

Local demand for a global intervention: policy priorities in the time of AIDS*

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This draft: September 16, 2009

Abstract

This chapter documents local demand for HIV/AIDS services in sub-Saharan Africa and seeks to explain patterns of demand using an original dataset from Malawi, a country hard-hit by the AIDS pandemic. As international agencies and national governments rapidly scale up HIV and AIDS interventions in sub-Saharan Africa, my analysis of cross-national public opinion data paired with survey and in-depth interviews of villagers and their headmen in rural Malawi suggest weak prioritization of HIV/AIDS programs. In this chapter, I test whether self-interest predicts policy preference; specifically, I look at whether HIV serostatus or being affected personally by AIDS predicts demand for HIV/AIDS programs. I find that though HIV-positive respondents are more likely to prioritize HIV/AIDS programs, demand for increased HIV/AIDS programs remains very low in high-prevalence settings. The data illustrate a misalignment of policy preferences in the global-to-local hierarchy of actors involved in HIV and AIDS interventions.

*This is a chapter from my dissertation, *The Political Economy of HIV/AIDS Intervention in Sub-Saharan Africa*. The research presented herein was supported by funding from the Globalization Research Center-Africa at UCLA, the California Center for Population Research at UCLA, the Fulbright Program, and NICHD R01 Grant #RHD053781 (Principal Investigator: Hans-Peter Kohler). Previous versions of this work were presented at the Princeton AIDS Initiative, a Working Group in African Political Economy Meeting, and the 2009 meeting of the American Political Science Association and I thank participants for useful feedback. I also acknowledge helpful discussions about the research with James Honaker, Edmond Keller, Evan Lieberman, Zachariah Mampilly, Daniel Posner, Tyson Roberts, Arthur Stein, Ann Swidler, Susan Watkins, and Daniel Young. All errors or omissions remain my own.

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1 Introduction

In this chapter I study local demand for HIV/AIDS¹ intervention in sub-Saharan Africa in service of two goals. The first aim is to present a descriptive account of weak demand for HIV/AIDS services. My second task is to take advantage of an original dataset to highlight and explain patterns of demand. I use a cross-national public opinion survey and original data from Malawi to measure demand and, where it exists, probe its sources. Specifically, I test whether individual interests and/or social interests influence preferences for increased HIV/AIDS services. Data from rural Malawi show villagers and their headmen give little, if any, priority to HIV/AIDS services. Cross-national public opinion data present parallel paradoxical findings of demand for AIDS services: populations most affected by the AIDS pandemic are less likely to support increased resources be devoted to AIDS. Finding weak demand for HIV/AIDS services among the people experiencing the AIDS pandemic firsthand is puzzling: AIDS is fatal and has no cure or vaccine; treatment for AIDS has shown to dramatically improve and lengthen the lives of AIDS patients. What person living with HIV/AIDS would not prioritize such a treatment? More generally, who would not want to be protected from contracting a fatal disease?

The scale-up of HIV testing and AIDS treatment services has been touted by the global community as an important step forward in the fight against the AIDS pandemic (Grinstead et al., 2001; Porco et al., 2004; Bunnell et al., 2006) and international organizations fervently promote the global push to increase access to HIV testing and AIDS treatment services (UNAIDS, 1998; World Health Organization, 2002, 2003). International donors have responded with compassion, generously supporting interventions to prevent the spread of HIV and to mitigate the effects of AIDS in severely resource-constrained countries suffer-

¹HIV is an acronym for human immunodeficiency virus, a virus that causes acquired immunodeficiency syndrome, or AIDS. AIDS weakens the immune system, ultimately leading to death from opportunistic infections.

ing from a generalized epidemic. For example, in 2003, U.S. President George W. Bush launched the President's Emergency Plan for AIDS Relief (PEPFAR); the \$15 billion dollar commitment was the largest bilateral effort against HIV/AIDS in the developing world. In 2007, PEPFAR was reauthorized, committing an additional \$30 billion towards HIV/AIDS interventions. From the launch of UNAIDS in 1996 until 2005, available annual funding for the response to AIDS in low- and middle-income countries has increased 28-fold (UNAIDS, 2006, 224).

Though sub-Saharan Africa has only 10% of the world's population, it is home to 68% of all people living with HIV and AIDS. But do Africans living amidst the AIDS pandemic demand HIV/AIDS services, or is the motivation to scale up these services simply a Western import? Public opinion data from sub-Saharan Africa established that though concern about HIV has risen over time, AIDS has yet to register very high on the "people's agenda" (Afrobarometer, 2004; Whiteside et al., 2004), and scholars question the prioritization of HIV/AIDS intervention (Shiffman, 2008; Dionne, Gerland and Watkins, 2009; World Bank Independent Evaluation Group, 2009), particularly when spending on HIV/AIDS has been at a cost to general health systems improvement (Grepin, 2009; Garrett, 2007; England, 2007). Like activists and policymakers, scholars assert HIV/AIDS services are a public good (Lieberman, 2009, 2007; Kim and Farmer, 2006; Patterson, 2006; Walton et al., 2004; Ainsworth and Teokul, 2000). My study of the policy priorities of ordinary Africans facing the AIDS pandemic firsthand does not assume they perceive HIV/AIDS services as public goods, but also considers their preferences to be driven by a perception that such services are exclusive to the population that is sick or worried about future infection.

This chapter examines empirically what is often overlooked: the policy preferences of rural Africans with respect to development and health interventions for which they are the intended beneficiaries. In the West, people think about Africa first and foremost as a place suffering from AIDS. I argue that ordinary Africans are not naïve about HIV and AIDS,

rather the data shows other pressing concerns take precedence over increasing the availability of HIV/AIDS programs. The chapter is structured as follows: Section 2 proposes the testable hypotheses of the study. In Section 3, I present the data analysis, demonstrating weak demand for the scale-up of HIV/AIDS services. In Section 4, I conclude with a discussion of the implications of the misalignment of preferences for HIV/AIDS services.

