it [sewering Bridgetown] became a priority in the early 1970s. It came out of the shift from agriculture to tourism, as our main economic earner, during the late 50s and 60s. Because if you

[liv] Known sources of sewage disposal into the Carlisle Bay area included the Holiday Inn Hotel, and several government institutions, namely the Queen Elizabeth Hospital, Government Headquarters, and the Ministries of Health and Education.

> remember, our main economic earner was sugar and sugar was declining in that period. We were looking for some other means by which we could earn our foreign exchange. So it was argued that having this plant would allow us to preserve the coastline in the particular area."[290]

It was this connection between sewage disposal, tourism and economic growth that helped to propel the previously side-lined issue of human waste onto the national agenda.

Broad-based political support for the sewering Bridgetown emerges

As anticipated by technocrats, against the backdrop of increasing emphasis on enhancing and sustaining growth in the tourism industry, these ideas were particularly successful in generating support for investment in sanitation among political actors.[273, 296] In a parliamentary debate, quoting from his party's 1971 manifesto one MP argued that the Barbados Labour Party (then in opposition) had demonstrated concern for the consequences of pollution from sewage:

> "Barbados' air, water supply, beaches and city streets are all subject to the environmental pollution of modern life…beaches are spoilt by domestic waste, and areas immediately off shore are affected by sewage".[315 (p.5899)]

He then went on to insist that it was of upmost importance that the DLP government should allocate increased resources to address these problems:

> "[I]f we are dependent on tourism as one of our natural resources and, more important to me, if Barbadians are to enjoy the amenities of nature and ecological conditions of their country, they need protection from this type of danger which is posed to them."[315 (p.5899)]

In 1973, motivated by the connections between sewage disposal and the country's prospects for economic growth, the Government of Barbados approached the IDB for a loan to finance the feasibility studies and final design of a sewerage system for Bridgetown. The keen support of the Minister of Health and Prime Minister for the proposal was indicative of increased priority for environmental sanitation.[288, 290] According to one Ministry of

Health official, there was a general feeling among political leaders that "if the sewerage project was not done, the tourist industry would come to a crashing halt".[183]

It was felt by several informants and authors that this sense of urgency was the principal underlying factor that influenced successive governments to give increasing priority to establishing systems for the collection, treatment and disposal of human waste.[183, 218, 273, 275, 280, 290, 296, 314, 316] Despite heated partisan disputes that arose over the planned location of the treatment plant, so powerful was this dominant framing idea that broad-based, bi-partisan support for the policy solution—a sewerage system for Bridgetown—remained unshaken. In a personal interview, Dame Billie Miller, whose constituency was most affected by the project and who would later preside over its implementation, said:

> "There was a need to treat the sewage. It was the location that we quarrelled with but there was no quarrel with the concept. It was inevitable. That [the dumping of sewage into the sea] had to come to an end because it was degrading the reefs in our near-shore waters, and for public health purposes as well."[191]

5.4.3 The pivotal role of external financial assistance

One disadvantage of sewage systems is that they are expensive to build, operate and maintain, and require significant capital outlays (Appendix 5.1). As a result, financing such large scale sanitation projects is often a problem in most LMICs.[296, 317, 318] The fact that the availability of financial assistance failed to stimulate domestic action on sanitation in the past, suggests that this factor was not sufficient to generate priority on its own. However, the presence of external financial assistance did appear to be necessary for priority to emerge in the 1970s.

The feasibility studies conducted between 1971-1972 estimated the cost of a sewerage system for Bridgetown to be BDS $27.2 (US$13.6) million dollars.[300] To put this into perspective, government's average yearly total capital expenditure between 1972-1975 was BDS $30 million (current dollars), and capital expenditure on the health sector was less

than BDS$1 million per year over the same three-year period.[1] Moreover, in addition to substantial capital outlays, the project—which would be built by foreign firms—also required a significant amounts of foreign reserves.[191, 275] Thus, even though since 1970 decision-makers had been convinced of the need for urgent action where improvement in the collection, treatment and disposal of sewage in the Bridgetown-area was concerned, government could not afford to finance this on its own.

The availability of external financial assistance was therefore a critical factor in determining the timing of political priority in this case. In fact, according to then-Minister of Health, Erskine Sandiford, almost as a rule government sought external assistance to finance any capital-intensive works:

> "A sewage system is a capital project, and it is the policy of this Government to try as far as possible to support capital projects by funding from external agencies.... [W]e have taken steps to secure funds at most concessionary and reasonable rates, so that this particular facility and the benefits from the [sewerage] system can be brought to this country"[319 (p.7182)]

Indeed, it was not until a loan for BDS$19.4 million (or just over 70% of the projected cost) was granted by the Inter-American Development Bank (IDB) in 1975, that public allocations towards environmental sanitation began to grow significantly. By the end 1982, due to cost overruns, total spending on the project stood at BDS $42.8 million, with the government of Barbados contributing just over $18 million directly.[320, 321] Within the health sector severe cuts were made to accommodate this shift in priorities. By 1980, real spending on secondary-level services and mental health were 23% and 16% lower than they were in 1970. In stark contrast, spending on environmental sanitation had increased by over 17-fold over this same period.[1]

The role of domestic actors in drumming up external assistance

Between 1962-1965, the IDB had been one of the leading financiers of sanitation projects in the region with approximately 20% or more of all its lending going to the

sector.[287, 322] However, starting in 1965, the IDB began to reduce its lending for water and sewage projects and by 1973 work on sanitation accounted for only 2% of all loans. As a result, by the time Barbados signed its loan agreement for the Bridgetown Sewage Project with the IDB, sanitation was essentially at the bottom of the Bank's priority list.[287, 322]

The drastic decline in priority for sanitation, reflected an overall shift in the Bank's lending and developmental rationale away from investment in the social sectors and towards 'economic infrastructure' such as transportation, communication and electric power supply, which by 1973 comprised approximately 80% of all Bank assistance.[322] In this context domestic health officials played key roles in convincing the Bank to fund the project.[183, 191, 273, 275, 290]

In particular, these actors were able to win the Bank's support for the Bridgetown Sewerage Project (1975)[300, 321] and for conducting feasibility studies for sewering the South Coast (1981)[323] by arguing that that investment in improving sanitation was necessary to ensure the continued growth of the tourism industry—a rationale that resonated with the bank's development paradigm at the time. In a statement to the House of Assembly, the Minister of Tourism at that time, described the Ministry of Health's efforts in convincing IDB to fund the project:

> "…[M]y Ministry, both from the point of view of tourism and otherwise, strongly supported the Ministry of Health in requesting that [sewerage systems] be regarded as part of our new area of loans. But the problem that you get with some institutions is that they claim that Barbados' per capita income is so high and that sewage is really a social project…. We had to battle them and point out that this was not a question of a social project; this is a question of a project which had great economic implications for Barbados, because [of] the tourist industry…. I know now that as a result of the combined representations of all Ministries we have been able to demonstrate and prove that this is not only a social project, but an economic project…(sic)."[324 (p.3148)]

This became a central rationale driving IDB's investment in sanitation in Barbados.[276, 320, 321, 325, 326] In its rationale document for funding a subsequent sewage project

(on the South Coast), alongside its contribution to public health, the IDB revealed its major motivation for financing sanitation projects on the island:

> "The economy of Barbados depends on the maintenance of environmental quality. The sun, the beaches and the country's high sanitary standards attract tourists to Barbados. Over the last two decades, there has been a noticeable deterioration in the environment. Untreated sewage seeps from pits on shore to the sheet water and percolates into the coastal waters. Some sewage overflows into storm drains and directly through the beaches to the sea. In addition to the sanitation problem, contaminants in the water are badly stressing near-shore, patch and fringing reefs….Both the Government of Barbados and the Bank are concerned about the deterioration. The Bank financed the Bridgetown sewerage system to decrease contamination from sewage in the downtown Bridgetown area…."[320]

Decision-maker concerns over country-bank relations helps to ensure priority is sustained

The existence of external financial assistance from the IDB also proved instrumental in ensuring that priority for sanitation was sustained even after an election in 1976 resulted in a change in administration.[191, 273] Before the election, when the details of the loan agreement and plans for the Bridgetown Sewerage Project were finally made public, there were sounds of protest from members of the BLP (who were then in opposition) about the planned location of the plant.[191, 273] When the BLP came into power, the Minister of Health at the time and Member of Parliament for the City of Bridgetown (Billie Miller), had been one of the most vocal denouncers of the plan to locate the plant near Chapman's Lane, in Emmerton. In a personal interview she said:

> "Mr. Sandiford [the previous Minister of Health] had already signed with the IDB when we came to government in 1976. We thought it was very much politically inspired because the strongest voting box for the BLP has always been Chapman's Lane and still is. Even when I lost my seat, I won that box…. [W]e believed that the DLP deliberately chose to site the sewage plant at Chapman's Lane. It meant the relocation of hundreds of people—all of these people who voted for me. I was appointed as Minister of Health, which meant that I had to preside over that. I tried of course to see if the government could get out of it…"[191]

Similarly, while in opposition then-Prime Minister Tom Adams had voiced his opposition to the terms of the loan, which included promises by the Government to create a new authority to manage water and sewage disposal and to increase water tariffs[313]. However, by the mid-1970s the IDB had emerged as a powerful regional actor and, as Prime Minister, Mr. Adams knew that reneging on the agreement could jeopardize Barbados' relations with the Bank. Referring to the implementation of the Bridgetown Sewerage Project, in 1977 during his annual speech detailing the country's financial and budgetary proposals, Adams said:

> "This is a pledge to the IADB which must be carried out to maintain the good relations which exist between the Government and its principal source of overseas aid funds."[327 (p.1103)]

Indeed, at this time the Government of Barbados was seeking funding from the IDB for a number of other projects, including the expansion of its primary health care system (as discussed in Chapter 4).

5.5 Challenges in sustaining political priority for sanitation, 1982-present

Difficulty delivering on plans to sewer the South and West Coasts

While Archer and his team were able to realize priority for sanitation during the 1970s, sustaining and building on it over subsequent decades would prove difficult. Though the generation of attention and financial resources for the Bridgetown Sewerage Project could be seen as a triumph, in actual fact this project represented the tip of the iceberg in terms of what was needed to overhaul sanitation in Barbados. By the end of the project just under 2% of Barbadian households were connected to a sewerage system, though it was felt that this would have wider benefits due to the fact that Bridgetown is the main commercial area and that its coastal sites had been main points of sewage dumping in the past.[328, 329] The rest of the island continued to dispose of its waste via septic tanks or suck wells and sewage

continued to find its way into the sea. Aware that this project was only the beginning, even before the completion of the Bridgetown Sewage Project, technocrats in the Ministry of Health began advocating for similar systems for the island's south and west coasts[191, 273, 275]. Again, they argued that sewage disposal practices in these areas posed an imminent threat to coastal water quality and coral reefs and their calls did not go unheard. In 1979, the Ministry of Health announced plans to seek IDB funding to conduct feasibility studies for sewerage systems on the south and west coasts.[191, 292, 320]

At face value, the case for investing in sanitation in Barbados since the 1980s—and in particular for sewering the South and West coasts—seemed stronger than that made in the 1970s.[lv] The South and West coasts had become the major sites of expansion of the island's tourism industry, and by the 1980s together accounted for close to 100% of the island's hotels. According to several informants, there was also demand for change from hoteliers on these coasts who felt that the status quo was negatively affecting their tourism product.[191, 273, 275, 324] For example, in an interview, a Miller recalled that "[s]ome hotels on the South Coast had as many as four package plants on their property…and many of them couldn't get past two stars because they could not meet the international environmental standards." [191]

Also, in addition to continued concerns about the impact of sewage disposal on the marine environment, in 1992 an IDB-financed study showed that faecal bacteriological levels exceeded U.S. Environmental Protection Agency (EPA) standards for bathing water quality on several of the south coast beaches sampled, and, on at least one beach, was over five times higher than the standard.[330-332] Similar studies conducted on the west coast in 1996 revealed that 9 out of the 10 beaches sampled also failed EPA standards.[333, 334] So strong were the implications of these findings, that Cabinet decided not to make bacteriological water quality data public for fear of creating panic within the tourist

[lv] Like Bridgetown, the South and West coasts were also areas with high water tables, resulting frequently in overflowing septic tanks and contamination of the marine environment via seepage from suck wells; and there were frequent reports of hotels dumping raw sewage into the sea.[191, 273, 320]

industry.[lvi 273-275] And, since the early-1990s, there has been mounting concern among water and sanitation experts over deteriorating quality of the groundwater in the island's main aquifer (responsible for 30% of all potable water) in the face of evidence of elevated bacteriological levels detected in untreated water from that source.[lvii 273-275, 320, 335]

Yet, over the last three decades, attempts to generate actual resource priority for these projects have been beset with problems. It took more than a decade, before resources were mobilized for the construction of a sewerage system for the south coast and, more than three decades later, it seems that priority for sewering the island's western coast has evaporated all together. A number of factors have given rise to this difficulty in sustaining political priority for improving wastewater disposal. In particular, the legacy of problems in the construction and implementation phases of each successive project, the unavailability of external financial assistance over extended periods of time, and dampened political will (as domestic actors became increasingly aware of the high short- and medium-term political costs associated with implementing sewage systems), have been contributing factors. Most importantly, since the mid- to late-1990s, the departure of key sanitation advocates from the Ministry of Health, seems to have lowered the prospects for the re-emergence of political priority in the near future.

5.5.1 The effects of past policy experience on the politics of priority generation

The legacy of the Bridgetown Sewage Project

From its outset the Bridgetown Sewage Project was marked by controversy. According to a UN report, the government had identified the Emmerton, in Bridgetown as the city's worst slum area and a "*priority for clearance and renewal*".[336 (p.11)] The decision to locate the plant at Emmerton, was therefore seen by some as politically motivated and an

[lvi] Although more recent water quality data has not been made available, experts still feel that this situation is probably the case. [273, 275]

[lvii] Some experts believe that this evidence points to the need to *"eventually sewer the entire island"*[275]

attack on the poor.[191, 273, 337] Plans to relocate some 560 people in order to clear land for the plant, were met with loud outcries from both politicians and the majority of residents, who did not want to be moved. While ultimately *"it wasn't enough opposition to break the project"*[275], the political battle over citing the plant at Emmerton left a lasting imprint on the social and political landscape[273, 275, 301, 337]:

> "Well you know the song Emmerton, by Gabby[lviii]. That song was all about the relocation of people out of Bridgetown because of the building of the sewerage treatment Plant. There were a whole lot of battles that went on about the location of the plant and who would be affected."[273]

Later on, the fact that the lower-income areas adjacent to the plant site were not included in the zone to be sewered—many of them still relying on pit toilets as a result—only served to fuel this resentment and reinforce public perception that the project was not about the interests of ordinary citizens.[191, 301, 339] Also, despite assurances from technocrats that the plant would prove adequate for the city's wastewater disposal needs and that there would be no odour associated with its operation, less than 5 years after being commissioned—and just as plans for the South Coast Sewerage Project were coming on stream—the plant was accepting almost 6 times more sewage than it had been designed for, resulting in frequent breakdowns and complaints of foul smells. Businesses in the plant's environs complained that the stench was turning away customers, restaurants in the area struggled to stay in business, and residents who had fought to stay now asked to be relocated claiming that the odour from the plant was making them ill.[273, 289, 290, 302, 340-343]

Added to these problems were the issues of dust, noise, disruption and cost over-runs during the construction phase of the project, as well as low willingness-to-pay by the project's intended beneficiaries that resulted in a slow pace of link-up to the system once it

[lviii] Though the people would eventually resign themselves to what they felt was inevitable, a well-known Calypsonian, who was among those who had to move, immortalized the community's resentment in his song 'Emmerton'. The lyrics of the chorus, served as a threat to the political directorate at the time: "*But I hope yuh understan' how I feel 'bout Emmerton, My home land, my home land, my home land….An' I hope yuh know it's true, dat I'll nevuh fuhgive you because looka, looka wha yuh do to my Emmerton"*.[338]

was completed.[lix] According to one journalist the sewage treatment plant, which governmental officials claimed would result in improved public health and environmental conditions, became *"one big political stink-up gone out of control"*.[343]

While some of these problems were perhaps anticipated, some of them—for example the bad odours associated with the plant—were not and according to one informant were the result of "a serious underestimation of the economic and social realities affecting the project" on the part of technical personnel and the IDB.[301, 345]

Once an accident, twice a trend—the implications of the South Coast experience on future priority generation efforts

Despite what seemed to be a genuine effort to learn from the bad experiences associated with the Bridgetown Project, the South Coast Sewerage Project was fraught with its own problems. Describing the project, one journalist wrote:

> "There could not have been, in the history of Barbados, a more worthwhile project executed in such a chaotic and disorganized manner as the South Coast Sewerage Scheme. Ordinary folk, like most of us who are not engineers, would have had no idea of the disruption which this project would cause. We are accustomed to roads being dug up in order to install pipes. Everyone is used to that and is willing to put up with the 'temporary dislocation'.... But no one could have imagined that a stretch of about 200 or 300 yards, roughly between Balmoral Gap and Pavillion Court, would remain churned up for three months and counting...."[346]

Again, contrary to what experts had promised, even with the use of micro-tunnelling—a technique to avoid the digging of trenches—there was significant and prolonged disruption during the construction phase. In a personal interview, the Director of the Barbados Water Authority, who was heavily involved in the project at the time, reflected that: "Unlike in the bigger countries where this method had been applied, [we

[lix] By 1990, though the government had made provisions to assist lower-income households with their connection fees, and after multiple public appeals, only half of all properties in the sewered zone were connected to the system.[344]

found that] in Barbados, because of the small size of our roads, when you block off one lane you have blocked traffic."[275]

According to the Minister of Health at the time, Elizabeth Thompson, compounding these frustrations was the fact that:

> "The company that won the bid did not perform at its maximum capacity in Barbados. They did not bring their best teams and we paid heavily for it. We had a lot of unfriendly encounters with the hoteliers, the restaurateurs, the Barbados Tourism Authority and others. Everybody wanted to the project to be over."[314]

There were repeated complaints from residents and business owners about the lack of professionalism and disrespectfulness of the foreign contractor's staff, as well as accusations that people in more affluent areas received better treatment than others from lower socio-economic groups who were inconvenienced by the project.[314, 346, 347] Also, government officials reported that the contractor failed to communicate effectively and did not properly coordinate work plans with the project manager and his team.[273, 314] These tensions led to increasingly negative media coverage between 1996 and 1998, and ultimately resulted in the termination of the firm's contract.[275, 347] The tendering of a new contractor to complete the unfinished work only served to prolong the project.[273, 275] By the time of the project's commissioning in 2003, spending on the sewerage project had exceeded original estimates by 70%, and government faced several claims due to related damages or losses from hotels and businesses.[1, 273, 275, 298, 325]

Furthermore, by the late 1990s, hoteliers and businesses began to voice their opposition to plans to sewer the West Coast.[273, 275, 314, 348, 349] According to the Director of the Barbados Water Authority, the absence of support for the West Coast project was in part "a reflection of the issues that arose around the South Coast and the negative publicity that [they] had then."[275] Describing this knock-on effect of the legacy of prior sanitation projects on priority generation efforts for further investment, the technocrat who had served as Project Manager of the South Coast Sewage Project, Dr. Hugh Sealy, suggested that the opposition they faced was not surprising:

> "I remember having a town hall meeting with the hoteliers on the West Coast in the middle of the construction of the South Coast project. They were seeing the dust and everything else that was being generated by having to build a system on the South Coast. And then we were telling them that this system on the West Coast would be 3 times larger…. The south coast collects from 3,000 properties, the West Coast was designed for 8,000. The south coast laid 44km of sewers, the west coast had over 140 sewers that had to be laid. So the hoteliers on the West Coast were saying: 'We don't really want this system'."[273]

5.5.2 The (un)availability of loan financing

The availability of external financial assistance from the IDB seems to have been a decisive factor in ensuring that political priority for improving wastewater disposal in Barbados was sustained. In 1981, before the completion of the Bridgetown Sewerage Project, the Government of Barbados received a loan from the IDB to conduct feasibility studies of sewerage systems for the south and west coasts.[323] However, more than 10 years had elapsed when the loan agreement for the South Coast project was finally signed in 1992 and accordingly, public investment in sanitation stalled during this period (See Figure 5.2). This dependence on external financing is not surprising, given the substantial initial investments requirements for the construction of municipal sewage systems. Stressing the importance of this factor, a member of the opposition (Mr. L. A. Weekes)[350] stated that even when "the conceptualization is there, the efforts are there…[and] the officers have made their inputs…the financing has always been a very important factor."[350 (p.230)] This view was shared by several informants.[191, 239, 275] In particular, the project's director at the time, suggested that "the timing [of the emergence of policy priority] was more about lining up the loans, and the bureaucracy of going to the IDB and the European Investment Bank"[273], than any other factor.

The reasons that funding from the IDB was not forthcoming were manifold. After 1982, the bank had growing concerns about the difficulties the government encountered in

encouraging beneficiaries to connect to the system, as well as the government's resistance to increasing water tariffs as had been stipulated in the loan agreement. The Bank also felt that there was a lack of evidence to support government claims that marine bathing water quality on the south and west coasts were indeed being compromised by sewage disposal practices, which was cited as a central rational for the projects. These factors, together with their overall policy of relatively low priority for social projects, put a pause on plans to sewer the island's South Coast for almost a decade.[320]

In 1989, the government made public its intentions to move forward.[351-353] However, in early 1992, the Minister of Health announced that the project was being put on hold while the a Bank-ordered study of bathing water quality on the South Coast was conducted, revealing just how necessary external financial assistance was for political priority to become a reality.[354-356] Further implementation challenges experienced on the South Coast only served to increase the IDB's trepidation in investing in Barbados' water and sanitation sector. In 1995, the Bank cited the slow pace of execution, major delays and cost overruns in past projects, and institutional weakness of the authority responsible for water and sewage, among its reasons for not actively considering proposals to fund another large-scale sewerage project on the West Coast. [276, 325, 326, 357]

However, in 2007, acknowledging that many of the region's countries were not on course to meet the Millennium Development Goal (MDG) of halving the number of people without access to clean water and sanitation by 2015, the IDB announced a new Water and Sanitation Initiative.[358] Reflecting increasing priority for the sector, in 2010 the share of bank disbursements allocated to water and sanitation was 6.7%, up from 2.8% in 2000.[359, 360] Once again, the availability of external financial assistance does not appear to be (by itself) sufficient to generate political priority, as several informants expressed doubt that domestic political priority would rise correspondingly.[273, 275]

5.5.3 The role of technocrats in navigating a difficult policy context

Unlike the period between 1969-1975 leading up to the policy decision to construct a sewerage system for Bridgetown, technocrats no longer had a monopoly over the initial stages of the policy process. As a result, sustaining priority for sanitation throughout the 1980s and early 1990s would prove a much steeper hill to climb than before. Firstly, the credibility of the EED had come under question due to the plethora of problems that had emerged with the Bridgetown plant.[191, 345] By the mid-1980s, among decision-makers, there was now awareness of the fallibility of sanitation experts. This is aptly illustrated in the remarks of the Minister of Environment in speaking about plans to sewer the South Coast to the House of Assembly in 1985:

> "In this particular case, I would like to point out that we have listened very attentively to the local experts as well as to foreign experts, and in terms of coastal conservation, there is no hard and fast rule as in the area of getting rid of solid waste or sewage. It is like the field of Economics, in which you can have ten economists in a room to solve a particular problem and they all come up with ten different solutions. You are dealing with nature, and whenever you make or effectuate changes in nature, you are never quite sure what will happen. Even though you may make a calculated or intelligent guess in terms of projection, and even though you may take into consideration the points raised by the other side, in all fairness one can never be absolutely sure what the outcome will be until after the project has been started."[361(p.2380)]

Also, past experience had made the public aware of the potentially disruptive effects of large-scale sewage projects. In the aftermath of the Bridgetown Project there were therefore a wider range of stakeholders—from concerned residents, to environmentalists, hoteliers and other business owners—who felt that they had a stake in the project and who were all potential sources of opposition. [191, 273, 362]

The role of technocrats in navigating these changes to the policy context is an important part of the explanation of how resources were finally mobilized for the South Coast Sewage Project, despite much opposition and increasing awareness among policy makers of the potentially onerous political costs. The EED, led by Archer and then Hugh

Sealy (his successor), made a concerted effort to better understand and learn from the failures of Bridgetown. They sought the input of key stakeholders and spent a considerable amount of time troubleshooting concerns and developing measures to mitigate potentially negative impacts of the project. [273, 320, 363] Speaking in parliament, then Minister of Health at the time described these efforts:

> "We established a public relations program that has been doing nothing else but sensitizing the people on the South Coast to the need for this particular project…. We have, in fact, incorporated the connections as part of the project so that the question of the cost of engineering for individuals would now be subsumed in the totality of the Project. We spent a lot of time making sure that some of the pitfalls with which we were not familiar when we implemented the Bridgetown Sewerage Project would not dog the South Coast Sewerage Project (sic)". [350 (p.196-197)]

Among the measures that were being taken to address key concerns, were plans to incorporate an odour reduction system and to employ a 'no-dig' or micro-tunnelling method to lay the majority of the sewer lines in order to minimize obstruction to traffic during the construction phase. Also, the EED's efforts were critical in obtaining high-level support for the creation of a compensation fund for businesses that might sustain financial losses during the construction phase and to finance a robust public relations campaign to keep the media and members of the public informed throughout the project's duration.[273, 363, 364]

Archer, and later Sealy, played especially prominent roles in masterminding these efforts, interfacing with decision-makers, the media, and hoteliers and other stakeholders, in a successful multi-pronged advocacy strategy that proved successful in assuaging order to allay fears.[273, 275, 365] Ultimately, decision-makers would once again put faith in these assurances that the previous pitfalls would be averted on the South Coast. In supporting the Minister of Health in her request to Parliament to approve the acquisition of land for the project, a fellow MP (Henry Forde) stated:

> "It is my understanding that we are not going to be faced with any large scale digging up of the roads in this area and that the connection will be done in a new and modern manner so that disruption will not be as significant as disruption was when the Bridgetown Sewerage Scheme was implemented. I hope that that

> engineering experiment will be successful…. I know that one of the most experienced and distinguished public officers, a public health engineer, is working with this project as Project Manager. I therefore expect and know that he will bring to bear on this matter all his experience, his knowledge, his skills and his expertise in ensuring that as good a job as possible is done."[350 (p.194)]

The absence of ingenuity and leadership by technocrats in accounting for declining priority

Unfortunately, despite these efforts the South Coast Sewage Project was riddled with its own set of challenges and mishaps. Now, fifteen years after feasibility studies on the West Coast were first conducted, political impetus to invest in sanitation seems to have dried up.[183, 191, 273, 275] In a personal interview Sealy reflected on this, saying:

> "I think that because the South Coast system took so many years to build and because it caused such significant disruption, both to tourists and to residents, that the government has lost the political will to build an even bigger system on the West Coast. So we have sort of a crazy situation where the government has spent US$4.5 million on preparing master plans, final designs and tender documents for the West Coast System, which we've had since 1997, but since then we've had no action on the West Coast." [273]

The result has been silence on the part of decision-makers, even in the face of indications from the IDB that resources may be available for water and sanitation projects once again. In explaining declining domestic priority for sanitation, several informants identified the inability of domestic actors to develop and experiment with new framing ideas as a contributing factor.[273, 275] Speaking about attempts to sustain priority for the West Coast, Archer's successor, Sealy admitted their failure in attempting to "sell" sanitation to policy makers in new and creative ways (as his predecessor had done in the early 1970s):

> "The problem was that we did not sell it correctly. This was the same Prime Minister who was always said that access to fresh water cannot be a constraint to further economic development—I was in that meeting when he said that. And we failed to link the two, we failed to say that if we went after wastewater reclamation we could kill two birds with one stone."[273]

Moreover, since 2003, the strong advocacy from within the Ministry of Health that characterised priority generation efforts for three decades seems to have petered out. Archer retired in 1994, after more than 20 years of relentless advocacy for improving sanitation, and in 1997 Sealy left his role as Project Director of the increasingly controversial South Coast Sewage Project.[273] Also, official responsibility for sanitation has been increasingly shifted to the Barbados Water Authority, where it is low on the priority list, and the EED—which was once the centre of sanitation advocacy efforts—has been moved from the Ministry of Health to the Environmental Protection Unit (located in the Ministry of Environment).[191, 273, 275]

In an interview, Sealy expressed the view that it is the absence of leadership on the part of technocrats (and not 'political will') that best accounts for the lack of resources for sanitation at the moment:

> "My biased opinion is that you don't have technocrats within government who are willing to stick their heads above the power pit and make a lot of noise. So what Arthur Archer started in the Environmental Engineering Division and the Sewage and Solid Waste Project Unit, and what I tried to continue, I think has lost impetus. You see, technocrats run the government, the politicians don't. They're just along for the ride. They are the ones who have to be visionary. They are the ones who have to see the synergies. They are the ones who have to push their Ministers."[273]

Indeed, reflecting on the critical role of technocrats in driving priority generation and in navigating difficult policy circumstances over the history of priority for sanitation in Barbados, this hypothesis does seem plausible.

5.6 Concluding thoughts

Again, in this chapter a small number of powerful domestic actors emerge as protagonists. In particular, this case study allows a further assessment of the power of such actors in explaining the emergence, decline and absence of priority, and provides an opportunity to gain insight into roles they can play in sustaining priority, even in the most

difficult of policy contexts. In this case, the actors who are central in the prioritisation process are sanitation experts from the Ministry of Health, from among whom Arthur Archer emerges as a notable leader. These actors played prominent roles in framing the problem of sanitation in a powerful new way and to some extent, in helping to mobilize external resources—two other factors that appeared to be necessary for priority to emerge in this case.