2 Seeing Like a Villager: Self- and Social Interests

The literature on governmental response to AIDS employs a top-down framework (Lieberman, 2009; Dionne, forthcoming; Lieberman, 2007; Bor, 2007; Patterson, 2006), and scholars typically assert the provision of HIV/AIDS services as a public good (Lieberman, 2009, 2007; Kim and Farmer, 2006; Patterson, 2006; Walton et al., 2004; Ainsworth and Teokul, 2000). However, HIV/AIDS services cannot be characterized as public goods because their use is not non-rival nor non-excludable. Treatment and care for those sick with AIDS inherently benefits HIV-positive individuals. For example, the lion's share of funding for HIV/AIDS services focuses on AIDS treatment, a service rationed by clinicians because of limited availability. From an individual's perspective, then, AIDS treatment is beneficial only to those who are successful in receiving treatment. This chapter uses a bottom-up perspective to consider the policy preferences of intended beneficiaries of HIV/AIDS programs. Accordingly, this chapter employs a theoretical framework that considers micro-level mechanisms underlying demand for HIV/AIDS services.

Policy priorities shaped by self interest² would predict demand to vary across populations

²Early studies of the behavior of mass publics in America proposed self-interest as a predictive motivation of opinions on political issues (Berelson, Lazarsfeld and McPhee, 1954; Campbell et al., 1960). Empirical tests show, however, that self-interest generally has not been of major importance in explaining the American public's political preferences (Sears and Funk, 1990), and survey data show that individuals rarely form preferences for economic policy on the basis of economic self interests (Mansfield and Mutz, 2009, 433). Even scholars skeptical of the role of self-interest concede, however, that there are exceptions. Sears and Funk (1990, 159-161) highlight cases in which virtually every indicator of self-interest had an effect: in situations with clear, substantial costs and benefits; in cases with both severe and ambiguous threats; and

differentially impacted by HIV and AIDS: we should expect those most likely to benefit from HIV/AIDS services to be more likely to prioritize these goods and services. The groups most likely to benefit from increased availability of HIV/AIDS services are people living with HIV and AIDS. The hypothesis below simply presents what a framing of HIV/AIDS services as excludable goods available to self-interested individuals would predict: those who expect to benefit will demand the good, and those who expect no benefit will demand resources be devoted to a different public policy problem.

$H1_A$ HIV-positive individuals will be more likely to prioritize HIV/AIDS services than individuals who are HIV-negative.

At the individual level, we should see HIV-positive individuals having stronger preferences for HIV/AIDS services than HIV-negative individuals. At the national level, $H1_A$ would predict countries with higher HIV prevalence to have a higher aggregate demand for HIV/AIDS services.

The literature shows the limits of pure self-interest in predicting policy preferences (Sears and Funk, 1990; Mansfield and Mutz, 2009), and I propose an alternative framework that considers social pressures as influences on policy preferences. Because attitudes are made, maintained, or modified through interpersonal processes (Erickson, 1988, 99), studies of policy preferences using only data about individuals would be incomplete. Imagine an HIV-negative villager who expresses a preference that resources be spent on HIV/AIDS programs. A simplified model assuming utility maximization using individual demographic and biomarker data would fail to predict the villager's preference: what benefit would AIDS treatment bring to a villager who knows herself to not be infected? But what if that same villager was the primary caretaker of someone sick with AIDS? Her strong and close connection

during the course of events politicizing self-interest. I find it difficult to characterize demand for HIV/AIDS services in Africa as meeting the latter criterion, but argue the former two criteria are applicable: AIDS is a severe and ambiguous threat and increasing the availability of AIDS treatment would provide a clear, substantial benefit to anyone sick with AIDS.

to someone who would greatly benefit from AIDS treatment could motivate her preference for increased AIDS resources.

Do Africans affected by AIDS have a stronger demand for provision of HIV/AIDS services than those Africans less affected by the disease? I expect relatives of HIV-positive respondents would have higher utility for HIV/AIDS services because relatives are the primary source of care for the sick. Spouses, in particular, will not just carry the burden of caring for a sick spouse, but could also have preferences for HIV/AIDS services because they expect they will also need such services in the future. I propose the following hypothesis to test whether social pressures influence policy preferences:

H1_B Individuals affected by HIV will be more likely to prioritize HIV/AIDS services than individuals who are not affected by HIV.

I operationalize “affected by HIV” two ways in this chapter: (1) whether a person knows or suspects someone close to him/her to be sick with or have died of AIDS; and (2) whether a person is a spouse, parent, or child of someone with HIV. Earlier scholarship used a broader measure, identifying AIDS-affected households “in asking not only about known AIDS cases, who are reluctant to be identified, but also about other chronic diseases that are associated with HIV/AIDS or parallel its affects” (Cross, 2002). I use more conservative definitions for the HIV-affected primarily because of the limitations of available data. At the individual level, we should see those respondents who know someone who died of AIDS demanding HIV/AIDS services more than those who have not reported someone close to them to have died of AIDS. Whereas *H1_A* proposes those who are directly affected by HIV/AIDS would prioritize HIV/AIDS services, *H1_B* proposes to test whether those indirectly affected would also prioritize HIV/AIDS services.

As caretakers of the interests of villagers, village headmen represent the lowest level of governance in Malawi. Headmen typically live in villages and thus experience the everyday

challenges of rural life alongside their villagers. What are the policy priorities of village headmen during the time of AIDS, and how are a headman's priorities shaped by his village's experience with AIDS?

H2 Headmen of villages where HIV prevalence and/or recent AIDS deaths were estimated to be high will give higher priority to HIV/AIDS services than headmen of villages with lower HIV prevalence or AIDS deaths estimates.

Evidence of village headmen demanding HIV/AIDS services in villages where HIV prevalence is estimated to be high or where a great number of recent deaths are attributed to AIDS would confirm *H2*. In the following section, I use both individual-level and nationally aggregated data to test these hypotheses.