First, we see that technocrats were initially successful in generating priority for sanitation, when they were able to transform this issue from one that seemed to be chronically unappealing by nature, to one that easily attracted broad-based political support. When marine biologists released a new study, it was Archer (a lone sanitary engineer in the Ministry of Health) who connected the dots—linking investment in sewage systems to the protection of the marine and coastal environment and ultimately to the viability of the island's tourism sector. In doing this, his efforts appeared to be deliberate and pragmatic. Grounded in his understanding of the increasing importance of tourism to the national economy at the time, Archer was able to generate a new understanding of the role of sanitation that resonated with this national priority. He then proves successful in convincing powerful actors of the veracity and urgency of these claims by, working together with marine biologists, to mobilize what both decision-makers and international financiers feel is credible and substantial evidence.

Yet, what is most striking is that this idea has little to do with the public health merits of sanitation, and that the evidence used to make the case for action is not evidence of public health need but of bacteriological contamination of the marine environment, with primary concern for the health of coral reefs and to a much lesser extent that of the human population. While this is incredibly successful in generating substantial resources for a project that will also have substantial public health benefits, this case along raises questions about the impact of the nature of framing ideas on the prioritisation process. That responsibility for sewage disposal has now been mostly delegated to non-health agencies is

perhaps a response to this understanding of sanitation as being fundamentally an environmental issue.

Secondly probably due to the large up-front capital needed for the proposed projects, the presence of external resources appears to be a critical factor in accounting for the emergence of priority in this case. In the early 1970s, technocrats played pivotal roles in convincing the IDB to grant concessionary loans for the project, despite sanitation being relatively low on the Bank's priority list at the time. The importance of external assistance was underscored in the 1980s, when the hesitance of the IDB to finance the South Coast project effectively stalled the emergence of priority for sanitation, in spite of on-going efforts by technocrats. However, across the episodes explored in this case study, it is clear that the presence of external resources (on its own) was not sufficient to generate domestic priority. A clear example of this is the fact that although the IDB has expressed an interest in investing in sanitation, this has not been successful in rekindling the political impetus to sewer the west coast.

This case study also illustrates that other factors—crisis events, the role of international organizations, or past policy experiences—can encourage or constrain the emergence of priority. For example, we see how negative feedback from previous policy experiences can constrain the likelihood that priority generation efforts will be successful and can increase the transaction costs involved in supporting a given cause for authoritative decision-makers. However, the power of these forces (whether negative or positive) to influence the prioritisation process appears, to some degree to be mediated by the presence of powerful and persistent domestic technocrats who are actively seeking to place sanitation on the agenda.

For example, in the 1960s, PAHO/WHO had some success influencing the policy agenda (where the Rockefeller Foundation and the Colonial Office had previously failed) through the transfer of international paradigms about sanitation to domestic health officials through their repeated interactions with international actors. Conversely, in the absence of

sustained domestic advocacy for increased investment in sanitation, even noteworthy crises such as the cholera epidemic and unpleasant conditions in the capital city due to overflowing septic tanks can fall short of mobilizing actual resources.

Technocrats also play similarly decisive roles in the period of declining priority and backlash, which was in response to the legacy left by the Bridgetown Sewage Project. During 1980s, their persistence in strengthening framing ideas to keep sanitation on the agenda of decision-makers and in leading efforts to manage anticipated sources of opposition forms as an important part of the explanation of how priority is sustained in unlikely circumstances. Finally, while these actors appear to be pivotal, in this chapter we also gain insight into the limits of their power to influence the prioritisation process. In interviews, these actors are able to recognise their failures in accounting for and managing the real-world implications of their technical proposals or in seizing critical opportunities to advance their claims. These findings suggest that the ingenuity, power, oversights and/or mistakes of policy advocates are important factors in the outcomes of prioritisation processes. In light of these findings, the current apparent absence of domestic advocacy on sanitation does not bode well for the re-emergence of priority in the near future—a hypothesis that can perhaps be tested prospectively, as time goes on.

Chapter 6

The emergence of priority for AIDS at the beginning of the 21st century

6.1 Introduction

In an interview, a recently retired nurse reminisced about her time treating AIDS patients during the 1990s at Barbados' main public tertiary-level facility—the Queen Elizabeth Hospital (QEH).[366] She painted scenes of the hospital's small pulmonary unit squashed full of emaciated bodies waiting to see a lone physician.[60] As the number of cases increased this unit quickly became the unofficial 'AIDS ward'. At that time, with very little in the way of a budget and no designated staff, the clinical response to HIV/AIDS was largely reliant on a small group of dedicated volunteers on the hospital's AIDS Management Team (AMT).

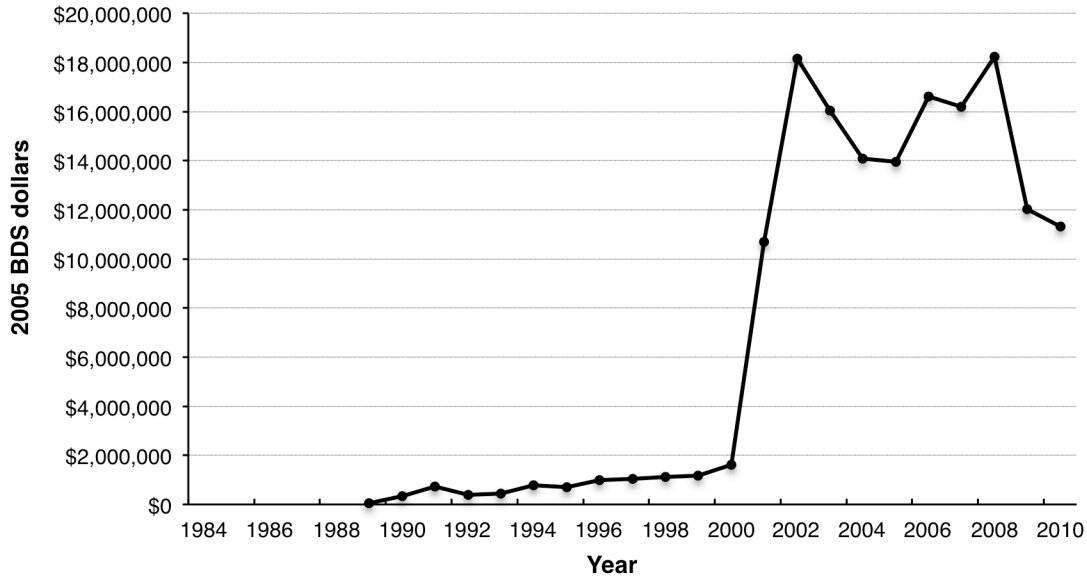
Today, a visit to Barbados' multi-million dollar HIV treatment clinic, the Ladymeade Reference Unit (LRU), makes it immediately apparent just how much the country's response to the disease has changed. The clinic is complimented by a number of other agencies, which offer an impressive array of support services for people living with the disease. However, the most profound change is the fact that almost all of the patients in the LRU's bright, spacious waiting room appear healthy. This is because since 2002, the Government of Barbados has provided life-saving antiretroviral (ARV) drugs free-of-cost for all who need it, transforming HIV from a death sentence to a manageable chronic condition.

[60] Dr. Timothy Roach, a pulmonary specialist, accidentally found himself in the driver's seat of the medical response as patients in the late stages of the disease often presented with a rare form of pneumonia.

A radical shift

Although Barbados detected its first case of AIDS in 1984, it wasn't until five years later that public financial resources were first allocated to address the disease. Even then, in 1989 a relatively modest resource was provided—just 0.01% of the health budget or approximately BDS $38,000 (2005 dollars). These resources grew exponentially in the first two years of the program, rising to BDS $736, 328 in 1991. However, throughout the 1990s there was very little growth in public investment for combating HIV (See Figure 6.1).[1]

Figure 6.1: Public expenditure on HIV/AIDS, 1984-2010 (in 2005 BDS dollars)



Source: Barbados Estimates, 1960-2010[1]

By the turn of the century, with a HIV adult prevalence rate of 2.89%, Barbados had one of the largest epidemics in the Caribbean region after Haiti and the Bahamas and AIDS had become the leading cause of death for adults between 25 and 49 years old. [367, 368] Moreover, even though highly effective ARV drugs became available in 1996 for the treatment of HIV, by 2000—with no earmarked funds for the treatment and clinical management of the disease—only 15 of the 350 patients being actively monitored by the AMT (or those who could afford it privately) were receiving these life-saving drugs.[369] The decision by the government in 2000 to provide universal access to HIV treatment heralded a

fairly radical policy shift. By 2002, public expenditure for HIV treatment, care and prevention had increased 11-fold in real terms, to over BDS $18 million 2005 dollars.

A historical explanation of priority for HIV

This chapter charts what seemed like the unlikely rise of HIV to the top of the domestic health agenda at the turn of the 21st century. In seeking to account for priority in this case, I place this within the context of the history of the government's response to the epidemic since 1984. I begin by describing the socio-political backdrop against which AIDS surfaced in Barbados, and identify some of the factors that stoked initial denial and inertia on the part of the government. I then consider the key drivers that led to the emergence of public response to HIV between 1987 and 1991. I go on to explore the reasons why priority for HIV failed to grow in step with the epidemic's gravity during the 1990s, and why treatment failed to emerge as a priority even after it became available in the mid-1990s. Finally, I turn my attention to Barbados' response to HIV/AIDS during the first decade of this century. Reflecting on this historical trajectory and tracing the sequence of events that occurred just before this shift, I distil some of the key drivers of priority for HIV/AIDS.

6.2 The early years of the epidemic

Beginning in 1981, cases of a strange, seemingly fast-acting, and deadly disease began to emerge out of the United States. As one informant explained, "from the time that the first AIDS cases burst on the world scene in 1981, there was this enormous social and religious reaction that reverberated across Barbados"[214]. Though the nature of the disease and its methods of transmission had only just become clear, in the United States HIV/AIDS was already widely perceived as a disease that affected homosexuals, haemophiliacs, and

Haitians. This characterization of the disease was problematic in the Barbadian context for two reasons. Firstly, religious conservatism and associated widespread homophobia fuelled popular sentiments of the disease as a punishing plague inflicted on the "sexually deviant"[370]. Also, the identification of Haitians as a risk group by the CDC was quickly extended to encompass the Caribbean more generally, causing fear among regional leaders of potential negative impacts on tourism.[371, 372]

Ironically (given the CDC's classification of high risk groups), prior to 1984 in Barbados AIDS was generally perceived as a disease that struck white foreigners.[12, 214, 373] However, towards the end of 1984 it was clear that AIDS was no longer a foreign problem, when doctors at the QEH reported the island's first two indigenous cases of AIDS.[6112 214] By this time, the disease was already set against a backdrop of a global context of fear and stigma[12, 371].

Within three months a small group of well-respected medical practitioners, who had found themselves at the helm of delivering care to the first AIDS patients, brought the issue to the Barbados Association of Medical Practitioners (BAMP) for discussion.[12, 214, 374] Since one of these consultants was a member of BAMP's governing council, they were able to prompt the association to establish an "AIDS Task Force" with relative ease.[214] Over the next two years, the taskforce became the epicentre of Barbados' AIDS response. Under the leadership of a well-known medical consultant, Professor Mickey Walrond (a well-respected surgeon and recognised leader within the medical community), it focused on educating the general public about the disease, combatting endemic stigma among health professionals at the QEH, and lobbying the government to adopt critical policy measures.[214, 366, 371, 375, 376]

Although behind the scenes, the government was mostly compliant with BAMP's suggestions, for example by implementing universal screening of the blood supply and

[61] Doctors would later admit that, they had come into contact with AIDS at the Queen Elizabeth Hospital prior to this, when a young male visitor to the island had become ill while on holiday.[12, 214]

establishing a small committee to consider policy issues related to HIV in 1985, these actions were not publicized.[181] Instead, publically, the government first took the approach of sticking its head in the sand, either refusing to confirm or flat-out denying reports that Barbados had had its first AIDS case. [377-379] Despite this approach, which was purportedly intended to avoid undue public alarm, Barbados' "efficient gossip network"—perhaps a feature of its smallness—ensured that news of the arrival of AIDS to the island's shores was soon widespread.[380]

In March 1985, mentioning AIDS for the first time in the House of Assembly, a member of the opposition party (the Democratic Labour Party), Branford Taitt, stated:

> "Mr. Chairman, I just want to make the point that there is another very serious disease which up until recently, has been out of Barbados. I am told from a very reliable source that we now have had some semblance of our first case. I am not going to name the disease for fear that I be accused of terrorizing the community…. I am inviting the Ministry of Health to take the population into its confidence about these diseases, especially these diseases which cause the population to panic. It is better to tell the population the truth than for them to discover bits and pieces by getting slippages of information."[381]

During that sitting of Parliament, Taitt went on to ask more explicitly: "Let us know what the position is. Is there or is there not a case of AIDS in Barbados?" [381] No definitive response was offered at that time. Only after this challenge from Taitt, did the Ministry of Health finally confirm that Barbados had its first two cases of AIDS.[378] During this period there was some civil society-led effort to generate priority for HIV, however these actors had no powerful allies within government to help champion the response. This was not helped by frequent Cabinet reshuffles, three between 1984 and 1986, which resulted in changes to the incumbent Ministers of Health. Meanwhile, the media continued to stoke a wildfire of fear and panic, for which the absence of a government response would only act as fodder.[370]

6.3 The emergence of a government response

Between 1987 and 1991, the first signs of a robust government-led response began to emerge. First, in 1987 the Ministry of Health established the National Advisory Committee on AIDS (NACA), "to advise the Minister on measures to prevent transmission of HIV and to reduce morbidity and mortality associated with [the] disease."[382] Also, in 1989 and 1991 respectively, the Ministry of Health established the AIDS Information Centre and the AIDS hotline, as focal points for disseminating public information. Most importantly, in 1989 the Ministry of Health allocated a portion of its budget to AIDS for the first time (See Appendix 6.1, for a timeline of events related to HIV/AIDS policy in Barbados). Although the funding allocated was significantly less than requested by NACA—a provision of BDS $38,000 (2005 dollars) compared with a request of over BDS $1.5 million) in the 1988 budget—by 1991, public expenditure on AIDS had increased significantly to just over BDS$800,000.[1, 382]

Two main factors seem important in accounting for this change in the government's response. First, beginning in 1986 rising global priority for HIV resulted in a supportive external environment for local policy champions and increasing exposure of top government officials to calls by international actors for increased priority for AIDS in LMICs. Secondly, BAMP doctors, who had begun the response in 1985, were better placed to place HIV on the government's agenda, as they were closely connected to a newly appointed Minister of Health.

6.3.1 Increasing global priority for AIDS

In 1986 the WHO created the Special Program on AIDS (SPA), which was later renamed the Global Program on AIDS (GPA). Prior to this, international cooperation on AIDS had been virtually non-existent. However, under the charismatic leadership of

Jonathan Mann, WHO was finally awakening to the growing global epidemic. At the global level, Mann mobilized both political and financial capital to advance the fight against AIDS. On the political front, Mann was able to get the members of the World Health Assembly (WHA) to sign onto the "Global Strategy for the Prevention and Control of AIDS", which declared AIDS to be a "worldwide emergency". He then addressed the UN General Assembly in 1988 and led the General Assembly to pass its first ever resolution on a particular disease. On the financial front, he was able to mobilize substantial resources for addressing HIV/AIDS in LMICs. By 1989 the GPA had become the WHO's largest program. Between 1986 and 1990, the program's budget grew from US$500,000 to US $90 million and its staff from two to over two hundred people.[383-385]

The GPA's strategy for the prevention and control of HIV, which was unanimously adopted by the WHA, urged all countries to "create or strengthen national AIDS programs [or NAPs] in line with the global strategy".[386] The GPA was almost evangelistic in this endeavour, approaching the challenge in three main ways:

> "First, its leaders became tireless advocates, travelling the globe several times over, meeting with national leaders…trumpeting the necessity for creating NAPs. Secondly, they dangled the carrot of financial assistance. The resource-stretched developing nations would receive resources if they exhibited a willingness to pursue NAPs. Finally, SPA[later GPA] demonstrated that it could achieve demonstrable progress immediately."[383]

According to several informants, in Barbados these efforts helped to provide momentum to the AIDS Taskforce's efforts.[214, 376, 387, 388] Firstly, Barbados responded to the call to set up a National AIDS Program by establishing NACA. Also, at a donors meeting hosted by the Government of Barbados in 1988, the GPA was able to mobilize pledges of approximately US$12 million in funding for jump-starting HIV/AIDS efforts across the Caribbean region.[389] The provision of external financial assistance would however ultimately prove to be of limited power in mobilizing domestic priority as "national programmes experienced problems in accessing the funds because each donor organization,

as well as PAHO/WHO and GPA, all had different rules and procedures for accessing funds".[371]

However, the most powerful effect of these global efforts was via several 'high profile' opportunities, which helped to nurture the political leadership that was already emerging at that time. In 1988 Barbados' Minister of Health, Branford Taitt, attended a World Summit of Health Ministers, which was jointly organized by the British government and the WHO. There he, along with Ministers of Health from 116 countries, agreed to do everything in his power "to ensure that [their] governments undertake such urgent action [on HIV/AIDS]"[390]. Also, perhaps in recognition of their enthusiasm, in 1987 Taitt and Walrond (the leader of BAMP's Taskforce) were invited to represent Barbados on the Management Committee of the Global Program on AIDS (a committee on which only 15 countries were represented).[214, 375, 376]

Among these local actors, these experiences engendered a sense of accountability to the global efforts, making it harder for them to make statements or support policies that were incongruent with the GPA's stance. This impact is best illustrated by the dramatic change in the way that Taitt represented the epidemic during Parliamentary debates. In 1987, Taitt countered claims, made in an editorial in the Barbados Advocate (a local newspaper), that AIDS had become an epidemic.

> "We have a mere 51 cases in Barbados…yet in the reporting it was being said that we in the Caribbean had an epidemic of AIDS….That is an economic assault on the Caribbean, because if you say that there is an epidemic of AIDS in the Caribbean, visitors are not going to come."[391]

By 1988, the tune had changed dramatically. Defending the Ministry of Health's budget in Parliament, Taitt stated:

> "In this country today we have a danger from AIDS…[it] will affect our young people like nothing we have ever had to contend with. AIDS will take a substantial part of our economic resources down the road."[392]

The effect of Barbados' close alignment to the GPA was also evident in NACA's first report, which at the time was far more progressive, on issues pertaining to the rights of people living with HIV and AIDS (PLHAs), than the general public (and indeed the Parliament) seemed prepared to be.[376, 380, 382, 393]

6.3.2 Increased power of civil society actors

A change in government at the end of 1986, proved fortuitous for BAMP's efforts to place AIDS on the government's agenda. In particular, as Howe suggests, "[d]uring this period…Walrond emerged as the principal advocate for more attention to be paid to the AIDS epidemic".[370] Several informants felt that the close friendship between Walrond and Taitt, the new Minister of Health under the DLP government, was a critical factor in accounting for Walrond's effectiveness in successfully generating priority for HIV/AIDS between 1987 and 1991.[214, 376, 393] In an interview, when asked about the drivers behind this shift, Walrond admitted that this was indeed a critical factor:

> "I think it was a combination of things. It certainly was very current publically and internationally. But perhaps I knew him [Branford Taitt] very well, and I think that is where the impetus to set up structures and so on really came."[214]

Indeed, towards the end of 1986, four members of the BAMP Taskforce[62] (including Walrond) were asked by Taitt to assist the Ministry in establishing the NACA. In 1987 when the NACA was officially created, Walrond was appointed its first chair. As another informant reflected:

> "The success of any campaign in this country has a lot to do with the strength of the personalities involved…and their connections. Now very early, under the leadership of Professor Mickey Walrond, the National Advisory Committee on AIDS had a mandate that came directly from Branford Taitt, when he was a minister."[393]

[62] These actors were Professor E. R. (Mickey) Walrond, Dr. Wilfred dos Santos, Dr. Henrick Ellis, and Dr. Timothy Roach.

Taitt proved to be an important political ally. As one of the most senior members of the Democratic Labor Party (DLP), and former president of the party, he had the utmost respect of key political actors including the Prime Minister. Also having served as the leader of the country's delegation to the United Nations since independence in 1966, he was particularly poised to make use of the opportunities that were opening up in the international arena. By 1988, encouraged by Walrond, Taitt's involvement in publicly supporting efforts to address AIDS domestically soon caused him to rise to prominence within the WHO. There he became a vocal spokesperson for increasing priority for AIDS globally between 1991 and 1993, through his chairmanship of committees within the World Health Assembly (WHA), the Pan American Health Organization (PAHO) and the Commonwealth Health Minister's Conference.

In 1988, the MoH requested resources for HIV prevention in its budget for the first time. This request was readily supported by the Minister of Finance, Dr. Richard Haynes, who was also a member of the medical fraternity. Although the amount allocated (BDS $38,000 2005 dollars) constituted only 0.01% of the government's spending on health, this allocation of funds was an important part of the institutionalization of the AIDS response in Barbados.

The importance of connections to powerful actors

The importance of such connection to powerful authoritative decision-makers in determining the power of policy advocates was perhaps best illustrated by comparing this BAMP Taskforce's influence with that of another actor, who was ultimately unsuccessful in his attempt to mobilize bolder action on HIV among the political directorate. In 1990 Charles Schlosberg—a British GP who was on a visiting rotation at one of the island's polyclinics—published an open letter to NACA in the Nation Newspaper. Stating that he had asked about the sexual habits and behaviour of 290 patients, Schlosberg concluded that

"up to half of the entire population, at all ages from 10-60 or more, [were] at very definite risk of dying from AIDS within the next ten years". He concluded his letter by saying:

> "Barbados now is like a truck driving at full speed at a cliff edge on a dark night with the lights off. If the lights are put on now, it can escape with nothing worse than a bad squeal of the breaks. If not, then the children of 2000 will look back over the wreckage of the nineties and ask with every justification, WHY?"[394]

According to several informants, Schlosberg's letter was met with strong backlash from members of NACA and notably, by the Minister of Health (Taitt).[376, 379, 380, 395] As Professor Walrond, Chairman of NACA at the time, recounted in an interview:

> "Schlosberg was a doctor who came out here, worked at a polyclinic. He had no experience in this thing at all…[but] came to public attention with the great help of the press, particularly the Nation newspaper…. The Minister's response was: 'Who is this person? [And] what the hell is he doing making these public pronouncements from a polyclinic?'"[214]

The dispute played out in the media over a number of days, with NACA's Chair referring to Schlosberg's predictions as *"preposterous and unscientific"*. The Minister was vehement in his defence of NACA, terminating Schlosberg's contract (and essentially forcing him to leave the country) in response. Schlosberg's attempts to influence the agenda were instead seen as a tactic aimed at embarrassing the state. This stood in stark contrast to the collaborative alliance between members of the BAMP Taskforce and the Ministry of Health, whose efforts (albeit limited in scope) had by this time borne some fruit.

6.3.3 The institutionalization of a public response to AIDS

Between 1987 and 1991, civil society actors in conjunction with powerful allies within Government were able to advance the institutionalization of the government's response to HIV/AIDS. This seemed to be enabled by close personal relationships between a civil society leader and influential members of the political directorate at the time. In addition, increasing global priority for HIV helped to provide a supportive environment for

domestic efforts and played a key role in galvanizing and sustaining progressive action on AIDS.

The result of this combination of factors was a flurry of activity on HIV/AIDS, led by NACA, between 1988 and 1991. Several of its members appeared on television and radio programs and conducted educational seminars for youth groups, parent/teacher associations, and various government departments. Also, with assistance from the BAMP taskforce, NACA was able to sensitize all polyclinic staff, facilitate the training of the first set of HIV counsellors and offer a series of lectures for the Barbados Police Force.[214, 366, 376, 396] In 1988 NACA released its first report. The document reflected wide stakeholder participation and presented recommendations to the government on a range of issues, including prevention and control, management and care of AIDS patients, confidentiality, contact-tracing, reporting and notification, and the rights of people living with and/or affected by the disease[382].

In 1989, reflecting the progress that had been made in generating priority for AIDS since 1987, in a speech commemorating the 350th anniversary of the Parliament of Barbados, the Prime Minister mentioned AIDS as one of the major challenges facing the country.[397] Moreover, by 1990, Barbados had gained some global recognition for its progressiveness in responding to the epidemic. This was perhaps evidenced by their invitation as 1 of 15 countries to be represented on the GPA's Management Committee.[214, 376] Still, the gains in terms of resource allocation were relatively modest. For example, by 1990 the funds allocated were still less than half of what experts suggested was necessary for launching a robust prevention effort in Barbados.[1, 382]

6.4 One step forward, two steps backwards—a decade of low priority for AIDS

During the 1980s, AIDS was classified as a predominately homosexual epidemic. However, by 1990, the Caribbean Epidemiological Centre (CAREC) reported that over half of all new infections was the result of heterosexual contact.[375, 398] By the middle of the decade, evidence of a rapidly growing AIDS epidemic[63] was available to policy makers.[375] Between each year of 1991 and 1998, another 110 people died due to complications related to AIDS and the number of new HIV infections recorded rose steadily by approximately 170 new infections per year over the same period (See Appendix 6.2 showing reported HIV Cases, AIDS Cases and AIDS deaths, 1984-2010). Moreover, it was widely believed, among AIDS professionals, that these figures were grossly underestimated. By 1997, the Caribbean region had the second-highest HIV prevalence in the world, after sub-Saharan Africa, and HIV/AIDS had become the leading cause of death for both men and women between 25-44 years of age. With a prevalence rate of 2.89%, Barbados was ranked as having the third worst epidemic in the region, after Haiti and the Bahamas[399].

Also, amidst a worsening epidemic at home and abroad, scientific advances in treatments for HIV/AIDS brought great cause for hope during this decade. Although the U.S. Food and Drug Administration had approved zidovudine (AZT) as the first effective treatment for HIV in 1987, this had to be administered at quite high doses in order to slow the progression of the disease and as a result was associated with quite severe side effects. By the early 1990s, much more was known about this drug. In 1994 a short course treatment with AZT was shown to reduce the transmission of HIV from pregnant mothers to their unborn children.[400 (p.36-37)] Scientific advances in drug development for HIV continued throughout the early 1990s. In 1996, at the International AIDS Conference in Vancouver

[63] This evidence was felt to be relatively reliable as the Pathology department at the Queen Elizabeth Hospital, where all HIV tests were processed, reported HIV/AIDS cases monthly. Also, virtually all AIDS patients who fell ill presented at the QEH (as it was the island's only fully-equipped tertiary institution).

scientists announced a major breakthrough—a combination of three antiretroviral drugs or highly active antiretroviral therapy (or HAART) had been found to be extremely effective in treating HIV. Beginning in 1996, HAART helped to turn the tide of the AIDS epidemic in developed countries, where it quickly became widely available.[123 (p.41)]

If the period of 1987-1990 represented a step forward in the fight against AIDS, between 1991 and 1998 the priority status of HIV in Barbados seemed to take two steps backwards. During this period the government's response to the epidemic could be described as being anaemic, at best. Indeed, the UNAIDS global report in 2000 stated: "…ministries of health in the Caribbean have long been aware of the galloping epidemic and its implications for the region…."[367]. In a subsequent article, UNAIDS regional director lamented the region-wide state of apathy among decision-makers saying:

> "From island to island, HIV/AIDS is enveloped in a dark shroud of irrationality…support for the National AIDS Programs in human resources and budget allocations has decreased even as the epidemic increases"[401].

Only later (in 2001) would a representative from the government in power (M.P. Mr. L.R. Tull) admit that "the support of the Government [for HIV] [had] not been as generous as it might have been in the past…."[402] The weakened priority status of HIV was evident in the annual allocation to addressing the epidemic, which in 1999 was still only just over BDS $1 million 2005 dollars—more than half-million dollars less than what was requested by NACA a decade prior. Also, the change in the proportion of the health budget allocated to HIV/AIDS between 1991 and 1992 was negligible, moving from 0.23% to 0.36%.[1]

A number of factors may have contributed to the failure of priority for HIV to grow in step with the spread of the disease, between 1991 and 1998. First, in my interviews several key informants pointed to the impact of an economic recession on spending between 1991 and 1993. However, as discussed below, I find only limited evidence to support this. In particular, I find that two other changes help to account for the absence of priority for

HIV during this period. First, at the global level, priority for HIV faced significant challenges, with the loss of Jonathan Mann as the director of the GPA and decreasing resource priority for AIDS within the WHO. Secondly, the policy actors, who had driven the emergence of the response in the 1980s, lost political influence in the early 1990s and failed to successfully regain it over the course of the decade.

6.4.1 Economic recession, structural adjustment results in cuts to allocations for HIV/AIDS between 1991-1993

At the beginning of 1991, due to a contracting global economy, declining revenues from sugar and tourism (the mainstays of Barbados' economy at the time) and high government spending in the run-up to a general election, Barbados entered its most severe and prolonged economic recession since independence. The government was forced to seek IMF assistance and to adopt a stringent package of austerity measures, which included drastic budget cuts, the firing of approximately 2000 government employees and a public sector-wide wage cut of 8%.[226, 403, 404] Several informants pointed to this national macroeconomic context in accounting for reduced priority for HIV at the beginning of the 1990s.[214, 376]

In 1992, according to the Leader of the Opposition at the time, "[t]he surgeon general of the Prime Minister's Office…massacred [the Ministry of Health] with enormous cuts".[405] While the entire health sector faced budgets cuts between 1991 and 1993, the cuts to the AIDS program were the most severe of all program areas. In 1992, the program's budget was slashed by almost 50% and over the two years of this recessionary period, spending on HIV fell by 41% (See Table 6.1).[1]

Citing this, a Member of the Opposition pointed to the incongruence between the government's rhetoric and its actual priorities, as indicated by the budget:

> "The Minister of Health has gone far and wide on this Government's commitment to services to be provided in respect to

> AIDS…. How does the Minister reconcile this with his statements in the Press, both here and abroad, that the Barbados Government is deeply concerned? …You say that there has to be cuts. I would have thought it would have been more selective with the knife…. Indeed, the AIDS Task Force, led by Professor Walrond, is on the television nearly every night to try to promote AIDS control, AIDS prevention. How is the Minister going to justify a cut of the size we see in these Estimates?"[406]

Table 6.1: Real and percentage change in public health expenditure by program area, 1991-1993

Program area	Public health expenditure (2005 BDS dollars)		Percentage change 1991-1993
	FY 1991	FY 1993	
HIV/AIDS	**$736,328**	**$431,083**	**-41%**
Care of the Elderly	$39,099,847	$23,740,739	-39%
Primary Health Care	$40,958,857	$27,821,657	-32%
Hospital-based services	$131,381,892	$94,396,771	-28%
Care of the Disabled	$3,050,328	$2,211,020	-28%
Direction & Policy Formation	$24,782,633	$18,523,505	-25%
Mental Health	$23,518,903	$19,526,086	-17%
Pharmaceutical Program	$24,503,666	$23,906,936	-2%
Environmental Health/Sanitation	$35,429,309	$47,257,669	33%
Total	**$323,461,762**	**$257,815,467**	**-20%**

Source: Barbados Estimates, 1960-2010[1]

During this period, despite major scientific advancements in treating HIV/AIDS and the emergence of AZT as an effective treatment in delaying the onset of AIDS, NACA found it difficult to get increased funding, even from a willing administration.

> "[W]e had discussed and sent a paper to the Ministry about acquiring AZT but, because at that time the country was going through economic problems, we never got approval for that."[214]

However, by 1993 the Barbadian economy was already showing signs of recovery and, and budgetary records show that the impact of the recession on spending for HIV was short lived.[1, 403] By 1993, spending on HIV had been restored to just above what it had been in 1990. Yet, in relative terms, funding for HIV continued to occupy less than 0.3% of public expenditure on health and failed to grow substantially over the course of the decade (rising only to 0.36% by 1999) suggesting that other factors were likely at work in

determining resource allocation for addressing the epidemic over the decade (See Appendix 6.3).[1]

6.4.2 Decline in global priority for AIDS

In 1988 a new Director-General, Hiroshi Nakajima, arrived at the WHO. Like several others, Nakajima felt that the AIDS program had grown too large. Using his power and influence over budgetary decision-making, he systematically reduced global priority for the disease by placing bureaucratic barriers in the way of the, by then, meteoric rise of the GPA, led by Jonathan Mann. Nakajima became infamous for saying: *"Don't talk to me about AIDS; I have malaria, which is a much bigger killer of people, on my hands."* [407](p.59) According to Gibbons:

> "Mann's vision for the program called for further growth and expansion at a time when Nakajima was calling for retrenchment of the AIDS program… [In 1990] the annual AIDS budget was cut from a proposed $110 million in January to less than $85 million in March…"[408]

Frustrated with what he felt was a concerted effort to undermine the fight against AIDS, Mann resigned from his role as Director of GPA in 1990. His sudden departure left a much weaker effort than he had fervently built over the preceding 4 years. This decline of priority within WHO was further abetted by the reduction in financial support to the program from donor countries in the face of a global recession.

Under Mann, the WHO had become the definitive leader in the global fight against AIDS. The decline of the GPA thus had a ripple effect across the WHA member countries.[407] The absence of such high-profile attention for AIDS on the global front meant that there were fewer opportunities to engage leaders at the highest political level, and less funding with which to mobilize action, at the country-level. In particular, in Barbados, one repercussion of this was that the financial assistance, pledged by WHO for AIDS was not forthcoming.[214, 375]

In 1996, the UN created the Joint United Nations Programme on HIV/AIDS (UNAIDS), to fill the vacuum of leadership on global AIDS that had persisted since the decline of the GPA at the beginning of the decade. Like the GPA, UNAIDS sought primarily to generate priority for HIV/AIDS both among global institutions, donors and within LMICs. Likewise, civil society actors in Barbados sought again to leverage engagement at the global level to advance priority for HIV domestically. The chairman of NACA, Dr. Carol Jacobs[64], served as a member of UNAIDS' first Programme Coordinating Board between 1996 and 1998, where she represented Barbados and the Caribbean and used this position to generate increased attention for the region's growing epidemic. Yet this effort failed to lead to better resourcing of the fight to control the epidemic at home over her period at the helm of NACA (i.e. until 1995-1998).[379, 396]

6.4.3 Leading policy advocates lose political influence

Neither funding shortages nor international priorities can fully account for the reduction in priority during this period. Instead, one has to look at the relation between policy advocates and political leaders to better understand it. Finally, between 1991 and 1998, Professor Walrond, who had emerged as a key leader in priority generation efforts during the late 1980s, diminished in his political influence. Two main factors seemed to contribute to this loss of power. First, after Schlosberg's open letter to the committee was published in the media in 1990, the effectiveness of the committee's efforts to address AIDS came under increasing public scrutiny and criticism. Secondly, following a change in administration, Walrond (and by extension NACA) lost its foremost political ally with Taitt's departure from the position of Minister of Health.

[64] Dr. Jacob's appointment as the Chairman of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2000 came in recognition of her work on HIV/AIDS regionally.

Wounded credibility in the face of public criticism

In his analysis of media coverage of HIV/AIDS in Barbados, Howe suggests that the island's major newspapers capitalized on widespread fear and paranoia associated with AIDS, often publishing sensationalised and sometimes fabricated reports that "played a significant role in constructing and reinforcing distorted images of the cause and nature of AIDS as well as its mode of transmission".[65][370] Furthermore, NACA's attempts to try to counteract these stories often seemed defensive, adding to brewing scepticism of their messages. In describing perceptions of NACA, Howe (2000) writes:

> "…by the late 1980s there was a slowly growing public (and press) awareness that AIDS was also going to pose a serious threat to the heterosexual community. As a result, sections of the Barbadian press and public quickly began accusing the medical fraternity, in particular NACA, of deliberately underestimating the incidence of AIDS in Barbados."[370]

Against this backdrop, Schlosberg's claim that the island's HIV epidemic was far worse than NACA was letting on and that the committee was asleep at the wheel where HIV was concerned, was especially damaging to the public perception of NACA.[373, 376, 393] While Schlosberg quickly faced consequences from the political directorate for challenging NACA in this way, in the press he was characterized as heroic for standing up against this powerful group of medical professionals. [370, 409, 410] For example, in one letter to the editor, one reader thanked Schlosberg for his courage in "awakening the population to the seriousness of the situation".[411]

In one of our interviews, Professor Walrond recalled the impact of Schlosberg's letter on the public perception of the committee:

> "It was a big thing. The message was you fellas are wrong, you are hiding things from us; and therefore anybody who says anything outlandish becomes a respected researcher. I had such a battle."

[65] See Howe's chapter "Press and Public Reactions to HIV/AIDS in Barbados" in *The Caribbean AIDS Epidemic* edited by Howe and Cobley (2000), for a more in depth discussion of the role of the press in characterizing AIDS in Barbados during this period.[370]

As the committee's most visible and vocal member, Walrond bore the brunt of much of this criticism, and consequently found himself increasingly side-lined.[214, 376, 393, 412]. In 1993, he finally resigned from his position as NACA's Chairman. Explaining this he said:

> "I felt that…to some doctors' minds, I was becoming the issue. I was hearing remarks like 'What is a surgeon doing leading this thing. He doesn't know anything about it.' There comes a time that you say to yourself, now are you meeting resistance to things you advocate because of how people are seeing your involvement, or is it because your ideas are wrong…. And after a while I said, you know what, it might be better if somebody else leads this thing if my presence is a hindrance."[214]

In the absence of Walrond's leadership and energy, NACA floundered for the next two years.

The loss of a powerful political ally

The tumultuous recessionary period between 1991-1993, resulted in a major cabinet reshuffle in 1993 and ultimately a no-confidence vote in 1994 that ended 8 years of DLP rule. This resulted in Taitt's departure from the Ministry of Health and proved to be a major blow to priority generation efforts. For six years, his friendship with Walrond had ensured a responsive channel of communication between AIDS advocates and leadership at the highest level within the Ministry of Health. According to one informant, "…when the government changed Professor Walrond was sidelined because of his closeness to Branford Taitt".[393]

Professor Walrond, himself, admitted that he found it increasingly difficult to mobilize high-level support within the Ministry of Health[393].

> "[W]e had a new Minister of Health who decided that the whole battle on HIV/AIDS needed to be de-emphasized…. We were having a great deal of difficulty in getting the funds that we asked for, which were very little. I felt that this was also a kind of reaction to the previous Minister. It is like sometimes you get a new Minister and they feel they have to do something different."[214]

However, even though by 1996 (under the chairmanship of Dr. Carol Jacobs) NACA seemed to be beginning to regain the confidence of the public, support within the Ministry of Health proved much harder to rekindle.[214, 393, 396, 413] Between 1994 and 1999, Ministers of Health were labelled by key informants as "not interested", "not very positive", and even as "resistant" to placing a greater emphasis on HIV/AIDS.[214, 241, 393] Assessing the reasons for the lack of adequate resources for NACA's multi-sectoral plan between 1995 and 2000, the World Bank stated:

> "The lack of sufficient political awareness of the magnitude of the problem has meant that multisectoral efforts have not received adequate human or financial resources. Moreover, the NACA was essentially "advisory" and its operations highly dependent on the initiatives and resourcefulness of its leadership and membership…"

Similarly, the Bank also noted that the limited clinical care available for PLHAs during the 1990s was being provided by "committed volunteers, working with non-earmarked and inadequate resources (sic)".[369] While paediatricians at the QEH were able to lobby the government to begin providing universal access to AZT to prevent the transmission of the virus from pregnant mothers to their unborn children, members of NACA and the clinical team managing HIV/AIDS at the QEH were unable to mobilize support for the use of AZT (and later HAART) as treatment.[12, 214, 376, 393, 396] Dr. Timothy Roach, who was in charge of the AIDS Management Team at the Queen Elizabeth Hospital, remembered lobbying—to no avail—for the extension of treatment to those who needed it:

> "It just fell on deaf ears…. In fact, I was castigated by one Permanent Secretary—how could I possibly be asking for this when I knew the Government couldn't afford it? The argument was strictly financial affordability…. So the medications were available, but only for patients who could afford to pay."[12]

6.5 The emergence of priority for ensuring universal treatment access

In April 2000, heralding a radical shift in priority for HIV, the Government of Barbados announced its intention to provide universal access to HAART by the end of 2001 and have since made this a reality. [39, 369, 414, 415] Between 1999 and 2002, the government increased resources for HIV/AIDS by more than 11-fold to BDS $18.2 million (2005 dollars), and the proportion of public health expenditure allocated to this area had increased from 0.36% to almost 5%. Moreover, in a powerful sign of the increased emphasis being accorded to HIV, in 2001 the Prime Minister moved the secretariat for the National HIV/AIDS Commission (a successor of NACA) to his office. Since this time, the NHAC has pursued a multi-sectoral approach to the epidemic, involving eight government ministries (including the Ministry of Health), each of which have earmarked funds for HIV prevention.[396, 413, 415, 416] By 2008, the country had spent approximately BDS $116 million on HIV treatment, prevention and care, with the lion's share of this devoted to financing access to ARVs.

There is already evidence that this investment might be having a public health impact. Since 2000 the number of new HIV infections has been declining, although there are some concerns that this is not declining quickly enough.[12, 13, 214, 393, 417]. Also, with the availability of treatment, improved clinical management, and investment in state of the art laboratory monitoring facilities[66], the case fatality rate of AIDS had declined drastically from 17% in 1998 to 2% in 2008 (Appendix 6.4). In fact, in 2008 it was estimated that 87.6% of all adults who were in need of treatment (i.e. with a CD4 count of < 200 cells/mm^3) were accessing HAART via the LRU.

In particular, the emergence of priority for ARV treatment is somewhat surprising. Although ARVs had been available in wealthy countries since 1996, with the exception of Brazil, very few people in LMICs had access to these drugs due to high costs at the turn of

[66] Facilities for conducting CD4 counts and viral load testing are available through the government's treatment facility—the Ladymeade Reference Unit—and these are routinely monitoring in PLHAs.[418]

the 21st century. Indeed, as mentioned in the previous section, up to 1999 policy makers had insisted that HAART was not an expense that the government could afford. Since 2001, drastic reductions in the price of HAART (driven by generic competition), has resulted in rapid scale-up in the numbers of people on treatment in these countries. [123, 419] However, in April 2000, when Barbados announced its plans to provide HAART, the negotiations between major pharmaceutical companies and UN agencies in the Accelerated Access Initiative (AAI), which lead to these massive price cuts, had only just begun. [123, 420] In 2001, the cost of triple therapy in Barbados was still relatively high, at US$4500 to US$9500 per patient per year.[421] [67]

Thus, even by international standards, the emergence of priority for HIV in Barbados beginning in 2000 was considered to be progressive. For example, the Director of UNAIDS at the time, Peter Piot, hailed it as a "regional exemplar"[424] and the Director of the U.S. Government's HIV/AIDS program in the Caribbean, Rebecca Rohrer, was quoted by Marquez (2004) as saying:

> "I was a bit wowed by the degree to which Barbados has truly institutionalized a multi-sector approach to addressing HIV/AIDS. You are not only a role for the Caribbean, truly and honestly Barbados is a global role model. [I've] worked on HIV/AIDS in several countries in the former Soviet Union, south Asia and East Africa… Barbados has surpassed all. In fact, Barbados has surpassed US and western European efforts in this area!" [415]

At the turn of the century, political priority for HIV/AIDS and universal access to ART emerged in Barbados, even though this had previously been deemed unaffordable by policy actors and little had changed in terms of the price of these medications at that time. The government decided that HIV now warranted such an investment. Indeed, in a World

[67] Though Barbados became one of the first countries to begin negotiations with the AAI later that year, the extent of the price cuts that would result were not known[422]. Furthermore, because reductions offered by the pharmaceutical companies varied according to the country's HDI, for Barbados, the agreed prices for ARVs via the AAI was still relatively high—starting at US$2304 per person per year. In fact, major reductions in the price of ARVs in Barbados was not achieved until 2006, when the country started purchasing generics, through the Clinton HIV/AIDS Initiative.[423]

Bank report, illustrating just how high HIV was on the government's priority list, the authors stated:

> "According to the Minister of Health, the government prefers to invest in the procurement of those life-saving drugs for the active population than in any other new health programme. The Minister even raised [the point] that the government is ready to cancel a project for a new cardiovascular unit in favor of a programme on access to antiretrovirals for people living with HIV/AIDS (sic)."[369]

To explain this rise in priority for HIV, several authors have pointed to the role of the Prime Minister's leadership in mobilizing the system for change.[87, 418, 425] Yet, I argue that a more careful look reveals that the Prime Minister himself was motivated to act when: i) a powerful policy actor (who he respected a great deal) emerged to champion the issue; ii) he came to understand HIV as a threat to national economic development and "not just a health issue"; and iii) he became aware of the possibility of garnering external resources from the World Bank to finance this program.

6.5.1 A new policy champion emerges to lead priority generation efforts

In 1998, when the problem of HIV/AIDS arose as a topic of discussion among government ministers at a meeting of the Cabinet, an unlikely voice interrupted. According to several informants, the Minister of International Business and Foreign Trade—Senator Phillip Goddard—spoke passionately for several minutes about the need for a more robust response to the epidemic.[39, 414, 425, 426] This encounter with Goddard seems to have been a key turning point in this case.[12, 379] He responded by requesting a thorough update on the HIV epidemic in Barbados from the Ministry of Health, which was provided to the Cabinet in October of the following year (Appendix 6.1). Also, that year, Arthur appointed Goddard as Minister of Health.[414]

By the time Goddard took up the reigns in the Ministry of Health, he was already deeply committed to addressing the problem of HIV/AIDS and this issue was foremost on

his agenda. Soon after his appointment, he attended a meeting at the WHO at which he met Peter Piot, the executive director of UNAIDS at the time. Piot invited Goddard to accompany him on an official UNAIDS visit to Brazil—a country that was quickly becoming a shining example of an effective response to the epidemic in the global South and where access to ARV treatment was already having transformational effects.[39, 396] Goddard came home, determined to make these medications available in Barbados.

A powerful actor

Goddard was a prominent businessman from one of the island's influential white merchant-class families[68], which had a long history of political involvement and public service. For example, his uncle Senator Sir John Stanley Goddard, had recently played a critical role in brokering the social partnership between government, the unions and the business community, that aided the country through the economic recession of 1991. In 1994 Phillip Goddard entered the political arena—not through the electoral-politics, but by appointment to the Cabinet by Prime Minister Arthur—after playing a key role in the party's successful election campaign.[39, 414] His appointment as Minister of Health in 1999 supplemented the power he already wielded on the national political stage, as a result of his close relationship to the Prime Minister and the well-known family legacy that preceded him.

Taking strategic action to mobilize priority

According to several informants, Goddard took strategic action to mobilize the system for change. For example, he played a pivotal role in propagating ideas about the connection between HIV and economic development, which proved powerful in motivating Arthur to take action. One informant stated that: "It all started when Senator Phillip

[68] Founded by his father, Goddard Enterprises emerged as a corporate giant in the mid-20th century and is now one of the island's homegrown multinational corporations.

Goddard realized the economic implications of ignoring the epidemic and transferred his passion to the Prime Minister."[12] At home, together with longstanding AIDS advocates, he lobbied the PM for his office to take the leading role in coordinating the response, and pressed for increased domestic resources and was successful on both counts.

Also, using his influence as Minister and building relationships with key international actors (like Piot), Goddard effectively identified and seized opportunities in the international arena to mobilize external resources for HIV treatment in Barbados (and the wider-Caribbean). For example, Goddard became aware of increasing World Bank interest in addressing the Caribbean's epidemic, after the Bank hosted a meeting on the economic implications of HIV with Heads of Governments and Ministers of Finance in the region in January 2000. Goddard, immediately followed up on this meeting with Bank officials, and offered to host a meeting of donors in Barbados later that year. Both before and after this meeting he communicated extensively with international and regional partners, including the World Bank, UNAIDS and PAHO, to follow up on promises of financial and technical assistance.[39, 427]

In e-mail correspondence to me about the sequence of events that lead to the provision of a World Bank loan for treatment in 2001, the Bank's Lead Health Specialist for the Caribbean at the time, Patricio Marquez, said: "[Goddard] played a critical role in pushing forward the whole initiative. He and Prime Minister Arthur were really its champions." [427] Indeed, sustained and committed political leadership within the Ministry of Health had been absent since Taitt's departure in 1993 and so too had priority for HIV. The emergence of Goddard as a policy champion at the turn of the century seems to have played a pivotal role in the dramatic rise of HIV to the top of the national agenda.

6.5.2 The idea of AIDS as a threat to economic development helps to mobilize unprecedented support

Linking HIV to economic development shocks the system

In 1998, after Goddard's interjection in Cabinet on the economic implications of HIV, the Prime Minister requested an update on the HIV/AIDS situation from the Ministry of Health. This directive was not followed until Goddard took up the post of Minister of Health, almost a year later. The update stated:

> "The socio-economic impact of HIV/AIDS in Barbados is…of critical importance since there is a high mortality rate within the 26 to 40 age group of the population. This is the stage where most individuals are deemed to be at their most productive years. HIV/AIDS therefore presents a serious challenge to our economic development…. It is therefore essential that further measures be taken to bring a greater degree of control to a disease that is relentless and insidious by nature." [368]

This idea that HIV posed a serious threat to economic development helped to generate priority for HIV in Barbados, at the turn of the century.[12, 39, 376, 379, 380, 393, 396, 413, 414, 428] This new way of framing the epidemic was a sharp departure from the discourse around HIV/AIDS throughout the eighties and nineties, in which HIV had been characterized as a 'gay disease' or more commonly, among medical professionals who were advocating for action and resources to address the problem, as a predominantly 'bio-medical problem.'[379, 380, 429]

Moreover, propagated by influential and authoritative domestic and international actors and supported by startling anecdotal accounts of what the epidemic would do if left unchecked, this infused decision-makers with a sense of urgency and passion. In particular, this idea resonated deeply with Prime Minister Arthur, who is an economist by training. As one informant stated: "It was like a revival meeting…almost as if people were motivated by some sort of religious calling." [379] Indeed, the dissemination of this idea was almost evangelical in nature. On December 11, 2000, during a parliamentary debate to approve the World Bank loan for HIV prevention and control, every MP present that day addressed the

House on the subject of HIV[430] and support for obtaining the loan was unanimous. In her address, then Minister of Physical Development and Environment stated:

> "…[T]he concern now about the future development of Africa is that a generation has died and another generation will die as a result of AIDS. If we in Barbados do not try to protect our only resource, the human capital that we have, then Barbados is not going to be able to enjoy the kind of development that we are accustomed to nor are we going to be able to continue to build our economic growth."[431]

Supporting this, another MP said:

> "…no sum which we borrow to fight HIV/AIDS can be described as being too great, not at this stage of our development. I believe that this epidemic is more devastating than the Cholera which plagued this country at the turn of the century.[432]

Influential actors infuse this idea with power

The idea that HIV posed an economic threat was by no means novel. Indeed in the Caribbean during the 1990s several actors had made attempts to advance this claim. For example, this idea was strikingly similar to the warning advanced by Schlosberg in 1990.[394] Also, at the regional level CAREC, in collaboration with health economists at the University of the West Indies in Trinidad & Tobago, sought to put forward an 'economic case' for action on HIV.[69][396, 398, 434-437] Perhaps it was the combination of powerful domestic and influential international actors who propagated and supported this idea between 1998 and 2000, which gave it so much power in the domestic arena.

For example, in 1998, Goddard recalled pointing out the links between HIV and the island's labour force in a Cabinet meeting:

> "I remember telling them that this disease really has the capacity to destroy our labour force and our society if we don't do something about it now. When I was finished there was silence, and then the Prime Minister said: 'Wow'".[39]

[69] For example in 1994, Henry published a paper modelling the potential costs of HIV/AIDS in Trinidad & Tobago, both in terms of the costs associated with the care of PLHAs and in terms of potential earnings lost due to associated disability and death. Their study concluded: "[a]t least 1 percent of GDP is likely to be lost on an annual basis [due to HIV/AIDS] before the end of the century"[433]

Several other key informants corroborated this view that Goddard had managed to galvanize the Prime Minister to take the first steps towards action on HIV/AIDS. For example one key informant (a sociologist, who has written about the socio-political aspects of the disease in Barbados and the Caribbean) said: "The impression I got, was that Arthur was shocked at the implications that Goddard was raising about HIV."[379] Similarly, speaking about Goddard, the director of the island's treatment centre said:

> He is the one that convinced the Prime Minister that this was a worthy thing, and basically, it was based on the fact that not dealing with this disease was going to cause our workforce to be decimated…"[12]

It was not just the message, but also the messenger, with his strong connections to other authoritative decision-makers and perceived authority on economic matters as an accomplished businessman, that now made this idea compelling.[39, 379]

Then in 2000, the World Bank played a critical role in reinforcing and legitimising this frame at the Caribbean Group on Cooperation in Economic Development meeting held in June at the Bank's headquarters. The introduction to the report, presented to regional leaders and finance ministers at that meeting, read:

> "There is a growing recognition that HIV/AIDS is not just a serious health issue in developing countries, but a major developmental catastrophe that threatens to dismantle the social and economic achievements of the past half century. The challenge for Caribbean countries is to learn from the dramatic experiences of some African countries and act decisively now to prevent the progressive extension of the epidemic to the general population."[399]

The fact that the World Bank—the foremost global financial institution engaged in development finance—supported this idea was of critical importance to the island's political elite.[39, 396, 412, 414, 427] In an interview, a World Bank official said:

> "I guess the fact that the World Bank got behind this initiative signaled to them that this was not just a "health issue" but rather a regional socio economic challenge." [427]

That HIV was "not just a health issue" was a phrase that was repeated often among informants and is evidence of the effectiveness of the powerful actors that propagated this frame.[39, 379, 380, 393, 396, 413]

The (ir)relevance of evidence

Since the early 1990s, research efforts to establish a link between HIV and economic development had accelerated, with support from the World Bank.[438-443] Though some studies from high-prevalence countries in sub-Saharan Africa had indicated that there could be a connection, many of them had major methodological weaknesses. [439, 440, 444] In a 1997 study of the impact of AIDS on economic growth in 51 developed and developing countries, the authors concluded "that there [was] more flash than substance to the claim that AIDS impedes national economic growth."[445] By the year 2000 there was not yet consensus among economists on the nature and/or strength of the connection, prompting one author to ask: "Is this reality or a carefully concocted nightmare to highlight the importance of AIDS?" [446]

In the Caribbean, macroeconomic models of the impact of HIV suffered from similar weaknesses. In particular, even though studies had documented potentially devastating impacts of HIV in Jamaica and Trinidad & Tobago, no such studies had been conducted for Barbados (which differs substantially in terms of various social and economic parameters). Instead, anecdotal evidence of the epidemic's devastating impact on African economies was used to bolster this claim. For example in our interview, Goddard said:

> "I think Botswana did all the modeling for us. You didn't have to be a rocket scientist to see the impact that the disease was having in African Countries – like Botswana. It was devastating. Anyone could do some math on the back of a match box and see that we were heading down a slippery slope if we didn't pull things together."[39]

Indeed, with influential actors backing them, the lack of robust evidence seemed to be of little consequence to the effectiveness of this claim in mobilizing attention for HIV

domestically.[180, 379] Indeed, reflecting on the role of this powerful idea in catalysing the regional response to the epidemic, Sir George Alleyne (UN Special Envoy for HIV/AIDS in the Caribbean) stated:

> "The original data, which purported to show that HIV was going to wreck the Caribbean economies was bad data. 7 to 8 years later there is no evidence that HIV has had any major impact on the economy of the Caribbean. The Economists that produced that data were great, but the models they used were wrong. It was theoretical, and it is likely to happen but if you look at the models that we were given initially and look at the results they predicted, for example they preached doom and gloom with regards to the agricultural sector, you'll see that it hasn't happened. But it didn't matter, because the data were so compelling then that they convinced the politicians to take action."[180]

6.5.3 External financial assistance influences the timing of domestic resource allocation

Necessity or incentive?

In 2000, the World Bank launched the Multi-country AIDS Program (MAP) and began actively seeking to encourage the development of HIV/AIDS projects in the region.[427, 447] A year later, the Barbados HIV/AIDS Prevention and Control project became the first project to be approved under the World Bank's US$155 million Multi Country HIV/AIDS Prevention and Control Adaptable Program Loans for the Caribbean (See Appendix 6.1 and 6.5). Since then, Bank loans have comprised two-thirds of all government spending on HIV/AIDS. Several informants felt that the government simply could not afford to provide universal access to treatment on its own, without cutting other vital services, and cite the provision of these external resources as a principle driver of priority for HIV.[12, 214, 252, 376, 393, 396] Domestic budgetary allocations to HIV appear to corroborate this view. As, although government had announced its intention to provide universal access to treatment, a significant increase in resources did not materialize until after they had

managed to secure a 5-year US$15.5 million loan from the World Bank for the program[70] (See Appendix 6.3). Moreover, external financial assistance appears to have been critical to the sustainability of the program, as the Barbadian government negotiated a second loan in 2008 valued at US$35 million.[71,449]

However, the relationship between the availability of external funding and political priority for HIV is far from clear-cut. In 2000, the Government of Barbados announced its commitment to provide universal access to ART—committing a significant amount of domestic resources to the response— before World Bank assistance had become a probability.[39, 369, 414] Also, in interviews with more senior key informants, when asked whether or not Barbados could have financed the program using domestic resources they insisted that this would indeed have been possible. For example, Goddard said: "Yes, of course. But while it was not essential, it assisted us in not hampering other activities."[39] Similarly, one of the most senior officials in the Ministry of Finance insisted that "[Government] had just introduced the value-added tax and thus the cost was not seen as a deterrent".[412] Although it may not be possible to prove the counterfactual (that priority would have emerged in the absence of the Bank's assistance), these actors do admit that it is likely that the prospect of external financial assistance served to further incentivize the emergence of priority for HIV.

According to these informants, with the World Bank's interest in HIV/AIDS in the region peaking, Prime Minister Arthur and other finance officials saw it as a unique opportunity to regain access to the Bank's favourable lending terms, from which Barbados had graduated since 1993. [39, 393, 412] The loan would also be a source of much coveted foreign reserves, some of which would help cover the costs of importing the expensive medications and testing equipment associated with treating HIV.[393, 412, 450] Lastly, the provision of

[70] In 2001, Barbados and the Dominican Republic became the first two Caribbean countries to benefit from these low-interest loans under the World Bank's Multi-Country HIV/AIDS Program for the Caribbean Region[415, 448].

[71] The need for this funding was likely heightened in the face of the global economic recession.

external financial assistance would reduce the need to reallocate resources from other areas in health, or elsewhere, to HIV/AIDS, a deeply political and potentially conflict-ridden process. [12, 39, 412, 451]

Domestic policy actors help to mobilize external resources

Regardless of whether or not the loan was necessary or an incentive for the generation of priority, it seems clear that domestic policy advocates played a critical role in mobilizing this support in the first place. As Goddard stated:

> "We had to convince them [the World Bank]. However, they had made a blanket statement that they were willing to help the region to address HIV/AIDS. The World Bank, IDB etcetera, were all saying that we needed to do something…and we seized the opportunity."[39]

However, the Bank was not simply waiting with open pockets. Barbados had graduated from the Work Bank's lending program since 1993 and was no longer eligible for Bank assistance. Also up until that point, the Bank had focused on financing prevention (which it considered to be highly cost-effective) and had previously refused to allow its funds to be used to purchase ARVs, even in Brazil.[441, 442] Aware of these challenges, Arthur and Goddard in particular, strategically lobbied the Bank.