3 Local demand for HIV/AIDS services

3.1 The Malawi case

Malawi³ is an excellent case to study local demand for HIV/AIDS services because it, unfortunately, has a mature epidemic. UNAIDS ranks Malawi eighth on the list of nations hardest hit by HIV/AIDS, with a prevalence of HIV among adults estimated at 12% (National AIDS Commission [Malawi], 2007). Life expectancy is declining in Malawi, from 46 years in 1987 to 40 years in 2005 (World Bank, 2008). Although the first AIDS case was diagnosed in 1985, only in the mid-1990s, when international donors began to provide substantial support for HIV prevention, did the Government of Malawi develop comprehensive policies and

³Malawi is a small, densely populated country of 118,484 square kilometers with a population of about 13 million (Government of Malawi, 2007). It is a land-locked country located in the southern region of Africa, bordered by Tanzania to the north, Mozambique to the East and South, and Zambia to the West. Malawi is one of the poorest nations in the world: the gross national income per capita is \$170 with almost 63% of the population living off less than \$2 a day. Almost 90 percent of Malawi's population relies on subsistence farming and poverty rates are higher in remote areas. In addition to poverty, the country has suffered recently from recurring drought and famine.

programs.

The timing of the study takes advantage of a unique opportunity to study the contemporaneous scale-up of HIV/AIDS services. Only recently has Malawi, along with other high HIV prevalence sub-Saharan African countries, responded to the international call for expansion of access to HIV testing and AIDS treatment by dramatically increasing the supply of such services (Ministry of Health [Malawi], 2005*a*; Harries, Schouten and Libamba, 2006). HIV testing first became available in Malawi in the mid-1990s but was only accessible in private health clinics and research hospitals until 2003, when it became available in government hospitals for inpatients. In 2004 and 2005, the Malawi Ministry of Health received funding from The Global Fund to scale up the availability of HIV testing and counseling to all 28 district hospitals, as well as many rural government-operated hospitals and clinics. HIV testing services are offered free of charge at government-sponsored clinics. Antiretroviral therapy recently became available in Malawi in large hospitals in the two major cities, and in 2005, access was expanded to district hospitals. In line with the World Health Organization’s goal of “universal access,” the Ministry of Health aims to have 120 public facilities and 80 private facilities⁴ providing ART services by 2010 (Ministry of Health [Malawi], 2005*b*). Table 1 below summarizes the rapid scale-up of HIV testing and ART services in Malawi in recent years.

Table 1: Scale-up of HIV/AIDS Services in Malawi

	2002	2003	2004	2005	2006
# HIV Testing Sites	70	118	146	249	351
# HIV Tests Overall	149,540	215,269	283,467	482,364	661,400
# ART Facilities	3	9	24	60	103
# New ART Patients	1,202	3,703	6,769	24,657	43,981

Source: Ministry of Health HIV Unit [Malawi] et al. (2007)

⁴As of December 2005, 23 private facilities had started providing antiretroviral therapy services heavily subsidized by the government (National AIDS Commission [Malawi], 2005, 41).

The research sites selected for the study are rural because like many other sub-Saharan African countries, more than 80% of Malawi's population live in rural areas (United Nations Development Programme, 2008). Figure 1 is a map of Malawi indicating the three research sites; each region of Malawi is represented in the study as are the three largest ethnolinguistic groups.



Between 2007 and 2009, I conducted three studies in rural Malawi to learn more about local demand for HIV/AIDS services. The first study, employing semi-structured interviews of HIV-tested villagers and their near neighbors, was conducted in 2007 in Mchinji, a rural district in central Malawi; this study was a pilot project intended to inform the design of the two later studies. The second study was part of a larger survey on families and health conducted in three districts of Malawi in 2008, asking villagers to rank public policy preferences. The third study, also conducted in 2008, queried village headmen about the most important issues facing their villages, including a duplication of the question about policy preferences asked of their villagers. In the following sections, I use the Malawi data to describe local demand for HIV/AIDS services and analyze patterns of demand.

3.2 Villagers' public policy preferences

As part of a larger project on the consequences of HIV/AIDS in Malawi,⁵ villagers were surveyed to understand how rural citizens would rank a variety of public policy priorities. The survey was conducted between June and August 2008 in Mchinji, Rumphu, and Balaka districts and the sample included 3384 women and 2631 men, of which 4183 (70%) were successfully visited by the field team. Though the original sampling strategy in 1998 was not designed to be representative of the rural population in Malawi, the sample's characteristics are very similar to those of the rural population interviewed by the Malawi Demographic and Health Surveys that covered nationally representative samples (Thornton, 2008, 1837). A number of metrics in our study capture the "HIV-affected" population: HIV status of respondents; HIV status of spouses, parents, or adult children using linked data; reported household member deaths attributable to AIDS; and suspected HIV infection or AIDS deaths of people known to the respondent. I describe each of these "HIV-affected" metrics in turn.

In 2008, 4.3% of the MLSFH respondents who completed surveys tested positive for HIV. This is likely an underestimate of HIV prevalence in our sample as 6.8% of respondents completing surveys refused to be HIV-tested. Of the 211 respondents completing the survey but refusing to be HIV tested in 2008, 17 (8%) tested positive for HIV in a previous round of the longitudinal study.⁶ I impute HIV status of respondents who refused HIV tests in 2008 using both 2004 and 2006 HIV test outcomes, resulting in a sample in which 4.6% of the respon-

⁵The larger study in which my project was embedded was the Malawi Longitudinal Study of Families and Health (MLSFH), led by demographers at the University of Pennsylvania in collaboration with the Malawi College of Medicine. The MLSFH is a six-phase longitudinal study in three regions of rural Malawi. The project's overarching goal is to investigate the role of social processes in modern family planning and HIV/AIDS and the consequences of high morbidity and mortality. To date, the MLSFH has gathered five waves of individual-level data on HIV/AIDS, sexual behavior, religion, health, and economics, including the collection of biomarkers for HIV and other sexually-transmitted infections, village-level data, data on faith-based organizations and on sexual networks. More about the MLSFH can be found online at: <http://www.malawi.pop.upenn.edu>.