First, Goddard and Arthur helped to position Barbados as a regional leader in the fight against HIV/AIDS. Most importantly, they played a leading role in extracting explicit promises from donors (including the Bank) by organizing a critical donors' meeting in September 2000.[72] Describing this process Goddard said:

> "I sent an email to all the various Ministries of Health, copying Peter [Piot], the IDB and World Bank. And said that I was shooting to organize a regional meeting and inviting the extra-regional actors….The carrot on the end of the stick was….to see where the IDB and World Bank could help us with funding. We put the

[72] This conference generated pledges of almost US$200 million, from donors and lending partners, for the regional fight against HIV/AIDS. It also resulted in statements of commitment to bolster domestic responses to the epidemic from almost all of the Eastern Caribbean governments.[452-454]

> whole thing together with the help of the Foreign Affairs people and we had a very successful 2-day conference."[39]

Goddard and Arthur consciously took on significant roles in leading the regional response in hopes that this might overcome some of the barriers to attracting external financing from the Bank and other donors (namely the country's high economic status). [39, 396, 414, 452] As a result, in the eyes of the Bank they soon emerged as an indispensable regional forerunner. Indeed in describing its rationale for providing the loan to Barbados, the Bank stated:

> "Barbados' proven economic and political leadership in the Caribbean implies that its absence from the program could significantly undermine the chances of success for the entire Caribbean program. Indeed, it is only due to Barbados' central role in the September 2000 HIV/AIDS Conference, and the Prime Minister's personal leadership, that the Caribbean countries now have a shared strategy for combating this epidemic."[455]

This proved successful in encouraging the Bank to request approval from its Board of Directors to include Barbados in the Adaptable Program Lending loan "as an exceptional case".[415, 455] Also, according to Sir George Alleyne (director of PAHO) this also gave key domestic policy actors leverage in negotiating the inclusion of treatment in the loan:

> "I remember very well when the World Bank came to discuss this loan. World Bank officials had said: 'Well, we won't pay for treatment'. During that time, I was having lunch with the representative from the World Bank and the Prime Minister, and the Prime Minister said to him: 'If you can't pay for treatment, then we don't want your money'. I was so proud!"[180]

Arthur and Goddard eventually succeeded in convincing the Bank to overturn this and Barbados became the first country to receive World Bank funding for HAART.[452, 454, 456] These interactions suggest that the relationship between domestic and international funders was not one-directional in this case.

6.5.4 The role of 'high-level' political leadership in generating and sustaining priority, 2000-2008 and beyond

Advocacy by Goddard and other AIDS advocates, the powerful connections that had been drawn between HIV and economic development, and the lure of external financial assistance from the World Bank, proved critical in mobilizing the Prime Minister to act. Arthur had been in office since 1994, but like most other leaders in the region, he had been virtually inactive on the issue of HIV/AIDS before 1999.[241, 399, 401, 457] However, by 2001 he had emerged as a widely recognised leader in the fight against HIV both domestically and regionally. Addressing the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June of that year, Arthur asserted:

> "A threat to human security of this order of magnitude, in any other sphere of human endeavor, would inspire a vast and commensurate mobilization of institutional and financial resources. Nothing less is now required to halt and to reverse the spread of HIV/AIDS."[458]

After assuming leadership on the issue, Arthur too became an important factor in priority generation efforts. For example, several informants pointed to the impact that shifting the administration of the country's response to HIV/AIDS to his office ultimately had an impact on the priority status of HIV/AIDS.[12, 214, 379, 380, 396, 413, 417] As Dr. Carol Jacobs (the first Chairman of the NHAC) said:

> "Putting it in the Office of the Prime Minister meant that immediately people had to pay attention. You know, they could no longer say 'oh, but I don't have time for that' or that it's just that little interest group harping on."[396]

That the Prime Minister Arthur was also the Minister of Finance, also meant that the program was now directly under the influence of the one who controlled the purse strings of government. Between 2002 and 2008, after Goddard left the Ministry of Health, Arthur continued to lend his support and political influence to the NHAC's efforts by ensuring that resources for HIV were sustained, and publicly championing the fight against HIV/AIDS in Barbados and the Eastern Caribbean. His critical role in this regard, has been better appreciated in his absence.[39, 214, 396, 413, 428]

In 2008, a general election brought 14 years of BLP rule to an end. Within days of taking up power, the new Prime Minister moved the management of the HIV/AIDS program from the Office of the Prime Minister to the Ministry of Family, Youth Affairs, Sports and Environment. This was seen to be equivalent to a demotion by several AIDS advocates.[39, 214, 393] As one leading journalist said in our interview:

> "Now you look into the paper and you don't see anything about AIDS anymore. It is as if it's gone off the radar. And the reality is, that it has not gone away. Far from going away, we're not quite sure where we are at–which is scary." [393]

In reality, real public expenditure allocated to HIV has indeed declined in 2009 and 2010 (See Appendix 6.3). Also, a World Bank mission earlier this year cited the "underutilization of available funds" as a major challenge.[449] This is occurring in spite of the fact that the adult HIV prevalence in Barbados is estimated to be as high as 1.9%.[13]

The current absence of either a powerful authoritative policy advocate or strong alliance between policy advocates and a powerful authoritative decision-maker, may be a reason for what appears to be evidence of declining priority for HIV since 2008. Indeed the World Bank mission's report suggested that "weak leadership [has] hampered NHAC's ability to coordinate the national response across agencies and has delayed implementation of the [second Barbados HIV Prevention and Control] Project".[449]

Several policy actors are worried that they will see the kind of decline in priority that was experienced during the nineties. However, it seems that at least one important characteristic differentiates the nineties from now. The generation of political priority for HIV at the start of the 21st century heralded the institutionalization of a governmental response to the epidemic. As articulated by one key informant:

> "In politics once you create an entitlement, it is one of the most difficult things to remove…. I don't think any politician will be willing to pay the political price of stopping free antiretroviral treatment." [180]

6.6 Concluding thoughts

In this chapter I have traced priority for HIV/AIDS in Barbados from reports of the very first case in 1984 to present. I find that a number of factors work together to help explain the trajectory of public resource allocation: the domestic and global political and economic context, the existence of external financial resources, the presence of powerful framing ideas, and the role of key domestic policy actors (including civil society actors and influential political leaders). I find the first three of these to be limited in their power to account for the emergence of priority over time, but that they may act as important vehicles for the fourth factor—key domestic policy actors, who drive priority generation efforts.

Firstly, changes in the economic and political context, on their own, are found to offer only limited help in elucidating why priority did or did not emerge in this case. For example, the economic recession of 1991 helps to explain why both political attention and resource priority for HIV declined during between 1991 and 1993, but doesn't explain why priority for HIV did not recover or grow until the end of the decade. Also while increasing global priority helps to create a supportive global environment between 1986 and 1990 and again beginning in 2000, this fails to fully account for the priority in this case. The fact that a similar increase in priority for HIV was not achieved in other countries in the Eastern Caribbean, beginning in the year 2000, seems to be evidence of the limits of this factor.[418] Secondly, while there is mixed evidence about the importance of external financial resources in driving resource allocation after 2001, it is clear that the issue had begun to rise on the domestic agenda and the government had made a public commitment to increasing priority for HIV even before it was clear that this funding would be available. Thirdly, ideas about the connection between HIV/AIDS and economic development that seemed so powerful in motivating a major increase of resources at the turn of the 21st century had been voiced as early as 1990.

Where these other variables fall short in explaining the generation of political priority for HIV, domestic policy actors, in particular, advocacy by domestic policy actors and political leadership, a small group of influential medical professionals, and the presence of a political champion, prove critical. For example, the fact that a small group of influential medical practitioners had already begun to lead a response to HIV placed the country in a good position to seize the opportunity that emerged in the global policy arena with the creation of the GPA. Also, although ideas about the connection between the epidemic and economic development had been articulated prior to 1998, it wasn't until Goddard characterized HIV/AIDS in this way, that these began to hold sway. This actor also appeared to play a critical role in mobilizing the World Bank to provide resources for Barbados' HIV response in the first place.

These actors not only prove critical in explaining the first signs of the government's response to the disease in 1987 and why priority for HIV emerges beginning in 2000, but they also help to account for why priority failed to increase in the 1990s and why it seems to have declined since 2008. In this case, their role in accounting for the priority status of HIV is not simply a function of their presence or absence but of their relative power (or political influence) over time. Across this chapter key policy advocates vary in their primary source of power. For example, for Walrond (and other civil society actors), the source of power was personal connections with powerful decision-makers and the fact that they were widely recognized for their medical expertise. For Goddard, the source of power was both positional (as a Senator and later as the Minister of Health) and personal (due to his relationship with the Prime Minister).

Whatever the source, the failure of priority to emerge when the epidemic was at its worst and the current signs that priority for HIV might be declining, highlight the fact that the influence of these central actors is vulnerable to change over time. In particular, across the case, connections to (other) powerful decision-makers appear to be an important determinant of the success of these key actors in generating priority. This seemed to be

especially true for Walrond, who as a civil society actor did not have any decision-making power of his own. While this case affirms the fact that actors outside of government can act as drivers of priority setting, it does suggest that in order to do so it might be necessary for them to have strong alliances with decision-makers—something that is not always easy to build.

Chapter 7

Insights from across three cases of macro-level priority setting in Barbados

7.1 Introduction

In the preceding three chapters, I have presented case studies of priority for three health issues in Barbados. Instead of taking a snapshot view of priority, I look at the status of priority over long-term horizons by tracing the historical evolution of public policy to ensure access to primary health care, to improve sanitation and to address HIV/AIDS. I find that each case study can be crudely divided into a number of episodes, in which priority is either absent, present, rising or declining. In Chapters 4-6, within each case, I identify factors that help to account for the status of priority during these distinct periods. In this chapter, I now turn to discuss four factors that emerge consistently in accounting for priority across the various episodes and cases as I synthesize my findings about how priorities are set at the macro-level in Barbados.

I find that the presence of powerful individual domestic policy advocates or 'policy entrepreneurs', the resonance of core framing ideas, windows of opportunities that emerge out of the policy context, and the availability of development assistance from multilateral development banks (MDBs), together provide convincing accounts of the historical evolution of priority for primary health care, sanitation and HIV initiatives in Barbados. All other things held constant, each of these factors affect the likelihood that priority will emerge. On their own, none of these appears to be sufficient to generate priority, although my findings suggest that domestic policy entrepreneurs are necessary and decisive linchpins.

The chapter begins by considering the central role of these actors and the features that influence their power as the principal agents of priority generation. However, since

they do not exert full control over any of the other factors, I propose an explanation of macro-level priority setting in Barbados that is grounded in, but goes beyond, the agency of these actors. I then consider each of the remaining factors—ideas, policy contexts, and external financing—in turn, paying specific attention to mechanisms of influence and the extent to which policy entrepreneurs mediate their impact.

7.2 The presence and influence of domestic policy entrepreneurs

Amidst this community of actors that participate in the policy process, a number of individuals clearly emerge as the protagonists or key agents of priority generation in each case. For example, in Chapter 4, we saw that despite the provision of financial assistance from the Colonial Office for the development of primary health care programs beginning in 1940, local efforts aimed at expanding access to primary-level care did not materialize until a small group of domestic public health technocrats emerged to champion the cause during the 1950s. Similarly, in Chapter 5, after unsuccessful efforts by several external actors to place sanitation on the agenda for more than a century, sanitation finally emerged as an issue requiring urgent public action with the appointment of the country's first sanitary engineer to the Ministry of Health in 1969. In Chapter 6, a small group of domestic civil society actors led by an influential medical doctor and later a politically-appointed Minister are brought into focus as key actors in accounting for the emergence of priority for HIV.

7.2.1 The role of policy entrepreneurs—theoretical insights from public policy

As discussed in Chapter 2 Section 2.2.2, although an emphasis on the role of individuals in influencing policy is ubiquitous in the health policy literature, there is limited theoretical and empirical clarity on who these actors are, what they do and how they influence the policy process. This contrasts with the field of public policy where scholars

have paid more attention to characterizing and theorizing the role of individual leaders or 'policy entrepreneurs' in influencing the policy outcomes.[56, 93, 459-461] Schneider and Teske (1992) define policy entrepreneurs as "individuals who change the direction and flow of politics"[93]. In his pioneering work on agenda setting, Kingdon (1984) notes that:

> "They could be in or out of government, in elected or appointed positions, in interest groups or research organizations. But their defining characteristic, much as in the case of a business entrepreneur, is their willingness to invest their resources—time, energy, reputations, and sometimes money—in the hope of a future return."[57, 462]

More recently, building on earlier work as well as his own empirical investigations, Mintrom has asserted that policy entrepreneurs are "an identifiable class of actors" who generally influence the policy process by: (i) perceiving opportunities for gain framing problems in politically (and socially) expedient ways, (ii) proposing policy solutions/innovations, (iii) crafting advocacy strategies and 'working the system', and (iv) building relationships and coalitions with other important actors and providing leadership to the advocacy efforts.[460, 463] Furthermore, while Mintrom acknowledges that policy entrepreneurs face constraints, imposed on them by their social, economic, political and institutional contexts, he suggests that these factors do not necessarily determine the outcome of their efforts.[463]

These insights on policy entrepreneurship resonate with my own empirical findings. All three cases emphasize that leadership by identifiable individuals, who propose and advocate for changes to the status quo, can have profound impacts on priority generation. These individuals were repeatedly identified and recognised by key informants for their critical role in driving change. The cases also affirm that a wide variety of actors can perform entrepreneurial roles in the health policy process. Policy entrepreneurs identified in the cases included technocrats from the Ministry of Health (Chapters 4 and 5), an appointed politician (Chapters 6), and a leader of a civil society organization (Chapter 6). My findings also suggest that policy entrepreneurs can often find room for manoeuver even

when the prospect of policy change appears dim. For example, technocrats in the Ministry of Health manage to sustain priority for sewering the island's south coast, despite growing popular opposition (and hesitance among decision-makers) after the experience of the Bridgetown project (Chapter 5).

Not only do I find that policy entrepreneurs are critical drivers of priority setting, but I also find that they are central factors in explaining why priority was either absent or declining at various points. For example, in Chapter 4, priority for PHC seems to stagnate after Byer leaves his post as Director of Medical Services. Also, the absence of new policy entrepreneurs since Archer's retirement from his post of Chief Environmental Engineer seems to form part of the explanation of why priority for sanitation now seems to have dried up (Chapter 5). The centrality of policy entrepreneurs in accounting for the priority status of health policies in all three cases necessitates serious consideration of the characteristics that distinguish them as particularly influential policy actors. This is the task of the next section.

7.2.2 Getting to know the principal agents of priority generation

The literature on policy entrepreneurship suggests that there are distinguishing features that seem to characterize policy entrepreneurs across time, space and (to some degree) policy contexts. For example, Kingdon suggests that policy entrepreneurs have a 'claim to a hearing', are well connected politically, are good negotiators, and are relentless in their persistence.[57] Taking this further, Mintrom identifies six defining characteristics of policy entrepreneurs. Among these, he includes creativity and insight, social perceptiveness and an ability to argue persuasively (See Table 7.1).[463] Similarly, my findings reveal common threads that characterize policy entrepreneurs in each case study. Policy entrepreneurs in the Barbadian context are recognised as having some degree of authority, have a high degree of political connectedness (either by having authoritative or decision-making power themselves or through personal or professional connections with those who

did), display a great deal of political savvy, and are marked by a sense of passion and commitment to advancing policy change.

Table 7.1: Comparison between key characteristics of policy entrepreneurs identified through empirical study

Kingdon (1984)	Mintrom (1993, 2000)	Findings from case studies
1. A claim to a hearing		1. Recognized authority
2. Known for their political connections	1. Social connectedness	2. Political connectedness
3. Strong negotiating skills	2. Social perceptiveness 3. An ability to argue persuasively 4. Creativity and insight 5. Strategic team building capability	3. Political savvy, in particular an ability to frame debates
4. Persistence	6. A willingness to lead by example	4. Passion and commitment

Sources: Kingdon (1984)[57], Mintrom (2000)[463]

These factors broadly overlap with observations of policy entrepreneurship elsewhere (See Table 7.1 above).[93, 459, 460, 462-464] However, they also depart from these in important ways as well. Firstly, Kingdon suggests that policy entrepreneurs possess "a claim to a hearing", either because they have been given the ability to speak on behalf of others, they hold an authoritative position within government, or because of they possess some relevant expertise. However, my findings suggest that it is not simply the possession of expertise or decision-making power, but these actors must be recognised by other powerful actors as having authority in relation to the policy problem and/or solution.

Secondly, whereas Kingdon suggests that policy entrepreneurs are known for their political connections and Mintrom points to social connectedness as a defining characteristic, I emphasize their connections with other actors who have authoritative power over resource allocation or legislative processes—what I refer to as 'political connectedness'. Notably, actors do not need to be publicly known as having these connections, as Kingdon perhaps suggests. Thirdly, in identifying political savvy, I encompass a number of characteristics identified by policy scientists that are all concerned with the capability of these actors to take strategic action in their given policy contexts. Finally, although the final characteristic, though comparable to Kingdon's emphasis on the

need for persistence, is expressed in the language used repeatedly by informants to describe these key actors in my own empirical research (See Table 7.2 below).

Table 7.2: Characteristics of policy entrepreneurs identified across the cases

	Policy entrepreneur	Source of authority	Connections to power	Example(s) of political savvy	Demonstration of passion and commitment
Primary Health Care	Dr. Maurice Byer Director of Medical Services	Expert and positional	Professional – Ministry of Health Personal – "old boys network" of policy actors.	Used personal connections with political leadership to expose the Prime Minister to the need for family planning at the primary care level by quietly inviting him (away from the media's lens) to interview young women who had had multiple pregnancies.	"Maurice Byer was able to achieve what he achieved because he was a man of great vision, he was a highly ethical, dedicated, and committed man who worked for the people, he had oodles of old world charm and persuasive power…and he just never gave up."[180]
	Cortez Nurse Chief Health Planner	Expert and positional	Professional – Ministry of Health	Used elections as a window of opportunity to place PHC on the agendas of both political parties and to create an environment in which there was competition between parties with regards to plans to address PHC.	"Government was pushed by the technical people in the Ministry of Health. We had a very progressive project manager and health planner at the time, Cortez Nurse."[171]
Sanitation	Arthur Archer Chief Public Health Engineer	Expert and positional – NGO	Professional – Ministry of Health	Capitalized on the findings of a new study to frame sanitation as a threat to the tourism industry. Played a central role in articulating and strategically propagating the frame.	"I think he should have been knighted posthumously…. He did a tremendous job. Even as he got older, because he stayed on and on and on way past retirement age."[273]
HIV/AIDS	Dr. Mickey Walrond Medical doctor, Leader of medical union	Expert and positional	Professional – Medical Association Personal – friend of the Minister of Health	Leveraged his relationship to the Minister of Health to generate support for HIV by advocating behind-the-scenes. Recognized rising global priority as an opportunity to increase domestic support.	"The success of any campaign in this country has a lot to do with the strength of the personalities involved and the conviction of those involved. Now very early, under the leadership of Prof Mickey Walrond, the National advisory committee on AIDS had a mandate."[393]
	Phillip Goddard Senator, Minister of Health	Positional	Professional – senate and political party Personal – friend of the Prime Minister at the time	Capitalized on the World Bank's increasing attention for HIV to organize a regional meeting and to secure financial and political commitments from both donors and domestic leadership.	"It all started when Senator Phillip Goddard realized the economic implications of ignoring the epidemic and transferred his passion to the Prime Minister." [12]

Recognised authority

Across all three cases, the point of entry of policy advocates into the realm of influence (where the government's agenda for action was concerned) was that they were each recognised by decision-makers as having either expert or positional authority in relation to the policy problem and/or solution. Often actors had a combination of these types of authority (See Table 7.2). While simply possessing recognized authority is not enough, in the same way that having business know-how or technical skills does not ensure successful entrepreneurship in the business realm, this did seem to be a necessary ingredient for successful entrepreneurship in the policy world.

Professional expertise was the primary source of authority for 4 out of 6 of the policy actors who played entrepreneurial roles across the cases. For these actors it was their subject-specific knowledge and professional experience that was the primary means by which they entered the policy process. In the primary health care case study (Chapter 4), when Dr. Maurice Byer came to Barbados in the early 1950s, it was his recognition throughout the region as a public health expert that gave him the platform from which he could usher in significant change. Similarly in the 1970s, Nurse brought expert knowledge to the newly created role of Health Planner in the Ministry of Health, which he gained through his postgraduate training in health policy and planning and his experience working on access to health care among immigrant communities in urban Toronto.

Again, we see that Arthur Archer's expertise as a public health engineer, which was recognized and respected by both national and regional actors, was an important source of his power to influence other actors (Chapter 5). In this case, experience was an especially powerful factor because he was the only person on the island with technical knowledge in the area of sewerage disposal, collection and treatment at the time. In all three cases experts also had some kind of positional authority (either in or outside of government). However, their expertise seemed to be the predominant basis on which they had "claim to a

hearing"[462], as their positions did not accord them direct authority over resource allocation or policy adoption. In one case, a politically appointed actor was able to wield influence based on positional authority alone. In Chapter 6, we see how a businessman and senator used his position as Minister of Health to mobilize unprecedented action around HIV/AIDS—an issue for which he had displayed deep concern before his appointment to the role.

My findings also illustrate how the absence of recognised authority can undermine efforts aimed at shaping the health agenda. For example, in Chapter 6, Schlosberg's attempts to call attention to HIV fall flat at least in part because he is deemed by powerful domestic actors to lack the expertise and/or experience. Furthermore, we are reminded several times that policy entrepreneurs depend on this recognition to influence the prioritisation process, and that they lose power when their credibility as experts is damaged or attacked or when they are no longer in authoritative positions. For example, in Chapter 5 Arthur Archer and his team of technocrats lose some of their power to influence priorities in, when their credibility as sanitation experts is challenged in the face of implementation issues with the Bridgetown Sewage Project.

Political connectedness

Each of the successful policy entrepreneurs possessed close professional and personal connections with (other) powerful political actors, which they were able to leverage to influence decisions about priorities. The degree of to which these actors were connected to relevant authoritative decision-makers, or 'political connectedness', proved to be an importance source of power. This seemed to be necessary for actors who were advocating on the outside of government and did not have decision-making power themselves. For example, in Chapter 6, the friendship between the leader of BAMP's AIDS Taskforce (Walrond) and the Minister of Health (Taitt) forms a pivotal part of the

explanation of why civil society actors were successful in generating priority for HIV beginning in 1987, and not before. It also helps to explain why NACA's influence declined after 1991, as Taitt's power over health policy decision-making and resource allocation comes to an end when he is moved from this authoritative position. Similarly, in Chapter 4, the absence of such connections between advocates and decision-makers helps to explain why domestic priority for PHC fails to emerge even in the face of pressure from the Colonial Office to invest in this area.

Indeed, because policy entrepreneurs usually do not have the power to single-handedly elevate an issue to national priority status (either by enacting policies or mobilizing the necessary financial resources), political connectedness appears to be important even when policy entrepreneurs hold decision-making power themselves. For example, in Chapter 6, personal connections to the Prime Minister features as an important explanatory variable, in accounting for how Senator Goddard is able to successfully generate priority for HIV/AIDS.

Among the various domestic actors who emerge to lead priority generation efforts across the case studies, senior technocrats from the Ministry of Health seem most likely to be able to foster more stable connections to authoritative power. Their positions as civil servants give them frequent, guaranteed access to the Minister of Health, through internal planning meetings, to the Minister of Finance via budgetary negotiations, and to the Prime Minister and members of the Cabinet through national-level 'Planning and Priorities' meetings. For example, in Chapter 5, from his position as Chief Environmental Engineer in the Ministry of Health, Archer is able to gain the confidence and respect of successive Ministers of Health and to wield influence over priority generation efforts for the entire duration of his service in the role (some 24 years).

Across all three case studies, an actor's level of political connectedness seems to be more decisive in determining the success of their advocacy efforts, than if they themselves held decision-making power. Regardless of whether the primary source of political

connectedness is professional or personal, the cases suggest that policy entrepreneurs have to allocate time and energy to build new connections and to nurture pre-existing ones. Most of all, they have to effectively leverage these relationships to advance their policy agenda.

Political savvy

While recognised authority and political connectedness play important roles in accounting for the power of policy entrepreneurs across the three cases, perhaps the most critical factor that distinguishes these actors is their ability to devise and execute effective strategies to generate support for increasing priority and to manage opposition. This political savvy is distinct from an actor's own power status, political connections or contextual circumstances. Their actions are not arbitrary and when they are successful it does not appear to be by accident. On the contrary, there is evidence in each case that policy entrepreneurs strategically plot and act to make change a reality.

For example, in Chapter 4 Nurse, a former public health inspector (a cadre of health workers not typically found in policy-making circles), did not come to the Ministry with personal connections to those in power and had little time to build his professional network before he began pushing for increasing investment in PHC. However, realizing that a controversial election was pending, he seized the opportunity to place the issue on the agendas of both major political parties. His efforts successfully politicized the issue of universal access to primary-level care and helped to mobilize political actors, who later helped to champion the cause. Similarly, in Chapter 5, understanding the growing importance of the tourism industry to national development, Archer jumped at the opportunity provided by scientific studies that linked improper sewage disposal to dying coral reefs and beach erosion by strategically linking investment in sewerage systems to preventing coastal degradation and protecting the country's main income source.

Like Nurse and Archer, other policy entrepreneurs who have led effective priority generation efforts were able to accurately identify their targets (i.e. the policy actors that had the power to give them what they want) and potential sources of opposition and had some understanding of the interests, concerns and preferences of key policy actors. They also understood the inner-workings of the health policy and budgetary processes and displayed an acute awareness of opportunities and constraints presented by the wider domestic and international contexts. Finally, they all seemed to have a deep-set knowledge of explicit and implicit power structures and social norms that define the Barbadian context, based partly on intuition and on previous experience (See Table 7.2).

In the case studies it appears that domestic actors are both more likely to develop effective political strategy. For example, two foreign actors—Dr. Humby (Chapter 4) and Dr. Schlosberg (Chapter 6)—fail in their efforts to influence the national health agenda. Not only were both these actors lacking in recognized authority and/or political connectedness, but their decisions to use the public shaming of decision-makers via the media as an agenda-setting tactic, identified the general public and not the political elite as the targets of their efforts, and in doing so revealed their ignorance of the dynamics of power in a small-island developing state. In both cases, these tactics stood in sharp contrast to those employed by politically savvy domestic advocates, suggesting that political savvy must be grounded in knowledge and perceptiveness where social relations in the national context are concerned.

Findings across the cases also suggest that political savvy may be more of an art than a science, and hence involves a process of trial and error on the part of policy entrepreneurs. Even when actors apply their context-specific knowledge and intuition in order to strategically manoeuvre their policy environments, they cannot always be certain that their assessments of the likelihood of success are accurate or that their efforts will work. For example, in Chapter 5, Archer fails to adequately consider the social and political ramifications of their policy solution. While this does not inhibit the emergence of priority

at the time, this has lasting ramifications for their future efforts to sustain priority for sanitation.

Passion and commitment

Lastly, all six of the policy entrepreneurs displayed genuine passion for addressing the problem and demonstrated enduring commitment to making their policy proposals a reality. In interviews, across the three cases, informants consistently described these actors as being visionary, tenacious, charismatic, passionate and committed in their calls for increased attention and resources to the issue that they were championing.

Describing Dr. Maurice Byer, a key policy entrepreneur in the establishment of Barbados' primary health care system (Chapter 4), one informant said:

> "Maurice Byer was able to achieve what he achieved because he was a man of great vision; he was a highly ethical, dedicated, and committed man who worked for the people; he had oodles of old world charm and persuasive power… to get people to do what they should do; and he just never gave up. He just kept on."[211]

Similarly, referring to Arthur Archer (Chapter 5), the sanitary engineer who was at the forefront of efforts to increase priority for sewage disposal, another informant said:

> "I think he should have been knighted posthumously…. He did a tremendous job. Even as he got older, because he stayed on and on and on way past retirement age."[273]

And in the HIV case, informants attributed the success of policy entrepreneurs in part to their passion and sense of conviction.[393, 426] Whatever their motivations in calling for change, according to several informants (and some of my own interviews with these actors) their passion and commitment was palpable and catching. This characteristic too is applied in the work of generating support and resources for their policy proposals.

7.2.3 Building an explanation that is grounded in, but goes beyond, powerful domestic actors

The case studies suggest that powerful individual advocates are necessary for priority to emerge. As discussed above, this small group of actors—referred to as policy entrepreneurs—are found to share a number of characteristics. However, these actors do not appear to be sufficient to generate priority on their own. For example, while domestic policy actors are an important part of the explanation for why sanitation stayed on the agenda, even in the aftermath of the Bridgetown Sewerage Project, they alone do not provide a convincing account for why resources for the South Coast Sewerage Project failed to materialize until more than ten years after plans had been announced. Similarly, although high-level political leadership is a central factor in the emergence of priority for universal access to ARV treatment in 2000, the story is less compelling without taking into account the role of emergent consensus around the idea of HIV as a threat to socioeconomic development, which proved pivotal in motivating the Prime Minister to act. Moreover, when even very powerful policy actors are unsuccessful in their efforts, for example in the case of the NHS proposal in Chapter 4 and in generating priority for sewering the West Coast in Chapter 5, we are reminded of the complexity of policy making and the fact that any explanation that attempts to capture the reality of how priority is generated, must go beyond the agency of these actors.

The cases explored indicate that a number of other factors—the domestic and international backdrop against which priority generation efforts are taking place, the existence of powerful framing ideas that have come to characterize the problem, and the availability of financial resources (in all three cases in the form of loans from international development banks)—help to provide much thicker accounts of priority across each of the cases and affect the likelihood of whether or not a policy entrepreneur's efforts will be successful. However, while policy entrepreneurs do not exercise ultimate control over these

factors, they do appear to act as decisive linchpins between them in providing convincing explanations of macro-level priority setting in Barbados.

7.3 The resonance of framing ideas

The findings presented in the preceding three chapters suggest that certain understandings about the nature and cause of problems and the potential consequences of inaction have the power to motivate authoritative decision-makers to act. As Shiffman asserts in his explanation of the rise and fall of issues on the global health agenda, my findings also challenge materialist ideals that the world (and by extension health policy) is made up of discernable objective facts, and following this that "a condition or risk is a problem when it becomes serious; a problem becomes a priority if it grows in scope and gravity; [and] a solution to a problem is shown to be correct because it alleviates the problem".[73]

In Chapter 6, during the 1990s, although there was reliable epidemiological evidence to show that HIV incidence was climbing and that (by 1995) HIV was the leading cause of death for men and women between the 25-44 years, resources for addressing the epidemic were not substantially increased during this period. Similarly in Chapter 5, despite more than 20,000 deaths during the cholera epidemic of the late 19th century, and evidence of disease due to poor sanitation throughout the first half of the 20th century, policy makers refused to invest in sewerage systems—a policy intervention recommended by experts and shown to be effective elsewhere. Perhaps ironically, when priority for improving sewage disposal emerged, the burden of disease due to typhoid, gastroenteritis and other diseases associated with poor sanitation was at a historic low. My findings instead resonate with social constructivist views, which purport that things derive meaning through interactive and interpretative social processes. While for materialists the main currency in demand is 'facts', for social constructivists it is 'ideas'. Moreover, although they are not always the

originator of these ideas, in all three cases I find that policy entrepreneurs play pivotal roles in developing/selecting politically salient framing ideas and/or in communicating these to authoritative decision-makers.

7.3.1 Social construction, ideas and framing in the policy process

Drawing on these concepts from social constructivists, collective action scholars have suggested that how an issue is 'framed' is a fundamental determinant to whether or not it will be recognized as a problem requiring government action. [465-467] According to Benford and Snow (2000), "by rendering events or occurrences meaningful, frames function to organize experience and guide action, whether individual or collective."[465] Central to this view is that there are multiple ways of understanding or portraying a problem or policy solution. According to Mintrom, knowing this, policy entrepreneurs (and other advocates) make a "deliberate effort to bring others to see problems in ways that are consistent with [their] own positions and policy goals".[463] Advocates therefore embark on an ideational and interpretive activity that collective action scholars refer to as "strategic social construction" or 'framing'—a quest to find, alter, revitalize, create and/or propagate the ideas that they feel have the best chances of mobilizing support and action[460, 462, 468].

Similarly, my research showed that problems could be framed in multiple ways. For example, throughout the course of the epidemic, policy advocates understood HIV/AIDS primarily as a highly infectious sexually transmitted disease associated with high morbidity and mortality. This primarily biomedical frame drove the country's early response to the epidemic, which was spearheaded predominantly by actors with medical backgrounds through BAMP and NACA. Other competing ideas about HIV, for example AIDS as a gay disease or a punishment from God, were dominant (and perhaps competing) frames outside of this circle of HIV advocates during the 1980s and 1990s. In 2000, a new way of

understanding the epidemic—the idea of HIV as a threat to economic development—motivated unprecedented action by the Prime Minister.

Table 7.3: Characteristics of successful framing ideas across the cases

	Powerful framing idea(s) that motivated decision-makers	Reason(s) for salience	Source(s) of credibility	Role of policy entrepreneurs
Primary Health Care	"It was the duty of every community which had the welfare of its people at heart to provide preventive health care in unison with those other well established medical services for the sick."[210] The persistence of means-testing at the primary care level was not only a source of inefficiency in the health care system but perpetuated social inequity and harkened back to the days of injustice under the Vestry system.	Propagated during the transition to independence as a new social contract with early-black governments. This frame appealed to the new sense of public responsibility for social welfare that was dominant. A general political commitment across party divides to addressing inequity and investing in social welfare (in the post-independence era). Contentious general election on the back of an economic hardship and public dissatisfaction with the government in power added to this frame's salience.	High infant mortality rates and sizeable burden of preventable disease. Public health experts. A study revealing gaps in the health care system – in particular showing that a lack in access to primary care was resulting in an overburdened A&E department.	Articulated a connection between PHC and good governance. Connected means-testing for access to PHC with memories of the injustice of the vestry system. Used the opportunity of a general election to propagate the idea among political leaders.
Sanitation	Improper disposal of sewage was killing coral reefs and resulting in coastal degradation. Left unchecked this would have a negative effect on the tourism industry and on economic growth. Investment in municipal sewerage systems was essential to combat this problem.	Economic growth and investment in growing the tourism sector was a priority of government. Tourism was accounting for an increasing share of national income	Scientist and anecdotal reports of dead/dying coral reefs, visible beach erosion. Evidence of high bacteriological pollution levels at beaches. Fetid conditions due to problems with overflowing septic tanks, in coastal areas. Marine Biologists, bacteriological studies/event that could threaten beach closures.	Collected key evidence of effect of sewage in coastal areas. First to explicitly articulate this connection between sewage disposal, tourism and economic growth.
HIV/AIDS	HIV was "not just a health issue". It posed an unprecedented threat to the workforce and to the country's economic growth and development. Substantial public investment in treatment and prevention was needed to stem the tide.	Government was particularly concerned with economic growth and Barbados' international image. The prime minister at the time was an economist.	Higher rates among young people, anecdotal evidence from Sub-Saharan Africa of impact, some Caribbean specific evidence from the HEU at UWI. The World Bank and powerful domestic actors, outside of the health sector (like Phillip Goddard), were articulating this connection.	Identified this frame as particularly salient, given the policy context. Played critical roles in propagating this idea in decision-making circles.

My findings also illustrate the power of new or revived framing ideas in improving the chances that priority will emerge. For example in Chapter 4 the idea that means-testing to determine access to primary-level services was a remnant of colonial injustice, revived an old but powerful idea that motivated renewed investment in primary health care beginning in the late 1970s. Also, in Chapter 5, a new frame that linked public investment in sewage disposal to the sustainability of the island's tourism industry and ultimately to economic growth formed an important part of the explanation of why priority for sanitation emerged. Across all three cases, the degree to which priority generation efforts were successful was not just a function of the power of policy entrepreneurs but also of the extent to which framing ideas used to portray an issue resonated with authoritative decision-makers (See Table 7.3).

7.3.2 Factors affecting the power of a framing idea in generating political support and action

Some framing ideas were more successful in motivating those with authoritative power to prioritize an issue, and to sustain this priority over time. For example, sanitation and public health experts saw sewage disposal as a problem requiring attention for almost a century, their concern was based on the idea that the proper disposal of sewage was essential for preventing disease. However, while the concept of taking pre-emptive action to prevent illness or maintain health was one that resonated among actors with public health training, this frame was not successful in motivating action on the part of the political directorate. This was so because framing ideas that held sway must resonate with the interests, preferences, or ideologies of powerful decision-makers. Benford and Snow (2000)[465] suggest that frame resonance is a function of two core factors—the degree of importance of the underpinning ideas to policy decision-makers (salience), and the extent to which the frame is believed to be true (credibility). I find these concepts useful in

accounting for the power of ideas in influencing priorities across the case studies explored here.

Salience

Across each of the cases, the transformative effect of framing ideas, which struck a chord with decision-makers, was repeatedly seen. For example, in Chapter 4, in the aftermath of the 1937 riots, a group of local doctors argued that the state's lack of investment in primary health care, a status quo perpetuated by the Vestry system, was a major source of public dissatisfaction and an on-going threat to socio-political stability. Policy actors built on this frame during the 1950s, successfully linking primary health care and the prevention of illness to the broader idea of social justice and equity and to the political ideal of the welfare state. In the transition to independence, as early black self-government sought to establish Barbados as a social democracy, this frame resonated with powerful decision-makers and cohered with their broader political priorities, among which welfare (namely health, education and housing) ranked at the top of the agenda. Two decades later, policy advocates amplified these old ideas to generate renewed priority for primary health care. Within the context of a highly contested election, coming out of a global recession, the idea that the persistence of means testing at the primary care level was a remnant of the social injustice that existed under Colonial rule, was of great significant and fit into a broader set of accusations by the opposition party that the government in power had been shirking its welfare role.

Similarly, in Chapter 5, with sugar rapidly declining as a source of national income, by the early 1970 tourism was of mounting importance to Barbados' economic growth and strategic investment in encouraging its sustainability and growth had been identified as a top priority of the government. Consequently, a frame that linked sewage to the island's beaches and marine life—primary inputs for the tourist industry—rendered it highly salient

among decision-makers, across both sides of the political divide. This stood in stark contrast to the results of a failed attempt to place sewage on the agenda by linking it to tourism some five decades prior—at that time the frame was of little salience as sugar was still the mainstay of the economy and very few white people contracted waterborne diseases.

In Chapter 6, the portrayal of HIV as an economic threat derived its salience from the fact that this frame appealed to the background and training of the Prime Minister at the time, who was an economist. The economic argument for government investment in combatting HIV/AIDS conveyed a sense of severity to the Prime Minister, perhaps much like high incidence and prevalence rates might do for an epidemiologist, shifting his own cost-benefit analysis with regards to the public financing of antiretroviral treatment.

Notably, in two of the cases, linking problems to future economic growth and development gave a high degree of salience to previously neglected problems. These findings emphasized the importance of the wider policy context, as well as the backgrounds, interests and ideologies of authoritative decision-makers, in determining the salience of a particular framing idea.

Credibility

The extent to which a frame was 'believable' was also an important factor affecting the power of ideas, and their ability to help sustain political support into the future. In this regard, the existence of evidence to support the core claims of the frame was of great importance. However, the nature of 'evidence' used to successfully establish credibility went beyond the narrow consideration of evidence in the health policy literature, as burden of disease or cost-effectiveness data. For example, in the case study on sanitation (Chapter 5), research conducted by marine biologists and anecdotal accounts from fishermen and other laypersons of dead or dying coral reefs and widely observed beach erosion, were

accepted as evidence of the impending disaster caused by marine pollution due to improper sewage disposal. Moreover, although much of this empirical evidence of coastal degradation that was attributed to sewage disposal was based on observations on the island's west coast, by presenting data showing elevated bacteriological levels in the marine environment around Bridgetown and linking this to what was being observed elsewhere, public health advocates were able to amass support for sewering the island's capital city (which for them had been a long-standing priority). In these cases where the frame purported a link between two phenomenon—the disposal of sewage and coastal degradation—the evidence only needed to infer causality (not prove it).

Another aspect of establishing credibility is the degree of coherence between the frame's core claims. Over time, incoherence or inconsistencies between the empirical reality and central ideas can be exposed, weakening the power of the frame. For example, in generating priority for primary health care, policy opponents pointed out an inconsistency between advocates' claims that there would be "no more pauper medicine" and the idea that primary health care would result in lower costs and a more efficient use of government resources, suggesting that the quality of care would be compromised. Similarly, more than four decades later, despite the fact that the island's West Coast remains unsewered, the disastrous effects to the tourism product that policy advocates had predicted have not materialized.

Indeed, the absence of evidence altogether presented a significant obstacle for frame propagation. For example, while advocates claimed that the National Health Service would improve access to services and efficiency, they could not substantiate these claims, leaving them vulnerable to the counter claims of the opposition (Chapter 4). Also, several informants suggested that the fact that government has prohibited the release of marine water quality data since the early 1990s, has undermined the powerful framing idea that drove priority for improving sewage disposal for more than two decades. Even so, despite the importance of evidence, it was but one ingredient in establishing credibility.

My findings suggest that the credibility of an idea's messenger(s) was also key to establishing the credibility of the frame itself. In Chapter 6, we saw that the idea of HIV as a threat to economic development proved powerful in motivating high-level priority for HIV at the turn of the 21st century. However, that previous attempts to frame HIV as a developmental threat (by Schlosberg as well as by health economists from the University of the West Indies) were unsuccessful during the 1990s emphasizes the fact that it matters who the messenger is. The fact that Goddard (who had a close relationship with the Prime Minister and was a respected businessman) was the one articulating this claim and that the World Bank corroborated it, infused this idea with power. In this case, the existence of sound, context-specific evidence corroborating the claim that a failure to invest in HIV would result in the demise of the country in terms of economic development, seemed almost irrelevant. Similarly, in the sanitation case (Chapter 5) the opinion of Archer (a local expert whose expertise was trusted by decision-makers) about the nature of the policy solution that should be pursued went unchallenged during the Bridgetown Sewage Project.

7.3.3 Framing – A deliberative process

Across all three case studies, framing was a deliberative process in which policy entrepreneurs played leading roles. It was deliberative to the extent that these policy actors intentionally sought to frame issues in politically salient ways (See Table 7.3). Also, it was a process because in their effort to find frames that motivated authoritative decision-makers, they had to take into account changes in their policy environment. Policy entrepreneurs considered the interests and backgrounds of the actors they were targeting, the domestic and international contexts, and the available evidence, when strategically choosing ways of framing an issue that would motivate decision-makers to act. For example, in an interview, Goddard revealed that he pushed the idea of HIV as a threat to economic development because he saw the opportunity to capitalize on new energy around HIV from the World

Bank and felt that this frame would resonate with the Prime Minister who was an economist by training, and who he believed had the power to usher in change.

It is important to note that these policy actors were not always the original source of framing ideas. Still, they capitalized on frames that they felt would be politically salient when they emerged and often played critical roles in propagating and articulating core claims. For example in Chapter 5, although the connection between sewage disposal and coastal degradation was first articulated by marine biologists, Arthur Archer saw this frame as a potentially powerful vehicle to advance his health policy goals. He played an active role in establishing credibility and became the primary messenger of this framing idea in policy circles.

Chapter 4 also demonstrates that ideas can be unwieldy and that frames can change in unanticipated ways once launched into the public arena. For example, Nurse (a health planner in the MoH) framed means-testing as a remnant of the social injustices that had been perpetuated under the Vestry system and linked this to his proposal to further expand the island's network of primary health care centres. However, once this idea was in the public sphere other actors could participate in the interpretive process. The problem was soon transformed into a more complex amalgamation of ideas—that means-testing with both historically unjust and that it was the reasons for long wait times and overcrowding at the hospital's emergency department (the only alternative for outpatient care that was free of cost and stigma). Similarly the solution transformed from an expanded network of primary health care centres to a proposal to establish a National Health Service.

While framing was often a conscious and deliberate process, policy entrepreneurs could not always anticipate the breadth or nature of the impact that these ideas would have, including their potential impact on future priority generation efforts or public policy decisions. For example, in Chapter 5, even though linking sanitation to environmental degradation and the health of the tourism industry was successfully in generating resources for this issue, it has also contributed to a general perception that sewage disposal is

primarily an environmental and not a health issue. The fact that much of the responsibility for sanitation has now been delegated to agencies outside of the public health sector might be in part a consequence of this.

7.4 The existence of policy windows

My findings suggest that contextual factors also play an important role in accounting for priority status. We are reminded that policy actors are not free agents, but that they are both constrained and enabled by the social, political, economic, institutional and historical contexts in which they operate. The role of contextual factors in influencing whether or not an issue will make it on to the public agenda has received attention from several public policy scholars.[56, 462, 463, 469] Kingdon has suggested that an important contextual feature are policy windows—transitory periods of time during which efforts aimed at generating support for particular initiatives are more likely to be successful.[462] These opportunities are thought to arise because of political events or occurrences (e.g. "a change in administration, a shift in the partisan or ideological distribution of seats…or a shift in national mood". Policy windows only open infrequently and can sometimes close quite quickly and "once the window opens, it does not stay open long. An idea's time comes, but it also passes…".[462]

Kingdon suggests that windows close because actors may feel that the problem has been addressed through some policy decision (even if it has not), failed attempts at priority generation discourage advocates from investing further resources in the effort, the crisis or 'focusing event' that sparked action ends, the change in administration or personnel that opened the policy window change once again or because policy advocates do not have a policy solution detailed and ready to go. Policy entrepreneurs play critical roles in determining the utility of policy windows to their policy initiatives. As Mintrom suggests, an open window may be inconsequential unless policy advocates detect it and use their

resources to take advantage of the opportunity.[463] Similarly, according to Kingdon, the most effective policy entrepreneurs "do more than push, push, and push their proposals or their conceptions of problems. They also lie in wait—for a window to open."[462] Much of this was in accordance with my findings. However I find that policy windows were unlatched by occurrences in the global policy context as well the domestic.

Just as the context presented opportunities for advancing priority generation efforts, it also presented constraints. Across the cases, policy entrepreneurs seemed to do more than just "lie in wait" for open windows—they also played critical roles in actively navigating constraints. These contextual elements had the power to stall priority generation efforts, yet (like the presence of policy windows) they did not necessary determine the outcome. Describing the potential of the context to impose limits on the influence of policy entrepreneurs Mintrom (2000) states:

> "Like other actors in society, policy entrepreneurs are not completely free agents. There are limits to what they are able to do, and these limits emerge from the combined effects of, among other things, the institutional structures governing policymaking, current policy settings, and the behaviors and expectations of other groups and individuals around them. This milieu shapes the opportunities and the actions open to policy entrepreneurs, but not in a deterministic fashion. A given milieu will not necessarily support or inhibit a given set of actions on the part of policy entrepreneurs".[463]

7.4.1 Policy windows in the Barbadian context

Changes in the domestic policy context caused policy windows to open—sometimes even in predictable ways. In Chapter 4, Nurse saw a general election as a window of opportunity to advance his proposal to expand primary health care, recognising the historical trend of pre-election spending increases in Barbados and the vulnerability of political actors on both sides of the party divide during this period. Nurse was able to use this fact, to obtain funding for the first "multipurpose health centre" (which served as a pilot

of his proposal and increased public expectation in the area of primary care) and to spark a public debate around improving PHC services.

However, policy windows were more likely to be unpredictable in nature. For example, in 1937, widespread riots in Barbados and elsewhere, led the colonial authorities to believe that they were under threat and resulted in an important opening between 1938 and 1939—the West India Royal Commission of inquiry into the underlying causes of the social unrest. The riots presented a golden but short-lived opportunity for political advocates (with a range of interests) to bring key policy issues to the attention of the previously inattentive Colonial authorities. Also, in Chapter 4, we were reminded that just as policy windows open, they also close. In this case, the period of transition from colonial rule to independence presented and widened opportunities for political participation that accompanied this, along with the rise of socialist ideals, presented novel opportunities for advocates to generate priority for the social sectors. Primary health care advocates used this period to drum up resources for the establishment of health centres. However, this window came to a close after three primary-care centres had been established and decision-makers felt that the problem had been adequately dealt with.

In all three cases, the international context also presented policy windows that provided opportunities for particular initiatives to be advanced at the country-level. For example, in Chapter 5, the fact that sanitation had been identified as a priority by both PAHO and the OAS and that countries had committed to improving access to water and sanitation in the Charter of Punta del Este, forms an important part of the explanation of its emergence on the domestic health agenda during the late 1960s. In Chapter 6, the establishment of the Global Program on AIDS by the WHO in 1986 and the program's rise to international prominence by 1989, and signs of increasing interest by the World Bank, the UN and other influential international actors at the beginning of 2000, provided similar opportunities for domestic efforts to increase priority for HIV.

International actors, institutions and events played critical roles in exposing policy decision-makers to problems and "softening them up" to specific policy ideas through political declarations, multinational conferences, and issue-specific campaigns. The presence of global priority could also open windows by shifting calculus of risk versus incentives in the eyes of domestic actors, for example through the promise of aid or opportunities to improve the country's visibility or global image. However, like other policy windows, these do not affect the emergence of priority in a deterministic way. In order for them to improve the likelihood of success, policy entrepreneurs had to seize the opportunity before the window closed.

7.4.2 The role of policy entrepreneurs in seizing opportunities and navigating constraints

In all three cases, open policy windows do not always necessarily lead to the emergence of priority. In order for these to have effect, policy entrepreneurs have to be present, they have to recognize that a window has opened, and they need to apply their political savvy to strategically seize these time-sensitive opportunities. Moreover, across the three cases, the policy context not only presented windows of opportunity, but also constraints. Even though policy entrepreneurs generally had little control over these contextual factors, the degree to which both opportunities and constraints affected priority in each case, was mediated to a large extent by these actors' abilities to decipher and navigate their policy environments.

Seizing opportunities

Policy windows only served to advance advocacy efforts when domestic advocates were present and able to perceive them in time to seize the opportunities they offered. For example, the presence of concerned domestic advocates to seize the window of opportunity

presented by the transition to black self-government in the early 1950s to influence the government's early welfare agenda, explains why priority for primary health care, and not for sanitation, emerged at this time. Similarly, though elections present predictable windows of opportunity to advance certain policy priorities, the only example of the strategic use of a general election in this way was in the primary health care case study.

The HIV case also illustrated that policy actors can sometimes create windows of opportunity to advance their cause. Working with the World Bank officials, Goddard helped to organize a donor's conference on HIV in Barbados. He hoped, specifically, that the conference would act as a policy window and that it would catalyse high-level action that would not have materialized otherwise. It was at this conference, in the presence of donors that the Prime Minister announced his commitment to providing HIV treatments for all those who needed it. This event positioned Barbados as a regional leader, and helped to mobilize financial resources from the World Bank.

Navigating constraints

The case studies also highlight the fact that contextual factors can also impose constraints on priority generation efforts, narrowing the possibility that priority for an initiative would emerge at a given time or restricting the policy solutions considered. Here too, the presence and skill of policy entrepreneurs was important. The presence of powerful opposition in both the primary health care and sanitation case studies posed a challenge to priority generation efforts and prolonged the time horizon between the emergence of support among authoritative decision-makers and the actual realization of financial resources to address the problems.

The degree to which the presence of opposition impacted the outcome of priority generation efforts depended on the relative power of the opposition, and the ability of policy advocates to assess the possible sources of opposition and to develop strategies to

manage them. For example, in Chapter 5 the impact of opposition by a poor slum community on one hand and South Coast hoteliers on the other revealed the vast differences in the relative power of these actors, with the latter affecting the technical solutions pursued and causing delays to decision with regards to the location of the plant. Also, the absence of robust strategies to contend with opposition, in addition to the loss of powerful leaders of priority generation effort, resulted in the removal of plans to establish a General Practice Service (a core element of the NHS) from the policy proposal.

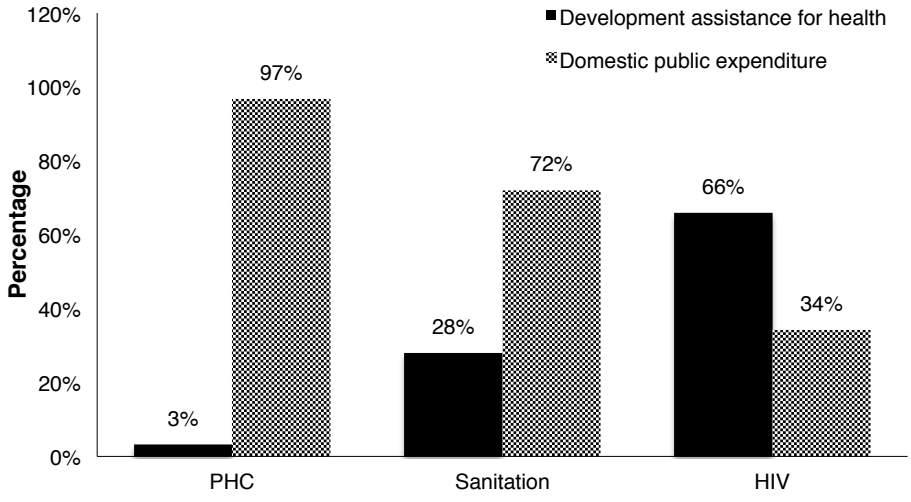
Another aspect of the policy environment that can inhibit the emergence of priority is the policy legacy. In the sanitation case, policy advocates face an increasingly uphill battle as the story progresses, and we see that past policy experiences can have a significant effect on the context in which subsequent priority generation efforts take place. However, we also see that policy entrepreneurs can learn from their past experiences and become better at dealing with contextual constraints. Under the leadership of a savvy policy entrepreneur, advocates were able to successfully navigate the negative effects of bad experiences with the Bridgetown Sewage Project, in generating priority for sewering the South Coast. Based on his prior experience with Bridgetown, Archer foresaw that the proposal would generate opposition from homeowners, hoteliers and business owners in the area affected. He spearheaded efforts to hold consultations with these stakeholders in order to hear their concerns and developed measures to mitigate the negative impact of the project on these actors, in an effort to minimize potential opposition. This was instrumental in the eventual emergence of priority for sewering the South Coast

Unfortunately, despite efforts aimed at managing the predicted negative outcomes of the South Coast sewerage project, this too was plagued by a plethora of problems. Recent difficulty in generating priority for continued investment in sewage disposal points to the importance of policy legacy and to the fact that even the most savvy policy actors are limited by their context.

7.5 The availability of development assistance for health

In all three cases, priority (in the form of a significant increase in budgetary allocations) did not become a reality until development assistance in the form of concessional loans from the Inter-American Development Bank (Chapter 4 and 5) and the World Bank (Chapter 6) had been secured. For example, in the sanitation case, the absence of development assistance seemed to stall the emergence of priority. Despite the presence of high-level political support for sewering the South Coast in the early 1980s, the necessary budgetary resources were not unleashed until almost a decade later when the IDB finally approved financing for the project. The importance of development assistance for health (DAH) in accounting for priority in the sanitation case could be rationalized on the basis that constructing sewerage systems requires sizeable capital outlays. However, this explanation does not hold in the HIV case where a World Bank loan was used predominantly to finance access to HIV drugs—a recurrent cost. Moreover, DAH also seemed to influence the timing of the emergence of priority for the expanding access to primary health care, even though IDB funds only accounted for 3% of public investment in primary care between 1975 and 1993 (See Figure 7.1).

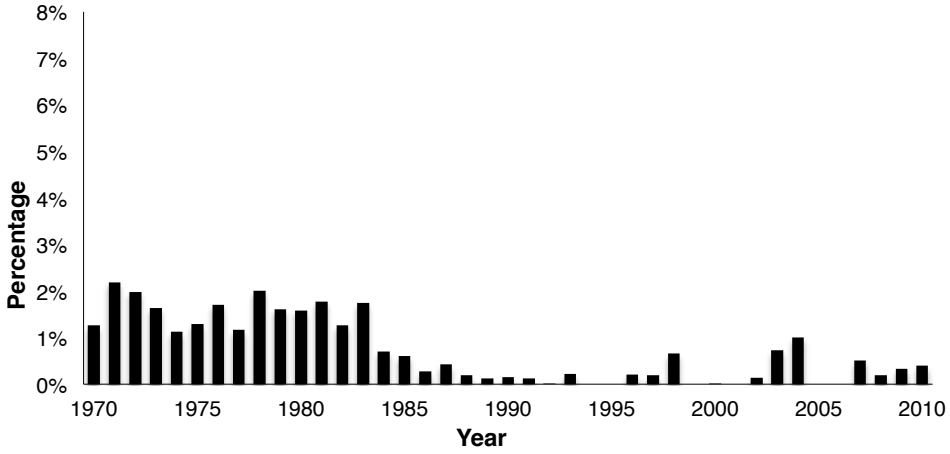
Figure 7.1: Funding for health initiatives in case studies, by source



Data sources: Barbados Estimates[1],1960-2010; AidData.org[259, 300, 470-475]

These findings were somewhat surprising, given the fact that external resources for health (and official development assistance more generally) account for a relatively small percentage of Barbados' GDP (See Figure 7.2, below). They suggest that the relationship between the emergence of priority and the availability of DAH in the case of Barbados is not straightforward.

Figure 7.2: Official Development Assistance as share of GDP, 1970-2010



Source: World Bank (2012)[154]

7.5.1 Explaining the importance of DAH in the Barbados case

Although it seems clear that DAH alone could not drive priority, its role in all three case studies warrants explanation. Key informants suggested that several factors, including a strong culture of incremental budgeting in the public sector, the contribution of external financing to foreign exchange, or the political and bureaucratic costs of reallocating financing resources within the health sector and between different sectors, could account for the fact that external financing seems to be necessary for the emergence of priority. In the HIV case, one powerful policy actor also expressed a belief that financing the program using a World Bank loan would make the program subject to strict monitoring and evaluation requirements, and increase the level of accountability of the program in terms of achieving its stated goals.

In particular, two of these hypothesis, are reflected in the body of scholarly work that has explored the impact of foreign aid on economic growth and the fiscal behaviour of governments in low and middle-income countries[476-479]. These scholars have suggested that, because aid is mostly fungible and usually comes in the form of foreign exchange, the availability of development assistance may provide fiscal and political incentives for decision-makers in recipient countries that go beyond the scope of the policy initiative itself. .[113, 476, 479-482]

Fungibility and foreign exchange?