⁶It is probable that additional respondents refusing to be tested in 2008 also know themselves to be HIV-positive, but were made aware of their status not by the longitudinal study; among individuals who know their status, HIV-positive individuals are four times as likely to refuse HIV testing than HIV-negative individuals (Reniers and Eaton, 2009).

dents who completed surveys in 2008 had in the past four years tested positive for HIV by the longitudinal study. In all analyses presented hereafter, HIV status is a binary measure equal to 1 if the respondent ever tested positive in MLSFH biomarker collection, 0 otherwise. Consistent with $H1_A$, I expected respondents who tested HIV-positive to prioritize HIV/AIDS programs more than those who have not tested HIV-positive.

In most cases, married respondents are linked in the MLSFH data; in fewer cases, respondents are also linked to parents or adult children.⁷ Because of marital and inter-generational linkages in the data, we can utilize the HIV biomarker data to identify a population of the AIDS-affected by denoting all those who are linked by familial connection in the dataset to someone who has tested HIV-positive. Respondents with spouses, parents, or children who ever tested HIV-positive in MLSFH biomarker collection make up 3.1% of our sample.⁸

Moving beyond sero-status of respondents and their linked-family members, we asked respondents whether they knew of someone who died of AIDS or is sick with AIDS to estimate the “AIDS-affected” population. Of the 784 respondents who reported a household death in the last two years, 85 (10.8%) of the deaths were reported to be likely or very likely attributable to AIDS, but overall, the population experiencing a household death attributable to AIDS was only 2.0% of our sample. In our sample, 3781 respondents (94.2%) report having known someone to have died of AIDS. Nearly three-quarters of respondents (2936 or 72.5%) report knowing someone who is HIV-positive. HIV prevalence is lower than the national average in our study population⁹ and household AIDS deaths are reported to affect only a small group. However, considering the number of respondents who report knowing someone to be sick with or having died from AIDS, the AIDS-affected population in

⁷In 2008, the MLSFH introduced parents of respondents into the sample. Not all parents were interviewed: dead parents and parents residing outside the village of their adult child respondent are excluded.

⁸This is an underestimate of respondents with an HIV-positive nuclear family member: it is likely that additional respondents also have HIV-positive parents and/or children but these relatives were simply not included in the study’s sample.

⁹In 2007, Malawi’s national HIV prevalence was estimated at 12%, and rural HIV prevalence was estimated at 8% (National AIDS Commission [Malawi], 2007).

rural Malawi is as significant as one could expect in the country whose HIV prevalence ranks eighth in the world. Consistent with $H1_B$, I anticipate respondents affected by AIDS are likely to give higher priority to HIV/AIDS programs. Table 2 provides summary statistics of measures of the AIDS-affected populations in the MLSFH study.

Table 2: Summary statistics: AIDS-affected variables

AIDS-Affected Variable	Count	Percent
Ever Tested HIV-Positive	194	4.6%
Recent Household Death Likely AIDS	85	2.0%
Knew Someone Who Died of AIDS	3790	94.2%
Knew Someone Who Is HIV-Positive	3040	72.7%
HIV-Positive Family Member in MLSFH	131	3.13%

Source: MLSFH 2008

The outcome variable of interest is respondents' ranking of five public policy priorities.

Respondents were read the following script:

Now, I would like to ask you your opinion on programs in this area. People have said they would like programs to improve life here in this area. Some programs that could improve life would be: more access to clean water, increased health services, more agricultural development, better education programs, and more HIV/AIDS programs. Unfortunately, the money available for these programs is very limited. If you had the chance to pick which programs were most important and which were not, how would you rank these five programs? There is no right or wrong answer; I just want to know what you think.

Respondents were then asked to rank each of the five policy preferences (clean water, health services, agricultural development, education, HIV/AIDS programs)¹⁰ in order of importance, where a score of 1 was assigned to the most important policy, 2 to the second most

¹⁰The selection of these policy choices was largely informed by my pilot study conducted in Mchinji, Malawi in 2007. The purpose of the study was to investigate local supply of and demand for HIV/AIDS services. The in-depth interview study included two groups of respondents: 30 HIV-tested Malawians and 19 of their "near neighbors," who were selected to act akin to a control group. The study's findings brought attention to the other pressing concerns faced by rural Malawians living in the time of AIDS. Even HIV-positive respondents in the study expressed preferences for clean water projects over additional HIV/AIDS services in the district. Because of the small sample size and the non-representative nature of the sample population, however, the interview study was not meant to draw inferences. Still, the findings from the pilot study are in line with findings of the later studies presented here.

important policy, and so on until a score of 5 was assigned to the least important policy. Figure 2 presents the responses as stacked histograms. Most notably, nearly half of the respondents ranked HIV/AIDS services as the least important public policy intervention among the five options. The priority ranking of HIV/AIDS programs has a mean of 3.8.

Table 3 displays results of an ordered logistic regression on the prioritization of HIV/AIDS programs. HIV status operates in the anticipated direction and is statistically significant. Respondents that ever tested HIV-positive in MLSFH data collection are more likely to give higher prioritization of HIV/AIDS services. Attribution of a recent household death to AIDS, knowing someone who is HIV-positive, or having an HIV-positive familial link in the MLSFH dataset fail to predict higher prioritization of HIV/AIDS programs; all three variables operate counter to the prediction of $H1_B$, and yet also fail to achieve statistical significance. However, if a respondent reports knowing someone who died of AIDS, the respondent is more likely to prioritize HIV/AIDS programs.