Devarajan and Swaroop vividly illustrate the essence of aid fungibility as follows:

> "Suppose an aid donor gives money to build a primary school in a poor country. If the recipient government would have built the school anyway, then the consequence of the aid is to release resources for the government to spend on other items. Thus, while the primary school may still get built, the aid is financing some other expenditure (or tax reduction) by the government. In such a case, donor assistance is said to be fungible."[480]

The idea that DAH, as opposed to adding to public expenditure on health, might be having a "substitution effect" by crowding-out government health expenditure that would otherwise be there, has received increasing attention among public health scholars.[113, 483, 484] Despite a lack of agreement regarding the existence of empirical evidence of aid fungibility, it seems plausible that DAH might be particularly attractive to policy makers because it can free up resources (that would have been spent on the initiative) to fund some other expenditure or tax reductions. Moreover, external funding for a health initiative can allow the government to pursue new policy goals without having to explicitly set priorities. Decision-makers may have been hesitant to adopt policy proposals without the assurance that DAH could be used to avoid the political costs of shifting the distribution of resources within the health sector or between different sectors.

Though one cannot prove the counterfactual—that government would have invested in HIV in the absence of the World Bank loan—the HIV case seems to lend some support to this hypothesis. Even though decision-makers threatened to walk away from loan negotiations and to finance the program using domestic resources (if the loan could not be used to finance ARV treatment) and although most informants felt that the program could indeed have been financed using government revenue, only one-third of all program costs have been financed using domestic funds over the past decade. Furthermore, the fact that these loans are a source of foreign exchange, only added to the power of DAH to incentivize domestic resource allocation. This was especially pertinent consideration for the Prime Ministers Adams and Arthur, who also served as the Minister of Finance, in both the sanitation and HIV case studies (Chapters 5 and 6).

7.5.2 The role of policy entrepreneurs vis-à-vis DAH in generating priority

Despite what appears to be the prominent role of MDBs in financing shifts in domestic health priorities, in all three cases there is convincing evidence that policy entrepreneurs had amassed the support of authoritative decision-makers before it was known whether external financing would be available. Most importantly, in Chapter 5, we saw that even though there now seems to be external funding available for further investment in sanitation, the government has been reluctant to pursue this opportunity to mobilize the necessary funds to sewer the island's West Coast in the light of negative experiences with such projects in the past.

Moreover, even though domestic actors did not have ultimate control over whether or not external resources were made available, in two out of the three cases policy entrepreneurs appeared to play key roles in mobilizing external resources for their policy initiatives. For example, in the sanitation case (Chapter 5), in the early 1970s it was the Government of Barbados pushing the IDB and not the other way. Making the connection

between the country's economic development and growing tourism industry and sanitation, Archer and his team succeeded in winning over IDB support for improving sewerage disposal at a time when sanitation (and investment in the social sectors more generally) was no longer among the Bank's priorities. Similarly, in Chapter 6, by strategically positioning Barbados as a pivotal actor in the regional fight against HIV/AIDS and by organizing a high-profile meeting of donors, Goddard proved successful in mobilizing a reticent World Bank to provide a concessionary loan to finance the provision of universal access to ARV treatment.

7.5.3 The impact of MDBs on policy content and sustainability

It is important to note that, while multilateral development banks were not the principal drivers of the emergence of attention or political support in any of the cases, once priority had emerged they did sometimes wield influence over the content of adopted policies. The extent of influence seemed to be correlated to the percentage share of the total government expenditure over the period of increasing priority (See Figure 7.1). The IDB and the World Bank ensured that policy solutions generally fell in line with their prevailing institutional ideologies, both indirectly, through the process of loan negotiations, the provision of technical assistance, and the financing of feasibility studies, and directly, through loan conditions and requirements. For example, in the case of HIV, in which a World Bank loan has financed 66% of the public response over the past 10 years, among its criteria for country involvement in the loan program for the Caribbean, the World Bank stipulated that countries should be able to demonstrate the presence of political commitment to addressing HIV at the highest level of government, and that the program should take a multi-sectoral approach. These became central features of the Barbadian program.[447] Similarly in the case of sewage disposal, loan conditions stipulated the establishment of a new semi-autonomous authority for water and sewage and an increase in water tariffs in

order to finance the repayment of the loan. In both cases these conditions were followed irrespective of their appropriateness and potential effectiveness in addressing the problem at hand within that specific domestic context.

In the sanitation case, the role of external financing in sustaining priority across changes in political leadership and in the presence of strong opposition, was demonstrated. Once the loan agreement had been signed, the importance of maintaining good relationships with loaning agencies helped priority to be sustained even when policy proposals went against the interests of powerful authoritative decision-makers.

7.6 Concluding thoughts

The previous sections, in which I have separately explored the role of policy entrepreneurs, framing ideas about the problem and proposed solution, policy windows, and the presence of external financial assistance in increasing the likelihood of the emergence of priority in each of the case studies explored, serve to identify key drivers of priority, to bring definitional clarity to key features of each of the four categories, and to identify some of the mechanisms through which these factors exert influence over the policy process. I have found that powerful framing ideas, key features of the policy context, and external financing for health, interact through the agency of policy entrepreneurs to generate priority for health initiatives in Barbados.

Findings across the case studies and episodes indicate that even though policy entrepreneurs were not always the central source of powerful framing ideas, they played crucial roles in developing politically salient frames that they felt would resonate with powerful decision-makers, and in marshalling evidence to support their core claims. Similarly, though the case studies illustrated that most contextual features were outside of the control of these central agents, their ability to recognize and seize opportunities and to minimize and manage the effects of negative contextual pressures on priority generation

efforts was of primary importance. Also, policy entrepreneurs sometimes played crucial roles in mobilizing loan support from development agencies. For example, in the case of the emergence of priority for HIV at the turn of the 21st century, a policy entrepreneur played central roles in propagating the idea of HIV as a development issue and targeted key decision-makers for whom he felt this frame would resonate. He also seized an opportunity, which emerged due to the World Bank's increasing interest in HIV/AIDS, and successfully positioned Barbados as a regional leader on the issue in order to influence the Bank to finance HIV treatment in Barbados, something it had previously refused to do. Other policy entrepreneurs play similar roles in the emergence of priority for sewering the city of Bridgetown in the early 1970s and in the renewed commitment to expand primary health care during the late 1970s and throughout the 1980s.

The findings suggest that these principal agents of priority generation are more likely to be successful if they are recognised as authorities, they are closely connected to other powerful actors or decision-makers, they are politically savvy, and if they exude a genuine sense of passion and commitment in their efforts to make their policy initiative a reality. However, since their authority can be called into question, their degree of political connectedness can decrease with changes in administration or when actors leave appointed positions, and exercising political savvy often calls for trial and error, domestic policy actors are also at the crux of convincing accounts of why priority is not sustained or why it fails to emerge altogether.

Chapter 8
Contributions, implications, and conclusions

8.1 Introduction

Through case study research on Barbados, this thesis has highlighted the need for more empirical research that considers macro-level priority setting in LMICs as a political process, which is informed by a combination of factors. In the first chapter, I describe the drivers behind growing interest in understanding national-level priority setting in LMICs and suggest that current knowledge on the subject is limited. Then in Chapter 2, I survey the small body of existing empirical literature. I suggest that, with a few exceptions, much of this has emphasized a number of unidimensional hypotheses, and I identify a number of gaps that persist. Drawing on methodological insights gained from this review, I go on to detail the methods used in my own multiple-case study of macro-level priority setting in Barbados and provide a brief overview of the broader health policy context in which the cases are set. In Chapters 4 to 6, I then present my findings regarding the factors influencing the evolution of priority for primary health care, sanitation and HIV. Finally, in Chapter 7, I synthesize these findings highlighting common insights from across these three cases of macro-level priority setting in Barbados.

Six important tasks remain in this final chapter. First, I reflect briefly on my methodological approach, highlighting the strengths of my study. Secondly, I discuss several limitations and possible sources of bias. Thirdly, I consider what scope there is for generalizability beyond Barbados. Fourthly, recalling the gaps I identify in the literature, I detail what I believe are this study's main contributions to 'opening the black box' of macro-level priority setting. Fifthly, I consider the implications of my findings for efforts to influence and improve priority setting in Barbados and further afield. And finally, I end the thesis by reflecting on the prospects for future research.

8.2 A critical review of the methodological approach

This thesis applied a case study approach to investigate macro-level priority setting in Barbados. This approach facilitates in-depth investigation of a complex process in its real-world context, and this thesis demonstrates its suitability to the task of understanding how priorities in LMICs are set in practice. In particular, my reliance on process tracing and incredible access to policy actors are notable strengths of the study. However, as with all research projects, there are limitations to the methods used. Moreover, the findings presented in Chapters 4 to 7, are subject to a number of potential sources of bias. Considering these strengths and limitations, in addition to the fact that the study is set in a single country, I admit that there may be limited scope for generalizing the particulars of my findings beyond Barbados. However, I suggest that it does hold some overarching insights that may be of value to the wider literature of macro-level priority setting in health.

8.2.1 Strengths of the study

While this thesis generally demonstrates the applicability of case study research methods to the task of better understanding how priorities in health are set at the national-level in LMICs, two strengths are of particular note. First, the study affirms the strengths of the process tracing approach in elucidating mechanisms and processes. Within-case analysis techniques, that weigh up alternative hypotheses—eliminating some, and providing reasonable support for others—help to strengthen the reliability of the case studies presented. Complementing this rigorous within-case analysis with comparison across three cases, proves extremely useful in identifying crosscutting factors and mechanisms and enables strong assertions to be established regarding their relative salience.

Secondly, the small size of the country also proved to be a notable strength, allowing me to obtain a high degree of detail across the three cases that might have been

possible if this study had been conducted in a larger more complex context, characterized by a much larger array of policy actors and arenas. Barbados therefore served as a microcosm in which new hypotheses could be developed about the mechanisms at work in priority setting in LMICs. These can now be tested through research on other countries.

Thirdly, my own connections to several influential actors meant that I was afforded access to many of the key policy actors involved in the three cases explored. Most of these actors gave generously of their time, in some cases meeting with me for many hours or on multiple occasions. Also several influential actors helped facilitate my access to key documents and reports that I would have otherwise been unable to obtain. For example, one interview with a former Minister of Health lasted almost 7 hours and this actor subsequently searched her personal files for copies of key policy documents that could not be found by current health officials. This experience was repeated with other actors. This has allowed me to offer 'thick' descriptions of the central actors and events in the cases—a critical input for ensuring the reliability of findings derived from process tracing. This is an important strength of this research and its contribution.

Finally, although this was not an original aim of this research, this process has allowed me to play a role (albeit a limited one) in reconstructing the history of public health policy in Barbados—a topic about which very little has been written. For example, I had the opportunity of a two-hour interview with Sir Carlisle Burton, the country's first Permanent Secretary in the Ministry of Health. Sir Carlisle was one of the few remaining informants who could offer first hand accounts of many of the events and actors of the 1950s and 60s, and was an important fount of information for Chapters 4 and 5. His death, just weeks before this thesis was submitted, highlights the importance of this reconstructive task and underscores the contribution of this thesis to it.

8.2.2 Limitations and biases

Despite these important strengths, there are several limitations and sources of bias that should be noted. First, as discussed in Chapter 3 (Section 3.2.1), successful process tracing relies on a careful reconstruction of events and processes over time. This requires the researcher to capture the finest possible level of detail using a variety of evidentiary sources, to ensure that the reconstructed story and ensuing analysis are reliable.[73] Yet, limits to the level of detail that could be obtained in this thesis were imposed, both by time and by the unavailability of certain data and documents. Government offices were often missing documents and reports, and while many of these were eventually sourced, some documents of potential import could not be retrieved. Also, as mentioned above, there is very little published work (either historical or contemporary) on health policy in Barbados. Therefore, even though a substantial amount of data was collected, events were reconstructed to a relatively high level of detail, and facts/perspectives triangulated where possible, it is conceivable that there are potentially critical pieces of evidence that have not been considered here. Another important limitation is that the inquiry is set in a single (very small) country. This has implications for the generalizability of my findings and is discussed in more detail in Section 8.2.3 below.

Secondly, a number of potential sources of bias and the measures taken to address them are also identified in Chapter 3 (Section 3.2.5), including the heavy reliance on elite interviews, and my own interpretive function. Another potential source of bias, is the fact that I had pre-existing connections to some policy actors and that over the course of this project I have built relationships with several informants. Despite the measures taken to address this—including triangulation of data sources, and the consideration of alternative explanations during data analysis—it is still possible that these proximate associations may have had some effect. In particular the heavy reliance on interviews and my relationships

[73] Bennett and Checkel (2012) suggest, that when using process tracing, "a single meeting or memo may prove to be the crucial piece of evidence that instantiates one explanation and undermines another".[142]

with domestic policy elites, might have influenced my finding that it is domestic actors that play the most critical roles in the prioritization process. However, it is unlikely that any bias introduced in this way would nullify the strong evidence to support this claim across the three case studies given the range of documentary sources that were also consulted. Also, although comparatively fewer international actors were interviewed, those who were (for example World Bank and PAHO officials), corroborated this finding.

8.2.3 Scope for generalizability

Despite these limitations, the strengths identified provide reasonable assurance of the reliability of my findings. Also, that these appear to be generally consistent across cases on three very different health policy issues, suggest they are generalizable to priority setting in health in Barbados more broadly. However, admittedly, the fact that the case studies presented are set in a single country, which has several notable peculiarities—namely its smallness, political stability, and relatively progressive achievements where social welfare is concerned—imposes limits to the generalizability of my findings. For example, the fact that Barbados is a tiny island with a population of under 300,000, perhaps means that 'policy entrepreneurs' are influential by definition. Also, while these actors did not act alone, 'policy networks' in this context are incredibly small, close knit and characterized by frequent overlaps in professional and personal connections, by default emphasizing the roles, resources and connections of individual actors. For example, key domestic actors were often connected both by professional associations and long-standing personal friendships or familial relations. Given these peculiarities, it is not likely that my findings are representative of macro-level priority setting elsewhere.

Although there may be limited scope for generalizability, in Chapter 7, I emphasize identifying theoretically grounded mechanisms that transcend the peculiarities of each case. Many of these findings do resonate with other robust empirical accounts of priority setting

in other LMICs, suggesting that the insights gained here are not at all irrelevant to the wider body of empirical research. In particular, there is a great deal of overlap with several of the insights that have emerged from the growing body of empirical research on the factors that influence the uptake of evidence into health policy decision-making in LMICs. For example, in exploring the evidence-policy interface, a number of studies have drawn on the RAPID framework developed by the Overseas Development Institute, which emphasizes the role of the wider domestic policy context, the links/networks between researchers and other key policy actors (including decision-makers), external influences (such as donors), and the credibility of the evidence and how it is communicated, in influencing the uptake of evidence.{Young, 2004 #810}{Hutchinson, 2011 #791;Hutchinson, 2011 #680}{Burris, 2011 #812;Sumner, 2011 #813}{Hutchinson, 2011 #791;Hutchinson, 2011 #680} Most strikingly, in their cross-country study of the role of evidence in policy development for cotrimoxazole prophylaxis in Malawi, Uganda and Zambia, Hutchinson et al. also conclude that 'policy entrepreneurs' played central roles. Looking across their three cases, the authors write:

> "Overall, the role of a policy entrepreneur was crucial in all cases, and, as an active agent, able to respond to and address barriers to policy development; providing additional evidence when questions were raised about the evidence base (particularly in Uganda and Malawi), making links between researcher and policy maker networks (most effectively in Malawi but also in Uganda and Zambia), and linking supportive policy champions with the evidence needed and the correct policy audience (in all three countries)."{Hutchinson, 2011 #680}

Likewise, while the particulars vary somewhat, my findings do suggest that powerful individual domestic policy actors or policy entrepreneurs play pivotal roles in determining domestic priorities, and presents some hypotheses about how these actors influence the allocation of public resources. This more general contribution to the wider literature is discussed below.

8.3 Opening the black box—Contributions to the literature

In the first chapter of this thesis, I suggest that current efforts aimed at improving the use of evidence to inform priority setting in LMICs, have had limited effectiveness because they have been pursued in the absence of empirical research to understand how priorities are actually set in practice. In particular, I assert that: "understanding how governments allocate scarce resources for health necessitates a look at the deeply political process concealed in the black box that transforms policy inputs into outputs." The last four chapters have contributed to opening that black box in the context of Barbados. Notably, in retrospect, 'priority setting' as observed in health care systems in high-income countries—that is, a systematic weighing and consideration of the efficacy and efficiency of alternative interventions—was not routine in Barbados. Consequently, this thesis has focused on the broader political process of prioritization and macro-level resource allocation at work. In doing so, I believe that this research offers several key insights for the wider literature on macro-level priority setting in LMICs.

In Chapter 2, I identified three major gaps that emerge in the existing body of empirical work (see Chapter 2, Section 2.5). First, I suggested that while some of the literature proposes that domestic policy actors can and do play principle roles in priority setting, there is a lack of consensus on who these actors are—their defining attributes and mechanisms of influence. Secondly, I revealed a weak understanding of how global and domestic actors and institutions interface in order to shape prioritisation decisions. And, thirdly, I pointed to limited understanding of the roles of evidence and ideas and (most critically) how these two concepts interact in the context of health policy in LMICs. The insights from across the three cases explored in this thesis offer contributions to each of these key areas. In addition, they also point to the role of contextual constraints in influencing, though not determining, the outcomes of prioritisation processes. Each of these is now discussed in turn.

8.3.1 Characterizing the central domestic actors

Although a focus on the role of powerful domestic policy actors (identified in the literature as policy entrepreneurs, champions, advocates or 'political leadership') in shaping national health priorities in LMICs was ubiquitous in the body of existing empirical work, I found that these studies often focused specifically on one type of actor (often high-level political leaders, but sometimes technocrats, bureaucrats or civil society leaders). Also, I found that studies frequently emphasized the particularities of an actor's actions in one case. The result has been poor clarity more generally on who these actors are and limited knowledge regarding their defining attributes and mechanisms of influence. In Chapter 7, looking across the three cases of priority generation for health issues in Barbados, I identify a class of actors—'policy entrepreneurs'—who drive the prioritisation process.

Through in-depth case studies the thesis offers 'thick' descriptions of these policy entrepreneurs involved in generating priority at the domestic-level, while allowing for some generalizations about the roles they play through cross-case comparison. The policy actors identified as principle drivers of priority in my own empirical work, do not appear to occupy specific positions in society or within the hierarchy of government. Sometimes these actors are technocrats or bureaucrats, sometimes they are civil society leaders, and sometimes it is the Minister who plays the role of entrepreneur. However, they need not necessarily be policy decision-makers (or to wield some other form of authoritative power within the state) themselves. Rather, they only need to have close links to others who do. Most critically, these actors are distinguished by their entrepreneurial roles, namely their ability to leverage their resources—expertise or authoritative positions, political connections, political savvy, and passion/commitment— and to effectively translate evidence and/or communicate politically salient ideas, in order to make a convincing argument for increasing priority in a particular case.

Notably, although high-level political leaders are often the most visible policy actors and may be directly responsible for legislating resource allocation or other policy decisions, they are not always the principle drivers of priority. My findings reveal that in some cases political leaders, who had been associated with elevating an issue on the government's agenda, were in fact being pushed by a sometimes (much less visible) policy entrepreneur. Moreover, by identifying systematic characteristics and mechanisms by which these actors wield influence, and by acknowledging that these actors do not necessarily determine the outcomes of prioritisation processes, this work responds to Reich's(1995)[100] criticism that the emphasis on political leadership or policy champions in the health policy analysis literature "ignore[s] the policy constraints of reform" (See Chapter 2, Section 2.2.2).

It can be argued that these findings are more likely to be true in a small country where there is generally a high degree of connectedness and which has a relatively high degree of equity (especially where education levels are concerned), than in a larger country where connections to power tend to be concentrated among certain social or economic classes and where social inequity is higher. However, the fact that the policy process tends to involve a small number of actors even in large countries and that much of the literature acknowledges that some kind of domestic political actor or group of actors is key, suggests that my findings may have applicability beyond Barbados.

8.3.2 Assessing the role of evidence and ideas

While attempts to improve priority setting in LMICs has focused disproportionately on providing burden of disease and cost effectiveness evidence, my findings indicate that a much wider array of evidential sources influence prioritisation decisions. Sources of evidence not only included epidemiological data, but also qualitative studies of health services utilization and coverage, expert opinions, and anecdotal or lay accounts of the

effects of problems. Indeed, even evidence of non-health effects related to sewage disposal proved successful in mobilizing action for sanitation. Notably, the use of cost-effectiveness studies in macro-level priority setting in Barbados seemed to be rare. This is consistent with findings from other LMICs, as discussed in Chapter 2 (Section 2.2.1). However, even broadly defined, although evidence proved to be a critical input in priority generation, my findings suggest that it did not determine priorities.

This research adds to the emergent body of literature within the field of health policy analysis that provides an empirical basis for emphasizing the role of ideas in explaining decision-making in practice. Like several of the 'thicker' accounts of macro-level priority setting discussed in Chapter 2[6, 9, 66, 127, 485], my work challenges materialist assumptions that argue that the implications of evidence for health policy decision-making are self-evident. Instead, I find the concepts of ideas and framing to be far more useful explanatory variables in accounting for changes in the priority status of issues over time. Moreover, while 'evidence' does influence the power of ideas, it is only one of several factors that does so. In particular, my findings suggest that the salience of ideas (or the extent to which they resonate with authoritative decision-makers) and the perceived authority or political influence wielded by the messenger(s), might be far more powerful determinants of an idea's ability to motivate action. This resonates with some of the findings reported by Smith and Neupane's (2011)[66] in speaking about the role of policy communities in shaping priority for new-born survival in Nepal.

My findings about the roles of ideas and evidence also contribute to the limited existing knowledge on the ways in which policy entrepreneurs influence priority setting. Though these actors are by no means the only disseminators or originators of ideas, translating evidence into powerful ideas about problems or solutions (or framing) and communicating these appear to be principal mechanisms through which these actors are able to influence the allocation of resources.

8.3.3 Understanding how global and domestic actors interact

My findings offer insight on how global and domestic actors interact to shape national priorities in health and the extent to which global actors can wield power in the domestic policy arena. These are two areas that have received limited attention despite the identification of a growing constellation of regional and global actors in health policy analysis of LMICs (as discussed in Chapter 2, Sections 2.2.3 and 2.5.2). I find some evidence that the presence of DAH plays a critical role in prioritisation decisions in Barbados, despite the fact that it is an upper-middle income and largely aid independent country. As discussed in Chapter 2.2.3, scholars studying macro-level priority in other middle-income countries have reported similar findings. However, it is perhaps surprising that, in the case of Barbados, these resources are in the form of loans from MDBs. In Chapter 7, based on my own empirical analysis, I identify two potential reasons for this, which have been accorded attention by the wider body of work on the impact of foreign aid on LMICs. First, the fact that these funds are often fungible and, as a consequence, that they can allow governments to circumvent the difficult political process of cutting budgetary allocations in one area, in order to increase allocations to another. And secondly, that finance ministers often see that DAH as a critical source of foreign exchange.

I also show that global actors can provide a supportive policy context by exerting 'peer pressure' on domestic actors to pay attention to particular issues. However, external actors (including donors/development banks) only seem to be successful in influencing national priorities in health when powerful, concerned policy entrepreneurs are present. Moreover, they appear to be more influential when they have an in depth knowledge of the country context, and when they form meaningful connections with domestic policy actors. It could be argued that this observation might have been influenced by the fact that Barbados is an upper middle-income country, which receives very little ODA. However a small number of empirical studies of national-level priority setting in low-income countries

have also made similar assertions, suggesting that these findings may have wider applicability.[100, 117-119]

Notably, while I find that the presence of DAH does not automatically mean that priority will emerge, my research illustrates that, in the case of capital-intensive projects, its absence can stagnate priority generation. Yet, the funder-recipient relationship does not seem to be strictly one-dimensional, and there are indications that domestic policy entrepreneurs can mobilize the support of external actors, even when they were not initially willing to fund an initiative.

8.3.4 Considering contextual constraints

Lastly, several thicker accounts of macro-level priority setting have pointed to the importance of a "favourable policy context" or "policy windows" in accounting for the emergence of priority.[6, 9, 49] In Chapter 7, I discuss similar findings based on my own empirical analysis. A historical look at priority for HIV, PHC and sanitation over time, allowed me to explore the drivers of increasing priority, as well as the factors at work when priority was either absent or declining. This approach, has allowed me to gain insight into the role of contextual features that narrow the possibility that priority for a particular issue will emerge at a given time.

A number of different contextual constraints are identified, including recessionary periods, negative policy legacies, and the presence of powerful domestic opposition. Though these examples of contextual constraints are not likely to be exhaustive, there are some systematic features that characterize them. Firstly, they are all largely beyond the control of domestic policy actors. Also, at times they all appear to have the ability to immobilize priority generation efforts. Yet, ultimately, these do not appear to be deterministic.

My findings suggest that even in the face of incredible constraints, policy entrepreneurs can often find room for manoeuver. The case studies illustrate that these actors often actively navigate obstacles that arise in the wider policy context by mobilizing the (public) support of powerful political allies; generating new evidence to bolster ideas or reframing problems/solutions in new and more salient ways; or by systematically responding to the concerns at the root of domestic opposition. Also, while contextual constraints may not ultimately hinder the emergence of priority, they can nonetheless influence the outcome of prioritisation processes by resulting in substantive changes to policy proposals put forward by policy entrepreneurs, or stalling the allocation/disbursement of resources and delaying policy implementation.

8.3.5 Beyond 'laundry lists' of factors

In concluding my review of the empirical literature in Chapter 2, I suggested that more extensive 'laundry lists' of the factors that influence priority-setting in LMICs, are unlikely to be of much assistance in opening up the black box, unless researchers are able to distinguish between the relative salience of these factors and establish links between them. Not only have I succeeded in identifying key factors affecting macro-level priorities in health in Barbados, but through rigorous within-case and cross-case analysis, I have suggested that among the many variables at work, four of these appear to be most prominent—the presence of policy entrepreneurs, powerful framing ideas, policy windows and constraints, and external financial assistance. I also assert that among these, policy entrepreneurs appear to be necessary for priority to emerge and serve as decisive linchpins between the other factors.

In addition to grounding my insights in relevant theory, I identify systematic ways (mechanisms) in which these factors influence priority in a real-world context. These can be treated as hypotheses in future work. Overall, my findings stress that priority setting is

indeed deeply political and that it is probably best explained by considering interrelations between several factors. It also illustrates the role of process tracing in capturing these interactions and establishing relative salience. This in itself is an important contribution to the task of "opening the black box" in LMICs more broadly.

8.4 Implications of findings for Barbados and further afield

A growing number of domestic and global actors seek to influence priorities in health at the national level. In Barbados and elsewhere this includes politicians, authoritative decision-makers, technocrats, bureaucrats, citizens, civil society organizations, global and regional organizations, donors, multilateral development banks, private corporations, and research institutions. These findings have several implications for efforts to influence, as well as those aimed at improving, priority setting in Barbados and perhaps further afield in other LMICs. These are discussed in further detail below.

8.4.1 Influencing priorities

The findings presented in this thesis may be instructive for actors who seek to influence domestic priorities in four key ways. First, I suggest that many different types of actors may be successful in influencing macro-level priority setting. When attempting to shape priority directly or indirectly (through the agency of others), policy actors—regardless of what positions they occupy in the political or social structure—should assess their own capacity and/or that of others to function as policy entrepreneurs. In doing this, my work suggests that, they should consider whether they are recognised as having some authority on the issue they are advocating for, what connections they have to powerful decision-makers at the time (if they do not hold this power themselves), the extent of their knowledge of the domestic policy environment (especially regarding the socio-political

dynamics of power), and their capacity to demonstrate longstanding commitment for the cause.

Secondly, the findings suggest that powerful ideas motivate decision-makers to act. Actors who seek to successfully use evidence (no matter how robust) to influence priorities must therefore engage with the realm of ideas. In making the case for increasing resources for their causes, they must play key roles in translating evidence to help characterize problems and propagating ideas, which they feel are particularly salient at the time and will resonate with principle authoritative decision-makers. Moreover, they can draw on a wide range of evidential sources, not just those with academic rigour, to do so.

Thirdly, in particular, donors and MDBs who seek to influence domestic priorities should realize that external resources or global peer pressure in itself is unlikely to be successful in motivating lasting change. Their efforts to influence government action can be greatly enhanced when they form meaningful connections with domestic policy actors, in particular policy entrepreneurs. Conversely, the findings also indicate that development assistance for health is often an important input in efforts to generate priority. Policy entrepreneurs can increase their chances of mobilizing external financial support by paying attention to shifting donor trends and priorities, and understanding the strategic interests of these institutions.

Finally, my findings suggest that even in the most highly constrained policy contexts, there may be room for manoeuver. Those who seek to influence priorities must continually assess their policy environments and be ready to seize domestic and global windows of opportunities that arise. They must play proactive roles in anticipating and navigating constraints. Even where priority has failed to emerge before, my findings assert that advocates should have cause for hope.

8.4.2 Improving priority setting

This thesis was primarily concerned with what actually happens, rather than what *should* happen. Yet it is impossible to ignore the moral import to set priorities and the need, especially when resources are very scarce, to do this well. In Chapters 4 to 6, I present detailed descriptions of the prioritisation process in Barbados. My findings suggest that a few influential individuals often drive priority setting, and that it need not be (and sometimes is not) based on sound evidence of public health need or cost-effectiveness. It also reveals that resources are often allocated without any deliberative effort to consider the opportunity costs of investing in one particular area. I believe that these findings have two implications for efforts to improve priority setting that are especially pertinent against the backdrop of what seems to be declining domestic resources for health.

Firstly, there is a pressing need to improve the availability and quality of policy-relevant evidence to inform framing efforts. In recent years, basic up-to-date burden of disease data has not been publicly available—e.g. the release of the annual CMO reports have been pending since 2003. Also, beyond the national budgets, more detailed health spending data and local data regarding the costs of various services provided by the health sector are generally unavailable. These are both critical inputs for BOD calculations and CEA. Evidence to inform priority setting should also include studies of access to and coverage of health services and on-going evaluations of public health sector programs. However, the presence of good evidence alone is unlikely to address the concern that prioritisation decisions seem to be mostly a reflection of the power of individual policy entrepreneurs and that they often fail to take into account the opportunity costs of increasing resources for one area.