Table 3: AIDS-Affected and Prioritization of HIV/AIDS Programs

AIDS-Affected Predictor	β	Std. Error
Ever Tested HIV-Positive	-.277*	.139
Recent Household Death Likely AIDS	.323	.208
Knew Someone Who Died of AIDS	-.278*	.132
Knew Someone Who Is HIV-Positive	.119	.070
Linked Relative is HIV-Positive	.181	.170

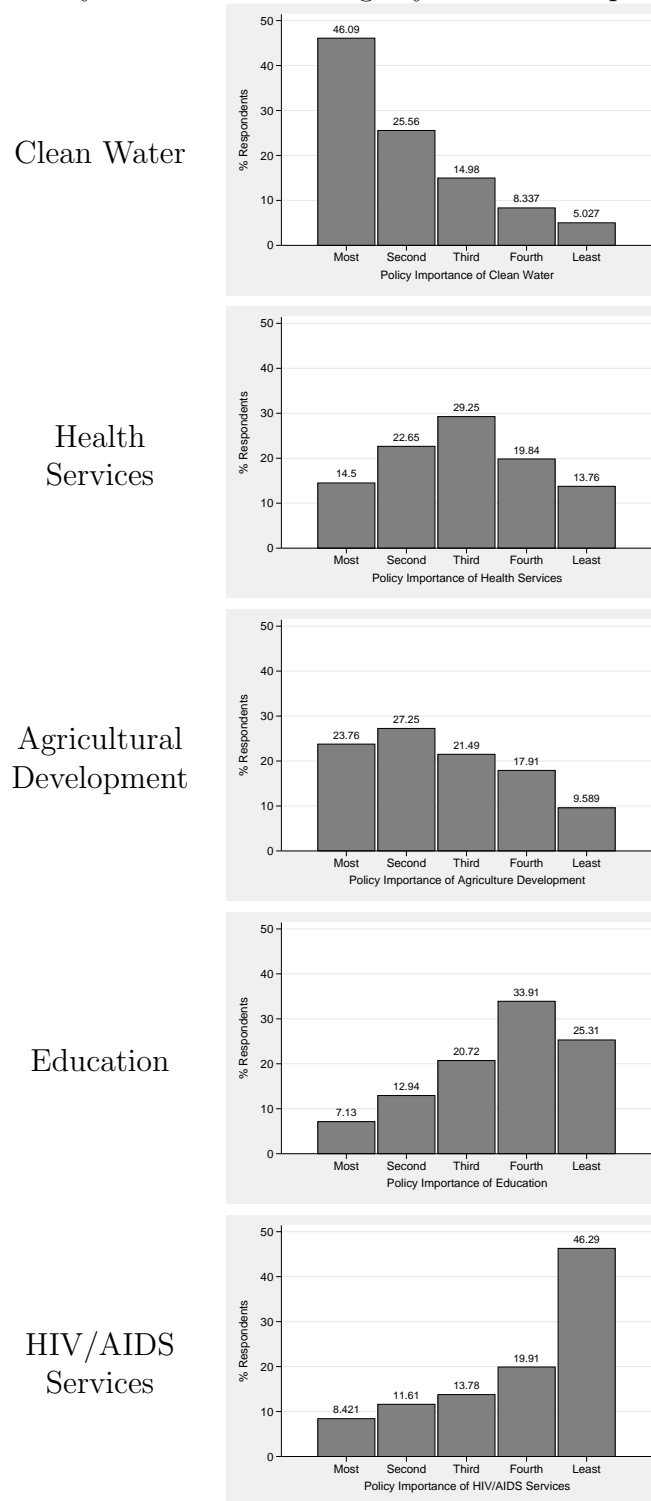
Source: MLSFH 2008

* p < .05; ** p < .01; *** p < .001

3.3 Village headmen’s public policy preferences

More than 80% of Malawi’s population lives in rural areas, where the highest authority in a village is a headman, also sometimes referred to as chief. Because in many of Malawi’s rural villages there are few public or government-supported services or infrastructure, the local headman plays an important role in shaping organization and mobilization to meet the

Figure 2: Policy Preference Rankings by MLSFH Respondents



village's needs. A considerable number of duties have been delegated to village headmen with the implementation of Malawi's Decentralization Policy.¹¹ I surveyed village headmen in three districts, one in each of Malawi's three regions: Mchinji in the center, Rumphi in the north, and Balaka in the south (N=122). Open-ended semi-structured interviews were conducted with a subset of these respondents (N=50). The advantage of studying village headmen allowed me to ask not what they want for themselves but what they want for their village. Essentially, I queried what goods and services are in highest demand at the lowest level of a "public."

The survey instrument was translated into Chichewa, Chitumbuka, and Chiyao and was administered in all villages in the study area of the MLSFH, the study from which I analyzed individual-level demand for HIV/AIDS services in the previous subsection. Enumerators were native or fluent speakers of the local languages in which the interviews were conducted. The survey was 15 pages long and interviews took 90 minutes on average to complete. When possible, appointments were made in advance and if the headman was unavailable, the research team would revisit the village on a later date. If after two attempts the headman was still unavailable, the enumerator interviewed an assistant headman or other person appointed by the headman to provide information in his absence; less than 20% of the surveys were answered by either assistant headmen or other village officials. We asked background information about the headmen, their villages, and the duties assigned to them by the government and their traditional authorities. We also asked headmen's opinions about politics and development and about their interactions with others.

We asked headmen to name the three most important issues facing their village. Responses were open-ended and coded into 20 possible categories. In summary, what we take away from the coding of the open-ended responses to this question is that access to clean

¹¹For example, as of 2008, all village headmen are required to keep records of births and deaths of all the people in their village using a government-provided register.