In their report on priority setting in health released earlier this year, the U.S. based Center for Global Development's *Priority-Setting Institutions for Global Health Working Group*, identifies "the need for a systematic process of priority-setting" in LMICs as a top

concern and suggests that investing in strong priority-setting institutions is critical to achieving this goal.[3, 20] Based on my findings, I also share this assertion. The fact that technocrats within government seemed to be more likely (than other actors) to sustain the powerful connections with decision-makers over time that are needed to drive resource allocation, perhaps indicates that within the Ministry of Health might be a good setting for such an institution. In particular, although it currently appears to be relatively weak in terms of influence, strengthening the Ministry of Health's planning unit may be a place to start. This department is already charged with presenting decision-makers with information for policy making and has trained health economists, policy analysts and epidemiologists among its staff.

However, the evidence presented in this thesis suggests that even if we seek to improve priority-setting processes in LMICs by generating more evidence and creating institutions, these measures are likely to be of only limited impact if they ignore the political realities of allocating resources for health. In particular, it is unlikely that policy entrepreneurs will be rendered redundant. This corroborates very recent findings by a number of other scholars. For example, in an empirical study of the factors affecting the translation of evidence into policy development in three African countries, Hutchinson et al. (2011)[486] also find that in order to be successful, evidence needs to be communicated to decision-makers by policy entrepreneurs who are well-connected politically. Also, in surveying the role of health policy think tanks in LMICs, Bennett et al. (2011)[487] point to the critical role of specific individuals within these institutions "in fostering trust and influence"[487] within decision-making circles. Policy entrepreneurs will need to be identified to drive efforts to move towards a more systematic and evidence-based decision-making process, as well.

8.4.3 Encouraging entrepreneurship

The central finding of this thesis, that policy entrepreneurs act as necessary drivers of macro-level priority setting, begs the question: can we encourage the emergence of such entrepreneurs, in the first place? In providing empirical accounts of how these actors function, it can be tempting to focus on particular idiosyncrasies of each individual's trajectory. Yet by identifying systematic features of these actors across three cases, it is clear that at any given time there are several individuals who posses the key resources to become successful entrepreneurs—that is, actors who posses some form of recognized authority, are embedded in social and professional networks, and may be prepared to be persistent in advocating for change. Moreover, as discussed in Section 8.4.1, those who aspire to influence resource allocation can actively seek to build these resources. However, perhaps the most important factor that distinguishes entrepreneurs, either in a business or policy context, is their ability to innovate—to envision change that goes beyond the status quo and to creatively pursue for it.

This thesis has focused on how these actors influence priorities and not on the factors that shaped their propensity towards entrepreneurial activity. However, throughout the cases, two factors seemed to be useful in mobilizing entrepreneurs. First, in all three cases, an important source of entrepreneurial spirit was exposure to new ways of thinking, theories of change, or policy options through higher education abroad or international/regional meetings. These experiences over influenced actors to challenge what was conventional wisdom at home—exposing them to new tools, tactics or policy entrepreneurs, sparking dissatisfaction with the status quo, and changing their perceptions of what opportunities for change existed. Secondly, another important source of entrepreneurial spirit came from other policy entrepreneurs who sometimes mentored other policy actors and helped to create a new generation of change agents by sharing their own networks and political know-how and by encouraging them to see beyond the status quo.

Although such interventions at the level of individuals is perhaps a place to start, structural, institutional and contextual factors might also influence the likelihood that policy entrepreneurs will emerge. Other measures, such as ensuring widespread access to information about health services and problems, opening up opportunities for genuine engagement in the policy process, and actively encouraging critical review of existing priorities and programs, may also be ways in which an environment that is conducive to policy entrepreneurship can be nurtured.

8.5 Final thoughts

This thesis argues that powerful individual policy actors or 'policy entrepreneurs' act as necessary drivers of macro-level priority setting in Barbados, although they do not single-handedly determine the outcomes. Explaining the emergence of priority across three case studies, my research also points to three other factors that can affect the likelihood that priority will emerge: the extent to which powerful ideas come to characterize an issue; the presence of opportunities or constraints in the wider policy context; and the availability of external financing. These factors do not operate in a deterministic fashion, but interact through the agency of policy entrepreneurs, who must successfully leverage or navigate them in order to shape priorities in health. In particular, this research stresses the fact that national level priority setting in Barbados is a *political* process and that priorities are shaped by a set of interrelated factors. In doing so, it illustrates the powerful role of health policy analysis in helping to open the black box of how public resources for health are allocated in LMICs elsewhere as well and stresses the need for further research.

Prospects for future work

In general, given the limited number of existing studies, there is a need for still more rigorous health policy analysis of macro-level priority setting in LMICs. Although this thesis has generated some hypotheses, which have broader application to Barbados and other LMICs, multi-country studies would help to further establish this. Also, admittedly, this thesis gives almost no attention to structural factors that influence norms and behaviours in the policy arena. Further research is needed to explore the individual, structural, institutional and contextual factors that encourage entrepreneurial activity among policy actors in Barbados and elsewhere; to establish whether certain kinds of evidence are more likely to provide powerful fodder for framing ideas; and to better understand the circumstances (other than the level of capital financing needed) that influence the importance of external financing in other middle-income countries. Future research should also explore the role of MDBs in Barbados and the Caribbean, focusing specifically on their role in priority setting and the implications of their involvement for policy implementation. Finally, operational research will be necessary to determine how best to encourage and improve the quality and availability of rigorous research evidence and how to build institutional capacity (in evidence synthesis and policy analysis) to aid more systematic priority setting.

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Appendices

Appendix 2.1: Search strategy used by Gilson & Raphaely's in their systematic review of the health policy analysis literature on low- and middle-income countries

Search terms:
health AND policy; health AND policy AND implementation; health AND 'policy analysis'; health AND politics; health AND policy AND agenda setting; health AND policy AND power; health AND policy AND interests; health AND policy AND discourse; health advocacy; health AND construct$ AND Africa OR Asia OR Latin America OR Caribbean OR Pacific OR Middle East OR East Europe OR developing countries OR transitional countries NOT US OR America OR UK OR Australia OR Canada etc.

Inclusion criteria, steps 2-3:
Published in English
Full article accessible
Health policy focus
Considers the processes of policy change and/or factors influencing these processes
Considers experience in low and middle income, including transitional, countries
Largely acceptable methodology

Inclusion criteria, steps 3-4:
Primarily empirical study or clear empirical base
Focuses entirely or mainly on policy change experience within or across country settings (analysis largely undertaken at meso- and/or micro-levels)
Largely acceptable methodology

Source: Gilson and Raphaely (2008)[5]

Appendix 2.2: Search terms used to supplement and update Gilson & Raphaely's systematic literature review, conducted December 2010

Searches were conducted of PubMed and Ovid SP was used to search Medline, Embase, and Global Health Abstracts, by combining the following sets of search terms:

health AND {policy OR policy analysis OR politics OR power} AND {priority setting OR priorit$ OR agenda setting} AND {Africa OR Asia OR Latin America OR Caribbean OR Pacific OR Middle East OR East Europe OR middle-income countries OR low-income countries OR developing countries OR transitional countries}

Appendix 3.1: Rationale for case selection based on budgetary analysis

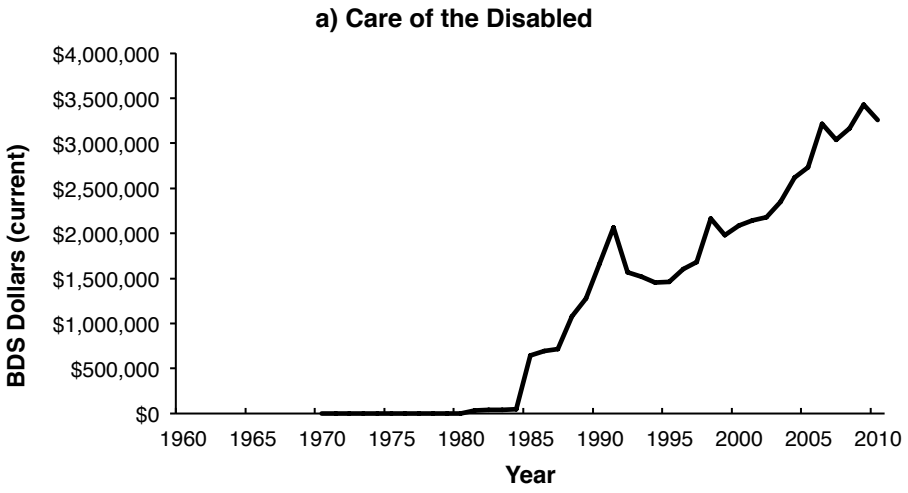
	Program Area	Criteria 1	Criteria 2	Criteria 3
a)	Care of the disabled	Yes	No	No
b)	Care of the elderly	Yes	Yes	No
c)	Environmental health*	Yes	Yes	Yes
d)	HIV/AIDS	Yes	Yes	Yes
e)	Hospital-based services	Yes	Yes	No
f)	Mental health	No	n/a	n/a
g)	Pharmaceutical Program	No	n/a	n/a
h)	Primary health care	Yes	Yes	Yes

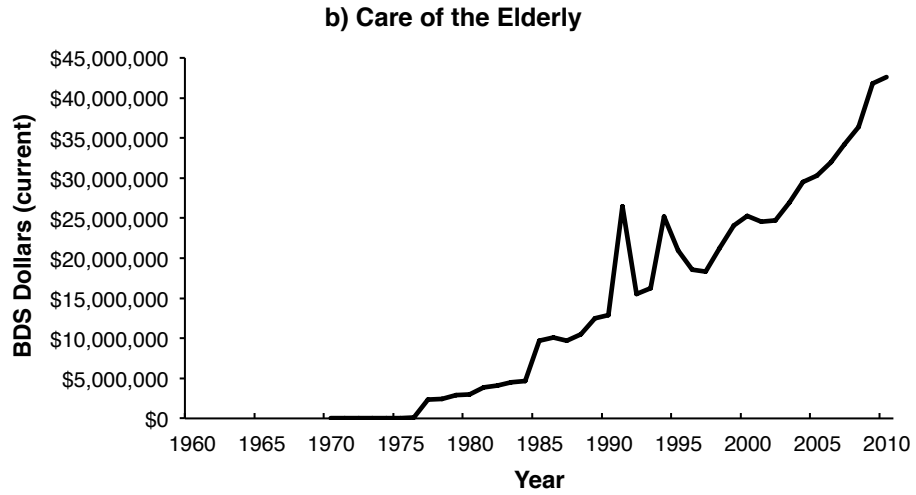
Notes: Case studies selected for the purpose of this thesis are shaded in grey. *Spending on sanitation was later extracted from "Environmental Health" which was comprised of a number of different programs

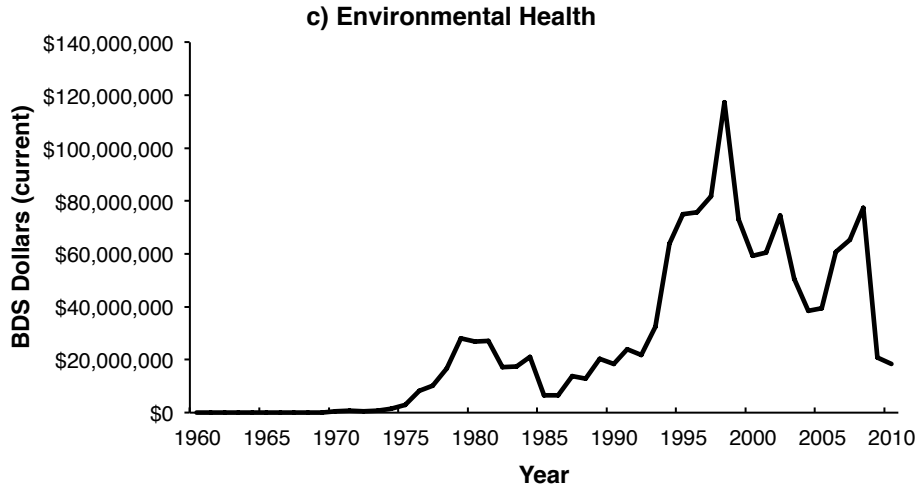
Criteria 1: Presence of one or more period(s) of marked, non-incremental change in the amount of financial resources allocated

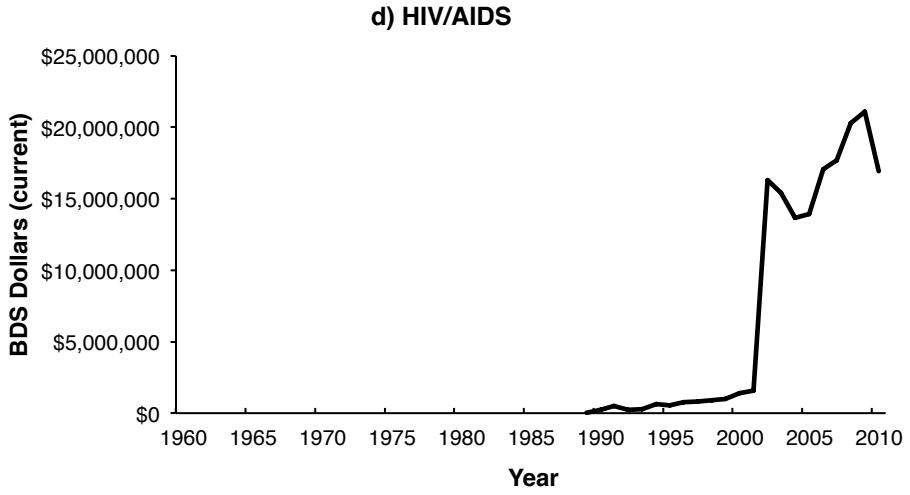
Criteria 2: Change is substantial (in absolute and/or proportional terms)

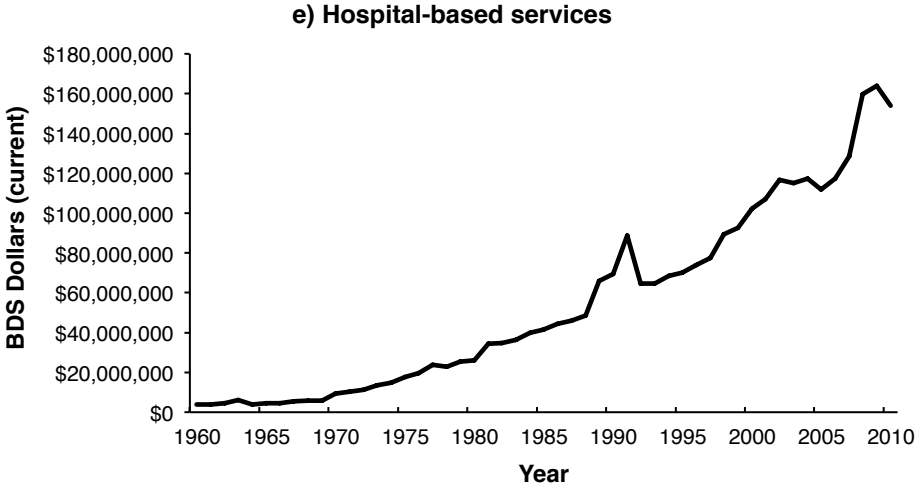
Criteria 3: Change could be attributed to a specific policy proposal or program



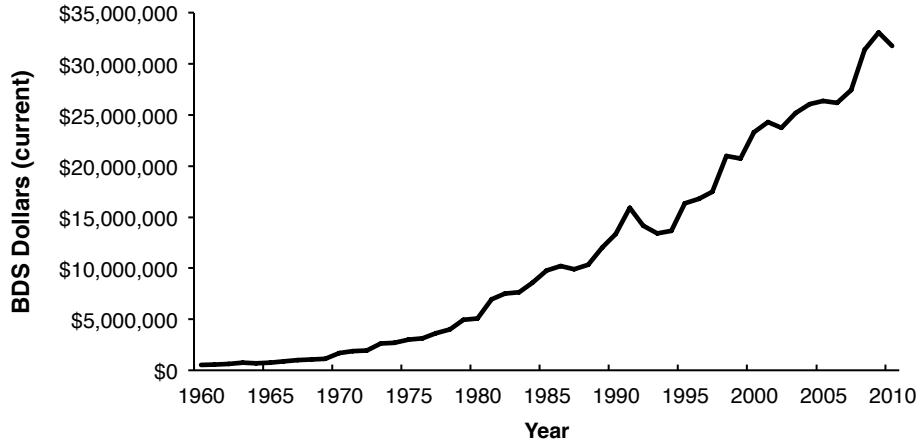



c) Environmental Health
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
BDS Dollars (current)
1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010
Year

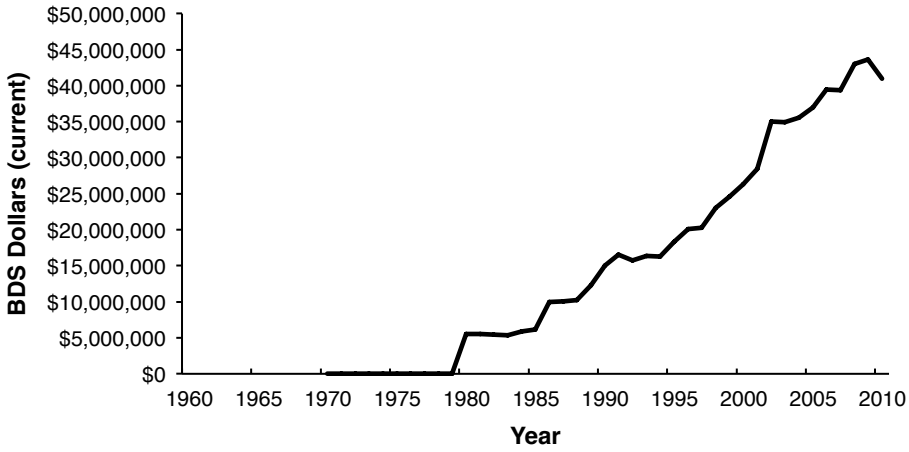

d) HIV/AIDS
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
BDS Dollars (current)
1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010
Year


e) Hospital-based services
$180,000,000
$160,000,000
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
BDS Dollars (current)
1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010
Year

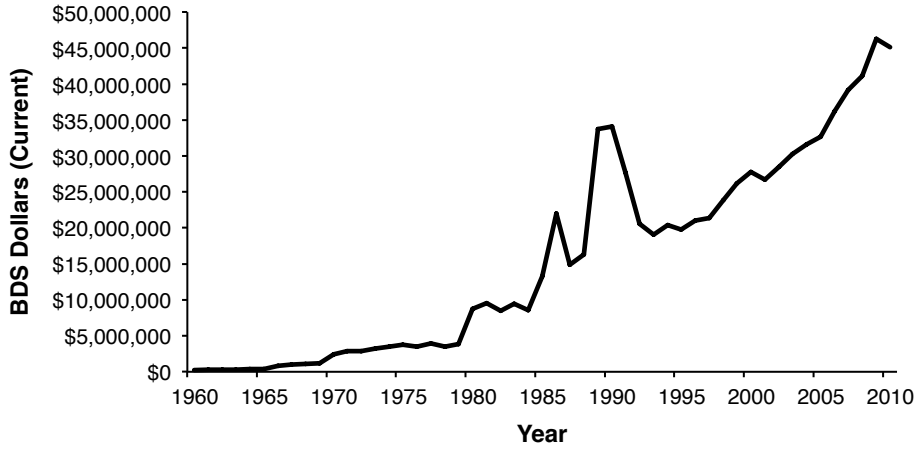
f) Mental Health



g) Pharmaceutical Program



h) Primary Health Care

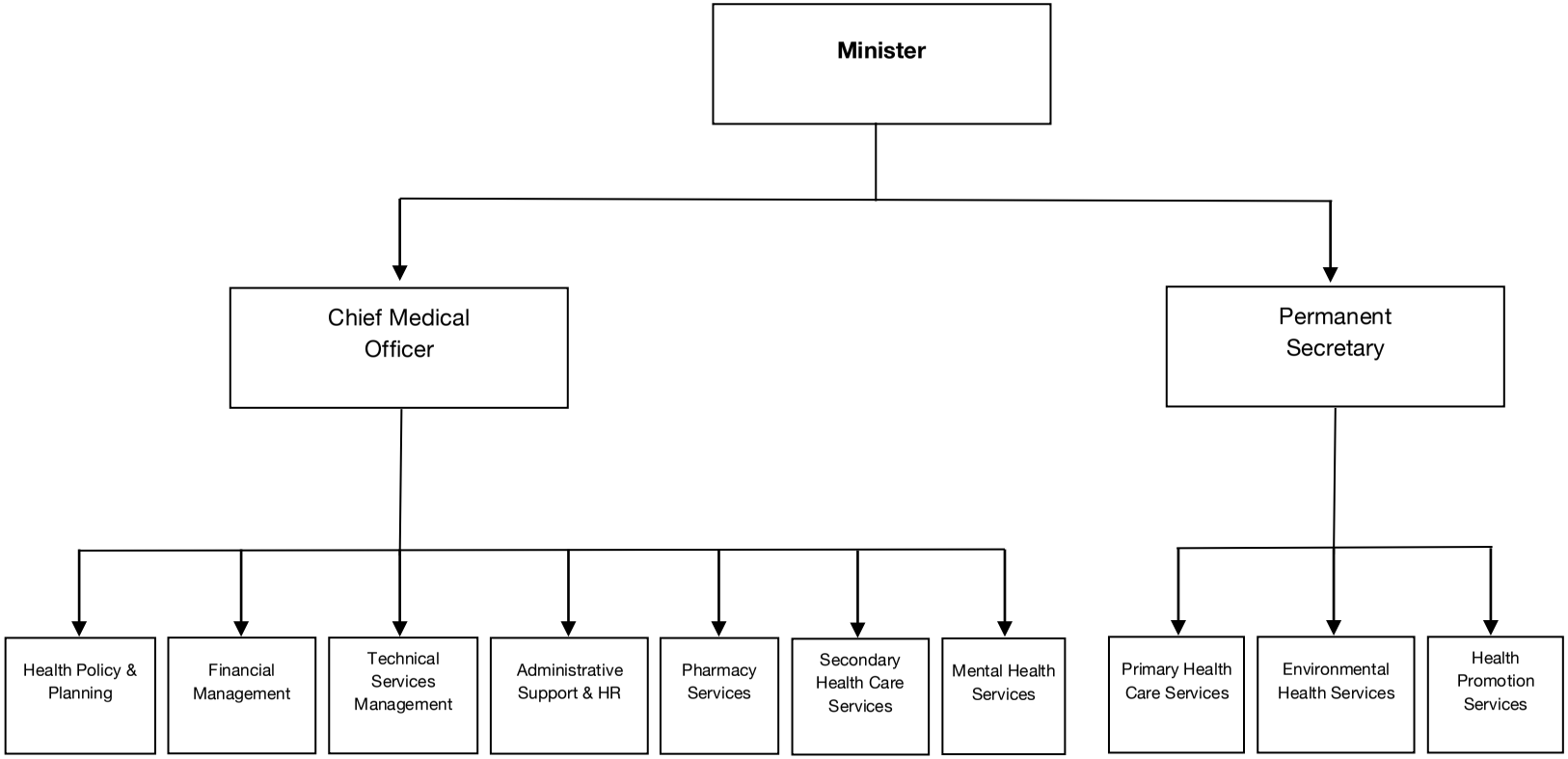


Appendix 3.2: List of Interviewees

	Name	Affiliation(s)
1.	Akiba Reid	Executive Director, AIDS Foundation of Barbados
2.	Alan Cobley	Professor of History, University of the West Indies
3.	Alies Jordan	Former Deputy Chairman, National HIV/AIDS Commission/Deputy Cabinet Secretary
4.	Anders Nielsen	Senior Lecturer of Medicine, University of the West Indies
5.	Anton Best	Senior Medical Officer – HIV Unit, Ministry of Health
6.	Aristides Barbosa	Barbados AIDS Team, World Bank
7.	Arlene Husbands	Caribbean Program Coordinator, Education Development Centre
8.	Avril Gollop	Cabinet Secretary, Head of the Civil Service
9.	Bernadette Theodore-Ghandi	Caribbean Program Coordinator, PAHO
10.	Branford Taitt	Former Minister of Health
11.	Carol Jacobs	Former Chairman, National HIV/AIDS Commission; Former Chairman, Board of the Global Fund to Fight AIDS, TB and Malaria
12.	Christine Barrow	Professor of Social Development, University of the West Indies
13.	Clive Landis	President, Caribbean Cytometry and Analytical Society
14.	Colin Brewer	Founder & President of AIDS Foundation of Barbados
15.	Cortez Nurse	Former Chief Health Planner, Ministry of Health
16.	Dale Babb	Clinical Medical Officer, Ladymeade Reference Unit, Ministry of Health
17.	Dame Billie Miller	Former Ministry of Health
18.	Danny Gill	Director of Planning Unit, Ministry of Health
19.	David Estwick	Former Minister of Health
20.	Donville Inniss	Minister of Health
21.	Doriel Branch	Retired Public Health Nurse
22.	Elizabeth Ferdinand	Senior Medical Officer for Primary Health Care, Ministry of Health
23.	Elizabeth Thompson	Former Minister of Health
24.	Erskine Simmons	Primary Care Physician
25.	Faye Prescod	Chief Budget Analyst, Ministry of Finance
26.	Gillian Barclay	Inter-country Advisor on Human Resources Development for Health, PA
27.	Grantley Smith	Director of Finance and Economic Affairs, Ministry of Finance
28.	Henrick Ellis	Chairman of the National HIV/AIDS Commission
29.	Henry Fraser	Former Dean of the Faculty of Medical Sciences, University of West Indies
30.	Hilda Thompson	Retired Public Health Nurse, Member of the AIDS Management Team
31.	Hon. Owen Arthur	Former Prime Minister
32.	Hugh Sealy	Project Manager, South Coast Sewerage Project, Ministry of Health
33.	Jacqueline Wiltshire-Gay	Director of the National HIV/AIDS Commission

34.	Jerome Walcott	Former Minister of Health
35.	Joana Godinho	Sector Manager for Health, World Bank
36.	John Mwansa	Acting Director, Barbados Water Authority
37.	Joy St. John	Chief Medical Officer, Ministry of Health
38.	Keith Simmons	Former Minister of Health
39.	Madge Dalrymple	HIV/AIDS Coordinator, Ministry of Tourism
40.	Margaret Sivers	Accountant General/Acting PS, Ministry of Finance
41.	Martin Cox	Former Permanent Secretary, Ministry of Health
42.	Maxine McClean	Minister of Foreign Affairs and Foreign Trade
43.	Michael Howard	Professor of Economics, University of the West Indies Cave Hill Campus
44.	Mickey Walrond	Founder of the AIDS Management Team, Queen Elizabeth Hospital
45.	Miriam Hinds	Director, Barbados Drug Service
46.	Nancy Headley	Chief Budget Analyst, Ministry of Finance
47.	Nicholas Adomakoh	Senior Medical Officer for Communicable Diseases, Ministry of Health
48.	Patricio Marquez	Project Manager, Barbados AIDS Team, World Bank
49.	Philip Goddard	Former Minister of Health
50.	Phillip Nanton	Project Officer, HIV/AIDS Response Programme, University of the West Indies Cave Hill Campus
51.	Ronald Fitt	Permanent Secretary, Ministry of Health
52.	Sanka Price	Senior Editor, Health Reporter, Nation News
53.	Sarah Adomakoh	Former Director, Chronic Disease Research Centre, University of the West Indies
54.	Sheila Stuart	Former Director of the Bureau of Gender Affairs, Ministry of Social Care
55.	Sir Carlilsle Burton	Former Permanent Secretary, Ministry of Health/Former Head of the Civil Service
56.	Sir George Alleyne	UNAIDS Special Envoy for HIV/AIDS in the Caribbean/Former Director, PAHO
57.	Tara Inniss	Professor of History, University of the West Indies
58.	Thomas Novotny	Consultant, Barbados AIDS Team, World Bank
59.	Timothy Roach	Clinical Director, Ladymeade Reference Unit, Ministry of Health
60.	Trevor Hassell	Director of the National Commission for Chronic Non-communicable Diseases
61.	Tyrone Lowe	Superintendent, Bridgetown Sewage Plant
62.	Valmay Arthur	Retired Public Health Nurse, Queen Elizabeth Hospital
63.	Vashti Innis	Retired Health Educator, Ministry of Health/Founder, HIV/AIDS Food Bank
64.	Winifred Harewood	Financial Controller, Ministry of Health

Appendix 3.3: Institutional structure of the Ministry of Health, Barbados



Source: PAHO (2008)

Appendix 4.1: Manifestations of 'primary health care' over time and comparison with Alma Ata's PHC approach

	Health Unit System	Polyclinic System	Alma Ata's PHC Approach
Relevant period	1945-75	1975-present	1978-present
Origins	Outcome of Royal West India Commission; drew on experience of Rockefeller Foundation	Built on pre-existing concept of health centres; Influenced by a Health Minister's visit to Cuba	Grew from examples of successful innovations in community-based health care delivery mechanisms in LMICs, e.g. barefoot doctors in China, and smaller community-based projects elsewhere around the world.
Delivery Infrastructure	Health centres	Multi-purpose clinics or Polyclinics	Not specified
Key Features/ Focus areas	1. Expanding access to primary health care through centres and out-posts closest to where people live 2. Management by medical officers, supported by a variety of health professionals including community health aides. 3. Community based programs to "arouse the health consciousness" of the local people 4. Household visits by nurses, community health aides and inspectors	Same as health unit system but, explicit focus on free universal access	1. Universal coverage of basic health services provided "as close as possible to where people live and work." 2. Focus on leadership by mid-level and community health workers in delivering care. 3. Emphasis on community participation in planning and implementation of programs and on local self-reliance in health development 4. Inter-sectoral coordination encouraged 5. Focus on use of appropriate affordable technologies
Services	Focus mainly on prevention and health promotion services	Integration of prevention and health promotion, with a wide array of primary-level curative, diagnostic and rehabilitative services	Provision of preventative, promotive, curative and rehabilitative services (including access to essential medicines) to address the main health problems of each community