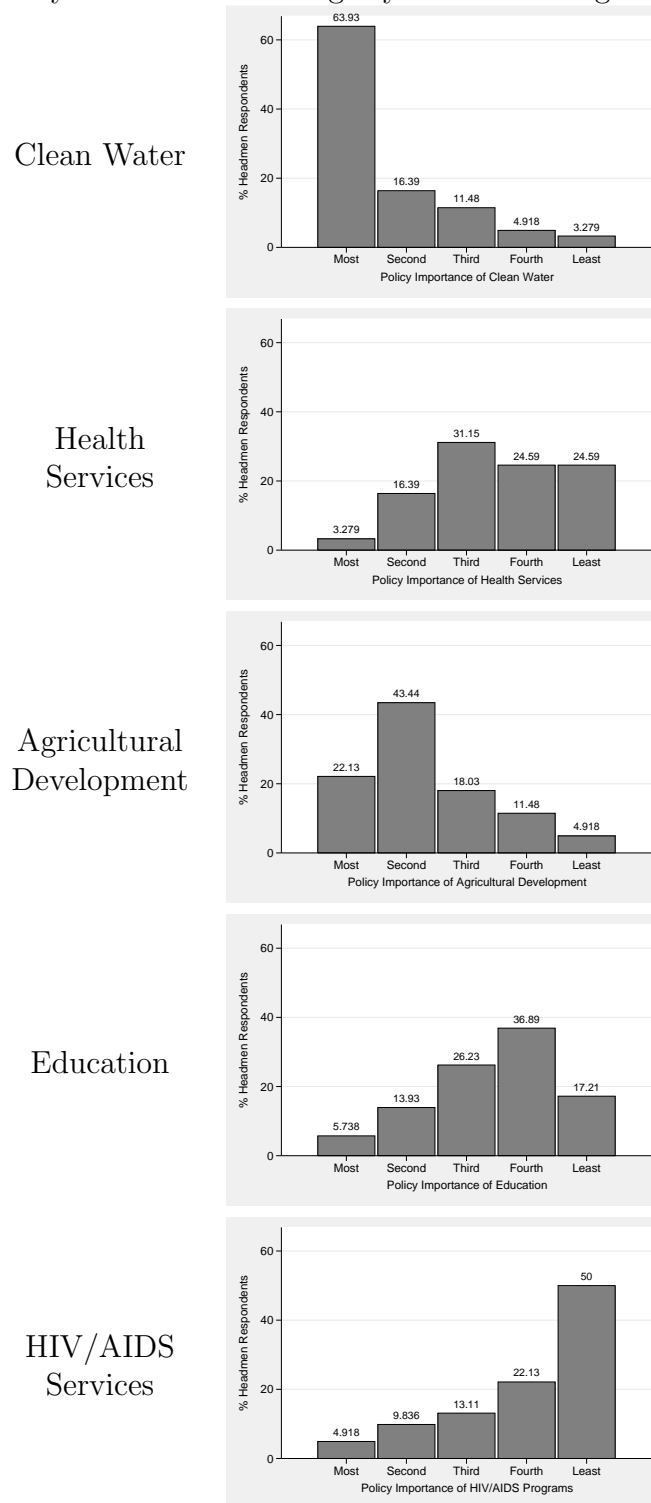
water is the highest priority. Other issues that were consistently reported as important were relevant to food security and agricultural development, diseases besides AIDS, and poverty. The data supports the other findings that HIV and AIDS are low priorities and are not typically considered among the three “most” important issues at the village level. However, it could be that the open-ended nature of the survey question failed to elicit a response relevant to HIV or AIDS services or programs. Because of this potential problem, we also asked the headmen to rank public policy priorities using the same question posed to the villagers under their care. Headmen were asked to rank preferences for: clean water, health services, agricultural development, education and HIV/AIDS programs. Their responses are captured in Figure 3.

Like the villagers surveyed by the MLSFH, access to clean water was the primary concern of headmen in our study, and HIV/AIDS ranked last among the five possible policy priorities. Health services ranked fourth most important. In the subsequent open-ended interviews we asked why. Headmen said that if there were clean water, they would not need health services. We asked, “but what about the people in your village sick with AIDS?” Responses ranged. Some headmen agreed with us that those people needed services but reminded us that even their HIV-positive villagers need clean water to stay healthy. Similarly, headmen would say that those who are HIV-affected need nourishment and thus need more inputs for their garden so that they can harvest more without having to work as hard.

Some headmen in the non-structured interviews did say that HIV/AIDS programs were important and that the people who are sick with AIDS in their villages need more. But when pressed to choose between assisting the HIV-affected and others, they ask why not provide something that will benefit everyone?

Perhaps HIV/AIDS ranks low because despite Malawi having one of the highest prevalence rates in the world, the population infected still only makes up a minority of the population, a group that is even smaller in the rural areas. Thus, if headmen thought there were

Figure 3: Policy Preference Rankings by MLSFH Village Headmen



few people with HIV in their villages, they would not prioritize HIV/AIDS services. We asked headmen to estimate how many adults in their villages were HIV-infected. Headmen's guesses about prevalence are close to reality: few are in denial about AIDS in their village and few overestimate the infection rate. Similarly, we asked what fraction of the most recent deaths could be attributed to AIDS. The average headmen guess was that 1 in 5 of the most recent deaths was AIDS-related. There was a non-negligible group of headmen who can attribute 100% of the deaths in the past year to AIDS.

Hypothesis *H2* predicts a positive relationship between a headman's estimates of HIV prevalence or AIDS deaths and his prioritization of HIV/AIDS services. However, in a logistic regression, I found that headmen estimates of HIV prevalence and deaths have no statistically significant effect on headmen prioritization of HIV/AIDS programs (results not shown). There were only six village headmen that ranked HIV/AIDS services as the most important public policy priority, and all six had estimates of village HIV prevalence and AIDS-related deaths that were below the average values in the sample. Thus, village experience with AIDS does not predict these headmen to highly prioritize HIV/AIDS.

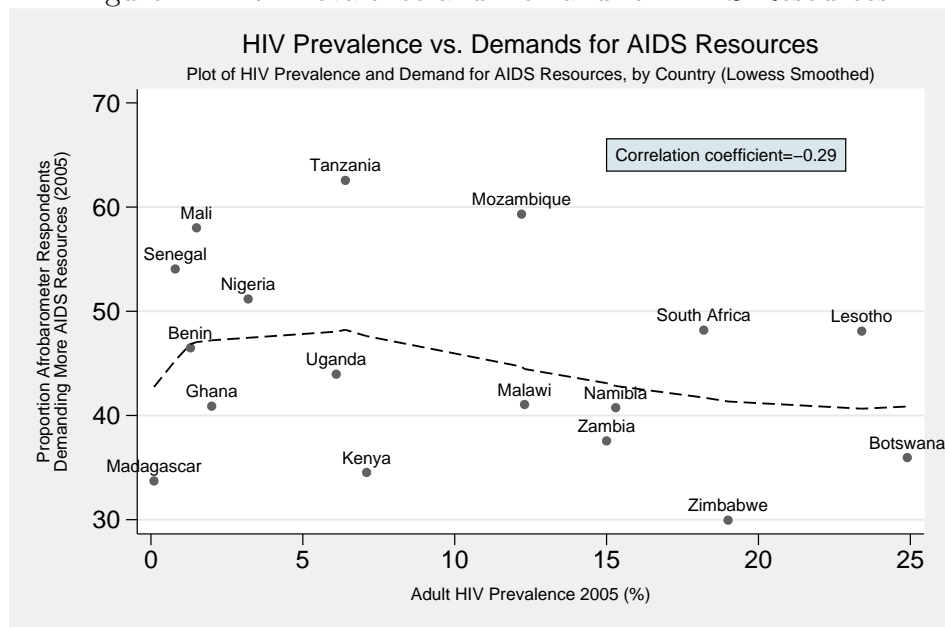
Summary of Malawi results

In the aggregate, the Malawi data demonstrate weak local demand for HIV/AIDS programs. However, at the individual level we see that proximate experience with AIDS – either being HIV-positive or knowing someone who died of AIDS – makes one more likely to prioritize HIV/AIDS programs. At the village level of governance, however, there is no evidence that village experience with AIDS can predict a headman's prioritization of HIV/AIDS programs.

3.4 Demand across Africa for devoting resources to AIDS

Low prioritization of AIDS services is not peculiar to rural Malawi. Data from the Afrobarometer¹² in 2005 show that citizens are still mixed on whether to demand more government resources be devoted to AIDS. Excepting South Africa and Lesotho, the countries with the highest HIV prevalence rates demanded resources be devoted to problems other than AIDS. Figure 4 plots the proportion of Afrobarometer respondents supporting more resources be devoted to AIDS in each country against national HIV prevalence. Higher HIV prevalence rates do not predict prioritization of AIDS resources. Data aggregated to the national level, then, fails to confirm $H1_A$ that higher HIV prevalence rates should predict greater demand for HIV/AIDS services.

Figure 4: HIV Prevalence and Demand for AIDS Resources

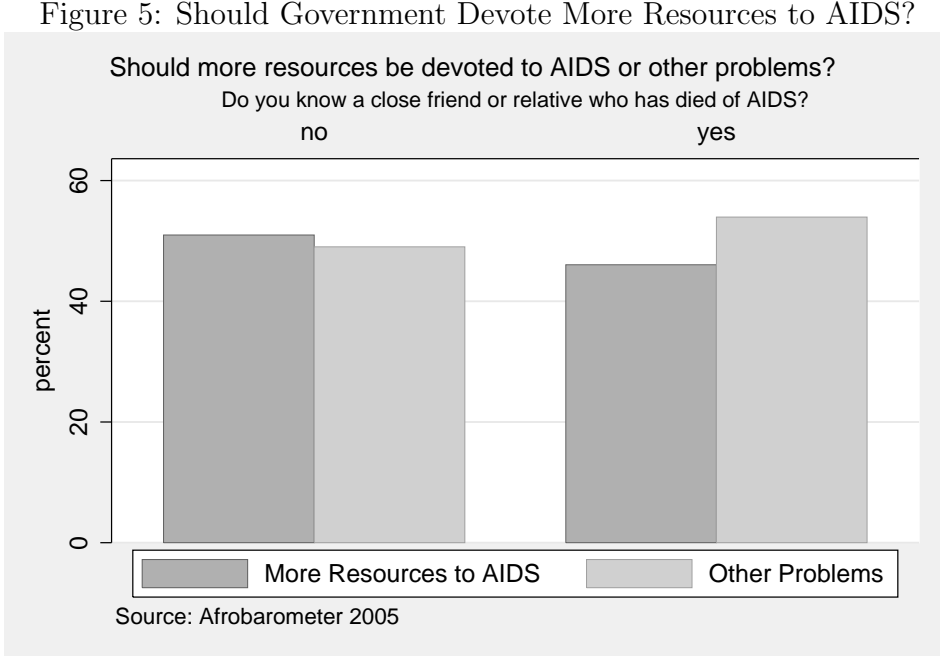


Source: Afrobarometer (2005) and UNAIDS (2008)

Afrobarometer data also allow us to test $H1_B$ if we operationalize whether an individual

¹²The Afrobarometer is a public opinion survey conducted in 18 African nations. More about the Afrobarometer can be found at <http://www.afrobarometer.org>.

was “affected by AIDS” as having reported knowing a close friend or relative who died of AIDS. Figure 5 separates responses about AIDS resources by whether the respondent knew someone who died of AIDS. Those who reported not knowing someone who died of AIDS were split on whether to devote more or fewer resources for AIDS. However, contrary to what $H1_B$ would have predicted, those who seemed to be more impacted by the disease – people who knew someone close to them who died of AIDS – were less likely to demand additional resources be devoted to combat AIDS, and were more likely to demand resources be devoted to other problems. This same result holds in each of the countries surveyed by the Afrobarometer (not shown).¹³



N=22614. Differences between groups of respondents are statistically significant.

Using nationally aggregated Afrobarometer survey data, I find that even in countries with high HIV prevalence, HIV/AIDS services have mixed demand. The data fail to confirm

¹³In some cases, country-level analysis shows a breakdown similar to the aggregated data for respondents who report not having someone close to them to have died of AIDS; in others the disparities are even wider; in Tanzania, for example, respondents not knowing someone close to them to have died of AIDS were even more likely to prefer resources devoted to AIDS (70% preferred resources devoted to AIDS, 30% to other problems).

Hypothesis $H1_A$, which predicted countries with higher prevalence will have higher demand for HIV/AIDS programs. Additionally, the individual-level data contradict the expectations of $H1_B$; those who know someone to have died of AIDS are less likely to prefer more resources be devoted to AIDS.