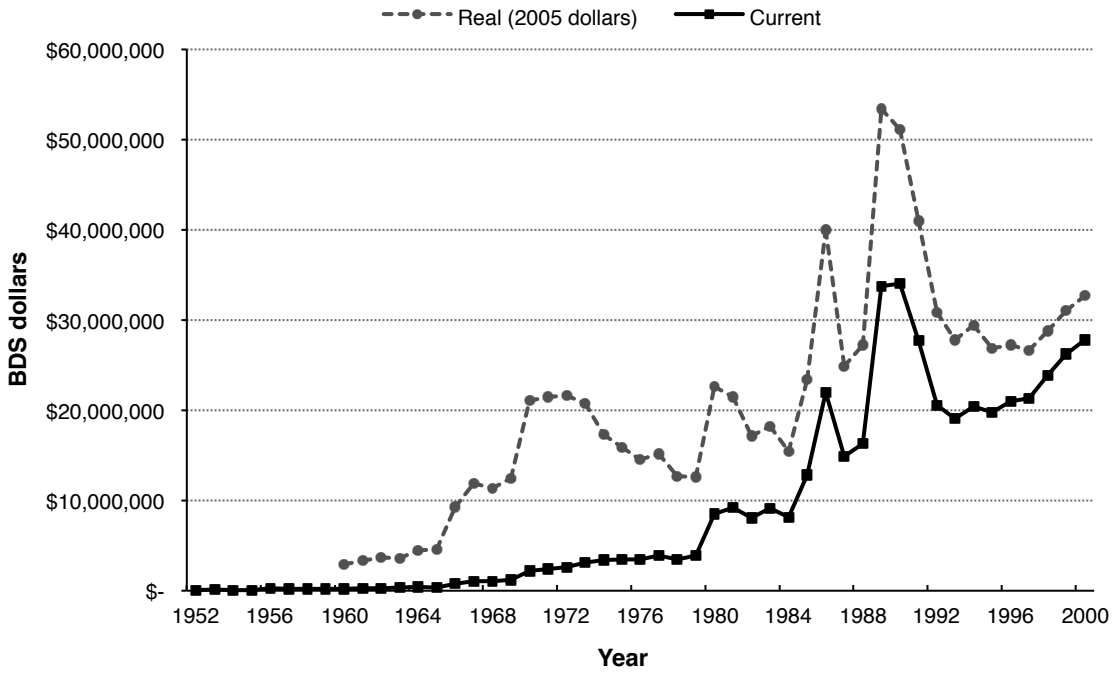
Sources: Theodore & Edwards-Wescott (2011)[7], Sinha (1988)[8], Ministry of Health (1978)[9], Colonial Office (1943)[10], Bryant (2009)[11], WHO (1978)[6]

Appendix 4.2: Table showing infant mortality and death rates for islands of the British West Indies in 1937

	Infant Mortality Rate (per 1,000 live births)	Death Rate
St. Kitts & Nevis	209	36.5
Antigua	171.1	20.6
Jamaica	118.5	15.3
Trinidad & Tobago	120.5	17.4
St. Vincent	117.8	15.3
British Guiana (Guyana)	121	21.9
St. Lucia	101.1	14.4
Barbados	217	18.5
Dominica	114.3	14.5

Source: West India Royal Commission Report (1945)[12 (p.135)]

Appendix 4.3: Graph of public expenditure on PHC in both real (2005) and current dollars



Notes: Due to absence of GDP deflator values for 1950-1959, both real and current data is presented

Source: Barbados Estimates, 1950--2010[3, 13]

Appendix 4.4: Table showing average annual percentage of total health expenditure spent on preventative and curative activities in selected West Indian colonies, 1942-1945

	Percentage		
	Government health expenditure (GHE) as a share of total public expenditure	GHE on prevention activities	GHE on curative activities
Antigua	17.1	22	78
Barbados	11.3	8	92
British Guiana (Guyana)	10.2	12	88
Dominica	15.6	8	92
Jamaica	9.8	18	82
St. Kitts & Nevis	18.6	31	69
St. Lucia	12.7	10	90
St. Vincent	19.6	15	85
Trinidad & Tobago	9.2	18	82

Source: West India Royal Commission Report (1945)[12 (p.141)]

Appendix 4.5: Description of the health unit system

The Health Unit System

In the first report on the activities and plans of the Colonial Welfare and Development Organization from 1940-42, the fund's comptroller Sir Frank Stockdale, outlined the 'health unit system' as a central pillar of the organization's attempt to foster the formation of long-term health policies in the West Indian colonies. Stockdale's report defined a health unit as *"an organization which provides a small community with health services similar to those given by a well-developed urban health department but on a much simpler and less costly scale"* (Colonial Office, 1943). These units were to:

1. **Focus on preventing illness and promoting wellness through the provision of a variety of services**, including antenatal and maternal care, child welfare services, school medical services, control and prevention of endemic diseases, improving sanitation and hygiene, and providing health education to community members.
2. **Be run by a multidisciplinary team**, including doctors, nurses, midwives, sanitary inspectors, health visitors and other auxiliary staff.
3. **Encourage more coherent public health intervention through the promotion of collaboration across sectors**, by developing links to efforts in agriculture, education, housing and social welfare policy and programs.
4. **Elicit the cooperation and participation of the community** in improving their health, using education as the principal tool for community-empowerment.

The inclusion, in the Comptroller's report, of the health unit system of organization was owing to the work of the Rockefeller Foundation in sharing their experience in the provision of rural health care via health units systems, an programme area in which the foundation had been investing since the late 1920s (Birn, 1998; McCaw Binns & Moody (2001). During the first two years of the organization, through the Rockefeller Foundation, the Development and Welfare Fund's medical advisor was able to visit several countries in South and Central America in order to examine the functioning of health units (Colonial Office 1943).

Sources: Theodore & Edwards-Wescott (2011)[7], Sinha (1988)[8], Colonial Office (1943)[10]

Appendix 4.6: Life expectancy at birth and infant mortality rate in Barbados by five-year period, 1950-1974

	1950-1954	1955-1959	1960-1964	1965-1969	1970-1974
Life expectancy at birth (years)	57.7	62.6	65.9	67.6	69.4
Infant mortality rate (per thousand live births)	132.0	87.0	61.0	46.0	33.0

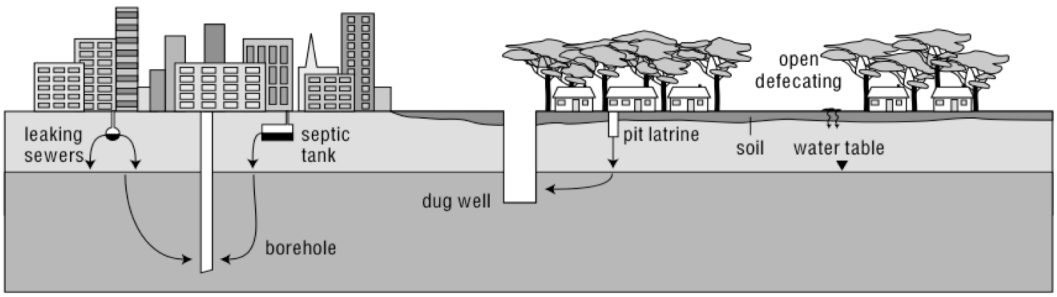
Sources: Theodore & Edwards-Wescott (2011)[7], Sinha (1988)[8], Colonial Office (1943)[10]

Appendix 5.1: Description of the main types of sanitation systems

	Sanitation System	Advantages	Disadvantages	Applicability
On-site	**Pit latrines**	Low-cost Not reliant on constant sources of water Can be quickly constructed Good in low-water table areas, as excreta is able to decompose in the soil	Flies Often have odour problems Difficult to construct in rocky areas High risk of groundwater contamination in high-water table areas	A high water table in Barbados' coastal areas means that this is not adequate in many parts of the island.
	Pour-flush latrines	Still relatively low-cost Little to no odour associated Low-volume of water needed Good in low-water (for same reason as above)	Require reliable access to water Only suitable in cultures were water is traditionally used for anal cleansing High risk of groundwater contamination in high-water table areas	Same as above
	Septic tanks	Can be used with flush toilets Very convenient for users Generally limited flies and odour Good in low-water (for same reason as above)	Relatively high-cost Access to piped water generally needed Need to be "desludged" Require high volumes of water High risk of groundwater contamination high-water table areas	Particularly problematic in Barbados, due to high water table. Extreme conditions in Barbados led to septic tank overflows and difficulty flushing toilets due to saturated tanks
Off-site	**Sewered systems**	Can be used with flush toilets Very convenient for users No flies or odours Wastes removed rapidly from site Considered by many as the 'gold standard' of sanitation	Extremely expensive, requiring major capital investment Large volumes of piped water is necessary Requires treatment before disposal As systems age, may be prone to leakage	Preferred method of sanitation in Barbados.

Sources: Carr (2001)[14] & AGROSS (2001)[1],

Appendix 5.2: Sources of faecal pollution of groundwater due to sanitation systems



Source: AGROSS (2001)[1]

Appendix 6.1: Timeline of global and domestic events* related to HIV/AIDS policy in Barbados

*Domestic events shaded

1981	CDC publishes first report on AIDS
	First AIDS cases detected in California and New York, first among gay men, then injecting drug users
1982	First AIDS case reported in Africa
1983	French scientists isolate HIV
	Experts become more confident that the cause of AIDS is infectious, and heterosexual transmission confirmed
	Epidemic in central Africa documented
	CAREC begins tracking the epidemic and providing laboratory support to member countries
1984	December, first (indigenous) AIDS case reported in Barbados
	Scientists identify HIV (initially HTLV-II or LAV) as the cause of IADS
1985	First international AIDS Conference held
	Test to diagnose HIV licensed for screening blood supplies
	April, BAMP establishes the AIDS Taskforce
	May, Barbados begins screening blood for HIV, 2 months before it was implemented in the United States of America.
1986	WHO's GPA established with Jonathan Mann as director. GPA encourages countries to establish National AIDS Programs.
1987	Branford Taitt becomes Minister of Health in the DLP Administration (until 1993)
	August, National Advisory Committee on AIDS (NACA) established in the Ministry of Health in Barbados (with Walrond as Chairman), following the mandate sent out by the WHO's Global Program on AIDS.
	Barbados asked to serve on the management committee of WHO's GPA
	FDA approves AZT for treatment of HIV
	CAREC establishes a program on HIV/AIDS

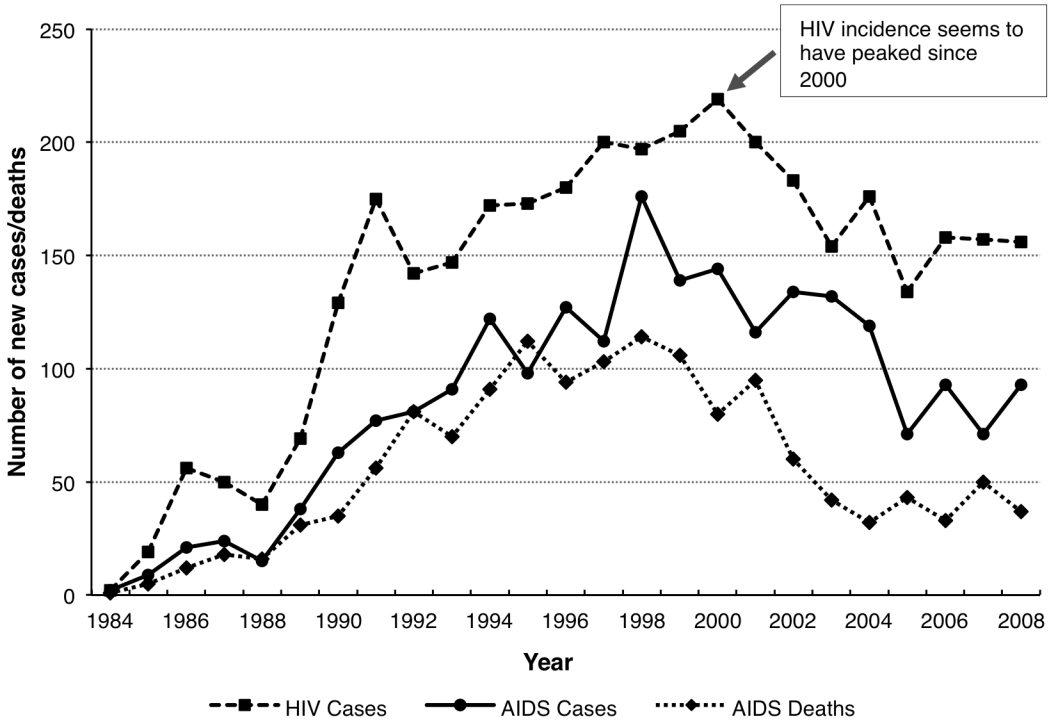
1988	June, a member of NACA is sponsored to attend the 4th International AIDS Conference in Stockholm
	Barbados' NACA releases its first report and requests a budget of BDS$1, 659, 554 for the year. Report highlights the potential economic implications of AIDS. For example, saying: "in other sectors financial implications will be felt in loss of production because most AIDS patients are in the 20-40 years age groups."
1989	AIDS Information Centre set up at the MoH's Headquarters, as the focal point for disseminating information about HIV/AIDS to the general public
	HIV/AIDS appears as a line item in the Ministry of Health's budget for the first time
1990	Michael Mann leave's the GPA and WHO begins to reduce priority for AIDS
	The AIDS Management Team (AMT), a multidisciplinary clinical team, is established at the QEH to focus on the provision of care and support for AIDS patients
	Barbados Ministry of Health establishes the HIV/AIDS Hotline staffed by (over 40) volunteers
	AIDS Society of Barbados (NGO) formed to provide public awareness and counselling for PLHAs
	Charles Schlosberg prints open letter to NACA in one of the major newspapers and the issue of the effectiveness of NACA becomes a major discussion point in media
1991	Impacts of major economic recession, and the fiscal consequences of pre-election spending, begin to be felt in Barbados and IMF assistance is sought. HIV budget severely cut.
1992	Rapid HIV test licensed
1993	CARE Barbados established with membership comprised of PLWHA.
	Branford Taitt is moved from the position of Minister of Health
1994	In Barbados, a no-confidence proves successful in ending 8 years of DLP rule in Barbados
	AZT is shown to reduce the risk of mother-to-child transmission of HIV and the rate of infections among infants begins to decline due to its widespread use
	Economists at UWI St. Augustine Campus, with assistance from CAREC< publish article entitled "The Cost of AIDS in Trinidad and Tobago"
1995	Dr. Carol Jacobs takes up reins at NACA (until 1998) and the institution commits itself to a more broad-based/multi-sector program and widens prevention/education efforts by targetting primary school children, out of school youth, commercial sex workers, religious leaders, parents and sexually active young people.
	In Barbados, PMTCT programme begins with the provision of AZT to HIV positive pregnant mothers.

	Elroy Phillips Centre, a hostel type facility, is established out of the need to provide accommodation for homeless HIV positive persons who would have otherwise remained in the hospital setting in acute nursing care
	The Health Economics Unit is established at the University of the West Indies, St. Augustine Campus and begins to publish studies modelling the economic impact of AIDS in the Caribbean. For list of papers/projects see: http://sta.uwi.edu/fss/heu/Health.asp
1996	The Joint United Nations Programme on HIV/AIDS (UNAIDS) launched and Barbados serves as a charter member of the PCB)
	In Barbados NACA consolidates its new mandate to establish a multi-sectoral response, in keeping with the recently formed, UNAIDS
	The results of studies, which show that a combination of antiretroviral drugs (triple therapy) significantly reduces risk of HIV-related illness and death, announced at the International AIDS Conference in Vancouver and in developed countries, many people begin taking the new treatment Brazil's President announces decision to provide free access to ART (usually locally produced generic drugs) via the National Health System
1997	UNAIDS launches HIV Drug Access Initiative in Uganda and Cote d'Ivoire – first introduction of ART in sub-Saharan Africa Brazilian drug companies begin manufacturing off-patent ARVs.
	Barbados recorded as having the second highest incidence rate of HIV/AIDS in the Caribbean, after Bahamas (UNAIDS)
1998	Health economists from UWI present their work on the socioeconomic costs of HIV/AIDS in Trinidad at the Barbados Central Bank's Annual Review Seminar. Senator Philip Goddard, Minister of International Business and Foreign Trade at the time, addresses Cabinet about the economic implications of the HIV epidemic
1999	June, Barbados Cabinet requests that the MoH provide an update on the HIV/AIDS situation in Barbados August, Phillip Goddard appointed as Minister of Health October, Cabinet is presented with a comprehensive policy paper on the HIV/AIDS situation in Barbados highlighting the potential impact of the epidemic on economic devleopment
	World Bank develops strategic plan to address AIDS in Africa
2000	January, UN Security Council convenes first session on AIDS April, Economist article "Deadly Silence" highlights the absence of action on HIV/AIDS in the Caribbean region.
	April, PM Arthur announces intention to provide free ART to all Barbadians.

	May 2000, Millennium Development Goals call for reversing the HIV epidemic by 2015
	May, UNAIDS launches Accelerating Access Initiative (AAI) and begins negotiations with top pharmaceutical companies to address affordability of HIV medicines and to work to increase access to treatment in developing countries.
	June, at a meeting of the Caribbean Group on Cooperation in Economic Development (CGCED) at the World Bank in Washington, DC. This meeting involved Prime Ministers, Ministers of Finance and other key decision-makers from member countries, country delegations, and senior representatives of international organizations. A presentation was made on the findings of a report prepared by the World Bank, with CARICOM and UNAIDS, which focused on the socioeconomic impact of AIDS
	International AIDS Conference in Durban, South Africa, significantly quickens global momentum to expand HIV treatment access
	July, Prime Minister Arthur brings HIV to the regional agenda at a CARICOM Heads of Government meeting in St.Vincent and the Grenadines. Regional leaders formally recognize AIDS as a threat to the region's economic and social development
	September 11-12, Barbados hosts the Caribbean Conference on HIV/AIDS a meeting of regional governments and key donors. Donor organization pledge to expand financial support, for HIV. In particular, the World Bank pledges a very substantial financial commitment (approximately US$155 million in the form of loans, interest-free credits and grants).
	September, World Bank officially launches Multi-Country HIV/AIDS Program (MAP)
2001	UN Secretary-General Kofi Annan calls for global "war chest" to fight AIDS
	February, in response to PM Arthur's call, CARICOM Heads of Government make a declaration of commitment to the Pan-Caribbean Partnership against HIV/AIDS during a Heads of Government meeting
	March, Pan Caribbean Partnership Against HIV and AIDS (PANCAP), a major regional initiative on AIDS, launched in Barbados
	April, at the Summit of the Americas in Quebec, Canada, World Bank President James D. Wolfensohn announced the World Bank's US$150 million plan to support the fight against HIV/AIDS in the Caribbean, fulfilling its pledge last September at a high-level meeting of country delegations and international organizations to significantly increase support for HIV/AIDS activities in Caribbean countries.
	June, UN General Assembly's first-ever special session on HIV/AIDS results in adoption of time-bound pledges to strengthen AIDS response
	June, the Barbados HIV/AIDS Prevention and Control project becomes the first program approved under the US$155 million Multi-Country HIV/AIDS Prevention and Control APL for the Caribbean. Although Barbados graduated from the World Bank in 1993, the World Bank Team obtained approval from the Board of Directors to include Barbados in the APL program as an exceptional case.
	July, CARICOM Heads of Government sign the Nassau Declaration on Health: The Health of the Region is the Wealth of the Region, which formally recognized the importance of health to the economic development of the region and set AIDS as a priority."
	July, the Government of Barbados obtains a World Bank loan of US$15.2 million (covering eligible costs from Pay 15, 2001). This was to help in the financing of the HIV/AIDS Prevention and Control Project (a subset of the National HIV/AIDS Program), which was projected to cost US$23.8 million over 5 years.

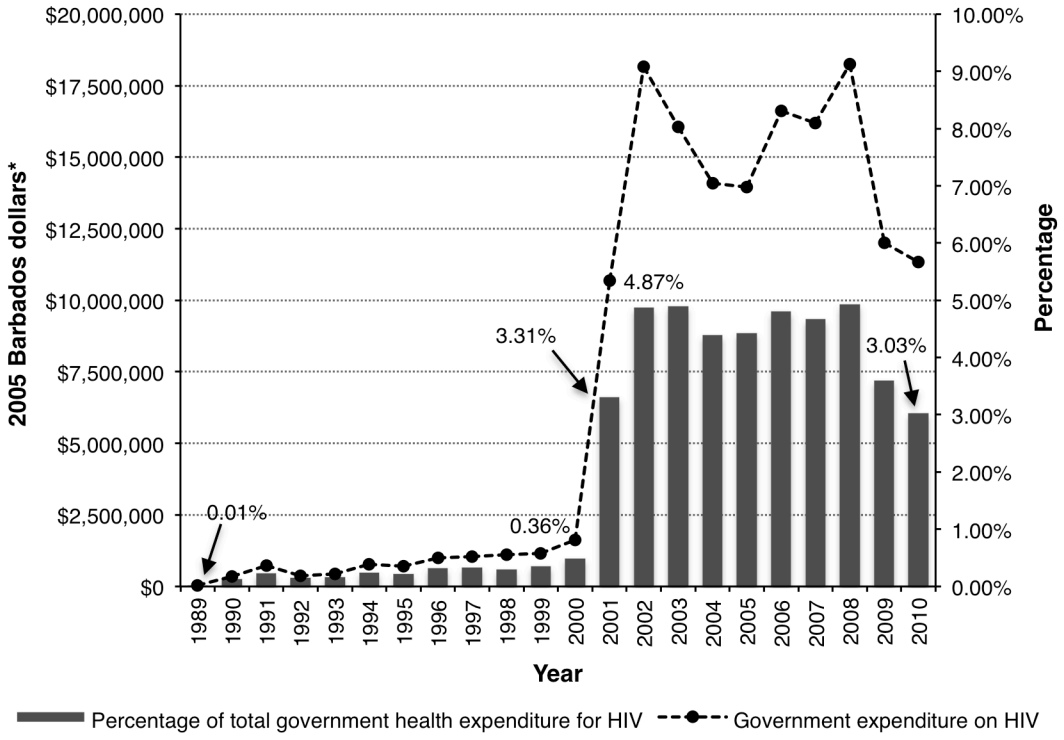
	National HIV/AIDS Commission established, with its secretariat in the Office of the Prime Minister. Dr. Carol Jacobs (former Chair of NACA 1995-1998) is its first Chair.
	November, Doha agreement allows developing countries to buy or manufacture generic drugs fro HIV and other priority diseases
2002	The Global Fund to Fight AIDS, Tuberculosis and Malaria launched
	AIDS becomes leading cause of death worldwide for people ages 15-59
	February, ARVs are made available to those Barbadian residents who need it free of charge.
	Phillip Goddard leaves position of Minister of Health
2003	U.S. President George W. Bush announces the President's Emergency Plan for AIDS Relief (PEPFAR) initiative, during his State of the Union address
	UNAIDS and WHO launch the "3 by 5" campaign to reach 3 million PLHAs in low- and middle-income countries with ART by the end of 2005
	Clinton Foundation secures major price reductions for AIDS drugs
2008	BLP government loses the general election after 14 years in power
	The NHAC is moved from the Office of the Prime Minister to the Ministry of Family, Youth Affairs, Sports and Environment
	Second World Bank loan for HIV treatment, care and prevention approved, valued at US $35 million
2010	Two consecutive years of budgetary allocations for HIV/AIDS recorded in Barbados
2011	At the International AIDS Society Conference in Rome (July 17-20), scientists announce that two studies have confirmed that individuals taking daily antiretroviral drugs experienced infection rates more than 60% lower than those on a placebo.
2012	August, a World Bank mission to Barbados reports that the country is under-spending on its loan

Appendix 6.2: HIV Cases, AIDS Cases and AIDS Deaths, 1984-2008



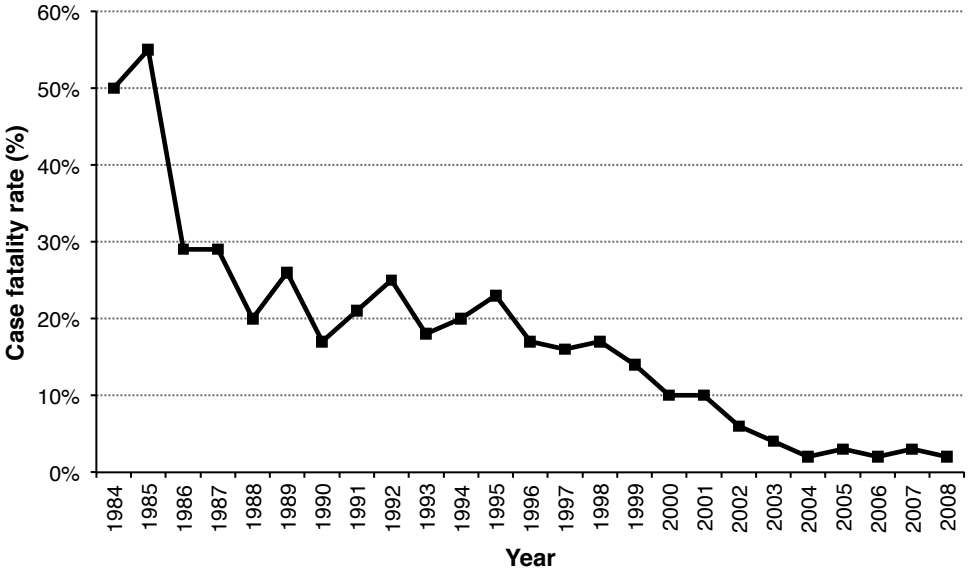
Notes: Yearly data based on aggregates of monthly epidemiological reports since 1986
Sources: 1984-2002 CAREC database[2], 2003-2008 data from Barbados NHS Database[4], Ministry of Health (2010)[4]

Appendix 6.3: Change in public health expenditure on HIV in real 2005 dollars and as a share of total government expenditure, 1989-2010



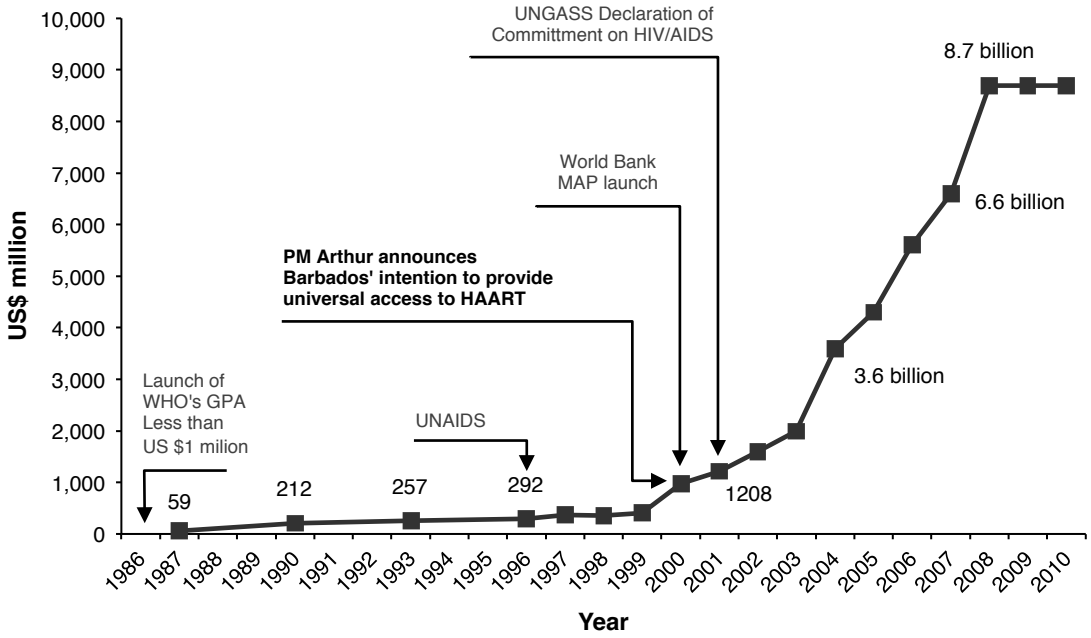
Notes: *Data from 1989-2009 is in real 2005 BDS dollars, however due to lack of GDP deflator data for 2010 has not been adjusted for inflation
Source: Barbados Estimates, 1960-2010[3]

Appendix 6.4: AIDS case fatality rates in Barbados, 1984-2008



Source: Barbados NHS Database, Ministry of Health (2010)[4]

Appendix 6.5: Total annual resources available from donor governments for AIDS, 1986-2010



Notes: No data available 1988-1989, 1991-992 and 1994-1995

Data is of resources from donor governments only (including allocations to the Global Fund). Does not include resources from private foundations or spending on HIV/AIDS by LMIC governments or out of pocket expenditures.

Sources: Data from 1986 to 1996 from UNAIDS (2007)[15]; 1996-2001 UNAIDS (2003)[16]; and 2002-2010 extracted form Kaiser Family Foundation and UNAIDS Report on Financing the Response to AIDS in Low- and Middle-Income Countries by Kates et al. (2011)[17]

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