4 Discussion

This chapter shows demand for HIV/AIDS services is weak in Malawi and other sub-Saharan African countries with high HIV prevalence. The data was collected during the same period when international actors advocated for and began implementing a massive scale-up of HIV/AIDS services. In the rush to stem the tide of the AIDS pandemic, it seems international actors have overlooked the many other day-to-day concerns of Africans. The data demonstrate a misalignment of priorities in the global AIDS intervention. Though the supply of AIDS services is being scaled up, my analysis suggests additional supply would continue to outstrip local demand. AIDS services are a low priority among rural Malawians, and cross-national data demonstrates mixed demand for resource devotion to AIDS unpredicted by experience with AIDS.

Why do the majority of rural Malawians fail to prioritize HIV/AIDS services despite the high HIV prevalence in the country? The reader should not confuse low prioritization of HIV/AIDS services as indicative of hushed discussion about AIDS because of stigma or denial. Rural Malawians talk about AIDS in open spaces (Watkins, 2004). Additionally, data presented here show that individuals are willing to share with strangers — in this case, interviewers — that someone close to them has died of AIDS, and in the open-ended interviews, respondents frequently reported their HIV status without prompting from the enumerator. Of the 2,522 MLSFH respondents reporting in 2008 to having ever been tested for HIV, 90% shared their results with their partner and 54% shared results with friends,

relatives, and others. Could the respondents' low ranking of HIV/AIDS programs merely be an indication that respondents are unenlightened (Bartels, 2005) and not aware that AIDS is fatal or of their risk in contracting HIV? No, Malawians are very knowledgeable about HIV and AIDS. The 2004 Malawi Demographic and Health Survey reported 82% of women and 92% of men knew that a healthy looking person can have the AIDS virus; similarly, 76% of women and 85% of men know that HIV cannot be transmitted by supernatural means (National Statistical Office [Malawi], 2005).¹⁴

The study's findings might change the way of thinking about AIDS as it is experienced by rural Africans. If a villager is HIV-positive, she may want antiretroviral therapy to prolong and improve the quality of her life; however, the HIV-positive villager is especially vulnerable to tuberculosis or diarrheal diseases prevalent in sub-Saharan Africa. The HIV-positive villager may prefer spending on general health services and generally improved public health via water and sanitation projects because these alternative diseases and opportunistic infections are a major threat to her quality and length of life. Perhaps the West should not think of AIDS as a special kind of illness, but a heightened sense of the other deprivations of poverty.

The study also points out an important quality of village headmen: their general alignment with villagers in policy preference rankings. Data analysis in the following chapter more closely studies the congruence of headmen and villager prioritization, providing convincing evidence that headmen would be reliable representatives of their villagers' interests. Whatever our normative judgments about the role of chieftaincy in the democratic era, the current role and influence of traditional leaders is "widely accepted as a given" (Logan, 2009), even accepting that roles and levels of influence are variant across African contexts. Head-

¹⁴For the sake of comparison, the Malawi Demographic and Health Survey in 2004 reported 82% of women and 90% of men know HIV infection is not transmitted by food, whereas 51% of Americans surveyed by the Kaiser Family Foundation in 2009 stated they would be uncomfortable having their food prepared by an HIV-positive person (National Statistical Office [Malawi], 2005; Kaiser Family Foundation, 2009).

men live in close proximity to the intended beneficiaries of rural health and development interventions, and thus have a close-up view of what is most important or desired by their communities. The headmen in our study ranked HIV/AIDS services last, giving priority to clean water and agricultural development. I suspect headmen fail to prioritize AIDS because the disease affects so few in comparison to issues of clean water and food security, thus water and food security will continue to take precedence. However, as health and development projects supported by states and international actors employ headmen as agents of intervention, the findings here demonstrate potential for misaligned preferences between principals and agents, casting doubt on the success of such interventions.

The treatment of HIV/AIDS services as excludable goods more accurately assesses demand for HIV/AIDS services by singling out the populations that would stand to benefit the most: those who have been personally affected by HIV. Though the results suggest the importance of HIV/AIDS services among those personally affected by HIV, demand for increased HIV/AIDS services remains very low. The study thus raises important questions about the misalignment of policy preferences for AIDS intervention in Africa.

The study raises important practical and normative questions. What are the practical implications of misaligned policy preferences? Will we see diversion of resources earmarked for HIV/AIDS at the local level because villagers and their headmen disagree with international and national actors' policy choices? Will there be an underutilization of HIV/AIDS services in rural Africa because demand is so low? When there is a misalignment of priorities, whose preferences should take precedence: those of international donors, or ordinary citizens? What should be the role of public opinion in policymaking? Does the HIV/AIDS intervention in Africa simply demonstrate the power of donors and the weakness of citizens? Governments are measured on how they are responding to HIV/AIDS (Desmond et al., 2009; Lieberman, 2009, 2007; Patterson, 2006; USAID et al., 2003) but this study would question whether African governments may be doing too much, because the people are demanding

something else. It is difficult to turn away aid money, even if earmarks are dictated by donor preferences. As van de Walle (2001) points out, officials have come to view donor resources as a series of free excludable benefits to be appropriated.

Relatedly, what are the implications for democracy in African countries experiencing a generalized epidemic? The disconnect between the supply of and demand for HIV/AIDS services in sub-Saharan Africa provides an insight into two competing pressures African policymakers face in the democratic era: the preferences of international donors and the preferences of citizens. Donors provide essential resources for development and health interventions, whereas citizens are relevant for electoral purposes. Scholars debate the potential impact on state capacity of AIDS disease (Price-Smith, 2002; Ostergard, 2002; de Waal, 2003), but the intervention against the disease also has potential political costs. As young democracies in southern Africa grapple with their many development challenges, the external push for prioritization of HIV/AIDS may provide short-term benefits in the form of earmarked aid, but risk future dissatisfaction from citizens by overlooking matters more important to them.

Finally, a closer look at the policy preferences of ordinary Africans teaches us something about self-interest influencing policy preferences. In the face of an incurable disease, self-interest can predict one's preferences for allocation of public resources. However, given only a small minority population of individuals is infected with HIV, in aggregating individual preferences, we see weak demand for provision of HIV/AIDS services.

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