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

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Abstract

International agencies and national governments are rapidly scaling up HIV and AIDS interventions in sub-Saharan Africa. However, cross-national public opinion data in sub-Saharan Africa paired with survey and in-depth interviews of villagers and their headmen in rural Malawi suggest weak demand for additional AIDS services in Africa. In this chapter, I question previous characterization of HIV/AIDS services as a public good, proposing instead to use a villager's perspective to estimate demand for increased HIV/AIDS services. I test whether HIV serostatus or being affected personally by AIDS predicts variant demand for HIV/AIDS services and find that even among the people most affected by AIDS — those who are HIV-positive and those who have lost someone to AIDS — demand for increased HIV/AIDS services remains very low. Even in a high-prevalence setting, policy preferences of villagers and their headmen center on the provision of public goods, especially clean water. The data illustrate a misalignment of policy preferences in the global-to-local supply chain of HIV/AIDS interventions.

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1 Introduction

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. 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 epidemic (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 humanitarian interventions to prevent the spread of HIV and to mitigate the effects of AIDS in severely resource-constrained countries suffering from a generalized epidemic. Following the United Nations General Assembly Special Session dedicated to HIV/AIDS in 2001, where then-UN Secretary General Kofi Annan called for support for a global fund to fight AIDS, The Global Fund to Fight AIDS, Tuberculosis and Malaria was established to coordinate mutlilateral efforts against HIV/AIDS. The largest bilateral effort against HIV/AIDS in the developing world followed just a couple of years later with a $15 billion commitment by the President's Emergency Plan for AIDS Relief (PEPFAR); 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).

But do Africans living amidst the AIDS pandemic demand these services, or is the motivation to scale up HIV/AIDS services simply a Western import? Public opinion data from sub-Saharan Africa established that though concern about the HIV epidemic has risen over time, AIDS has yet to register very high on the "people's agenda" (Afrobarometer, 2004; Whiteside et al., 2004), and scholars now present data-driven arguments questioning the prioritization of HIV/AIDS intervention (Shiffman, 2008; Dionne, Gerland and Watkins, 2009; World Bank Independent Evaluation Group, 2009; England, 2007). Whereas previous scholarship assume HIV/AIDS services are a public good (Lieberman, 2009, 2007; Patterson, 2006), I consider the possibility that most HIV/AIDS services are not perceived as public goods by Africans facing the AIDS epidemic firsthand. This chapter aims to study the preference formation of ordinary Africans, looking at a relatively new public policy problem with serious implications at the individual and national level.

In this chapter I study the local demand for HIV/AIDS services during the scale-up of HIV/AIDS services in sub-Saharan Africa. Survey data and in-depth interviews conducted at the level of implementation 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.

The chapter is structured as follows: Section 2 presents a model of local demand for HIV/AIDS services and also proposes the testable hypotheses of the study. In Section 3, I present the analysis of locally collected survey and in-depth interview data with cross-national public opinion data to demonstrate weak demand for the scale-up of HIV/AIDS services. In Section 4, I conclude with a discussion of the implications of the HIV/AIDS

policy preferences misalignment.

2 Rethinking HIV/AIDS services as public goods

This chapter uses a bottom-up perspective and considers the policy preferences of intended beneficiaries of donor programs for HIV/AIDS. Accordingly, this chapter employs a theoretical framework that considers micro-level mechanisms underlying demand for HIV/AIDS services. Because previous scholarship on governmental response to AIDS employs a top-down framework, the provision of HIV/AIDS services is depicted as a public good (Lieberman, 2009, 2007; Patterson, 2006). However, from an individual's perspective, HIV testing and AIDS treatment are beneficial only to the individual seeking out a test or treatment. By definition, public goods must be non-rival and non-excludable, however, even with donor assistance, state provision of HIV/AIDS services is limited and subsequently uptake is exclusive in sub-Saharan Africa. The lion's share of funding for HIV/AIDS services focuses on AIDS treatment, a benefit enjoyed by a fraction of those who are sick with AIDS. More in line with the villager perspective then, is the consideration of HIV/AIDS services as excludable goods with variant demand across populations differentially impacted by HIV and AIDS. I aim to test whether those most affected by AIDS or those most likely to benefit from HIV/AIDS services to be the population demanding these goods and services. The hypotheses below simply present what a theory of HIV/AIDS services as excludable goods 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.

Do HIV-positive Africans and Africans affected by AIDS have a stronger demand for provision of HIV/AIDS services than those Africans not personally impacted by the disease? The study presented here tests the following hypotheses:

H1 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 would predict countries with higher HIV prevalence to have a higher aggregate demand for HIV/AIDS services.

H2 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 have died of AIDS; and (2) whether a person is a spouse, parent, or child of someone with HIV.[1] I use more conservative definitions for the

[1]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).

HIV-affected primarily because of the limitations of available data. At the individual level, we should see those citizens 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. Linked data also allow us to test at the individual-level whether being related to someone who has tested HIV-positive leads to stronger demand for HIV/AIDS services. 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.

H3 The more worried an individual is about future HIV infection, the more likely s/he will prioritize HIV/AIDS services.

Hypothesis H3 allows us to test whether individuals who consider themselves at risk of becoming infected with HIV will demand more HIV/AIDS resources. The expansion of treatment would be desired by individuals worried they might become infected in the future, subsequently requiring treatment. I use individual-level data measuring worry about future HIV infection and policy preference data to test H3.

H4 Village headmen who see HIV/AIDS as a serious problem in their villages will give higher priority to HIV/AIDS services than headmen who do not see HIV/AIDS as a serious problem in their villages.

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 H4. In the following section, I use both individual-level and nationally aggregated data to test the aforementioned hypotheses.

3 Local demand for HIV/AIDS services

3.1 Local demand for HIV/AIDS services: The case of Malawi

Malawi is a small, densely populated country of 118,484 square kilometers with a population of about 13 million (Government of Malawi, 2007). Malawi 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. Like many other sub-Saharan African countries, more than 80% of Malawi's population live in rural areas (United Nations Development Programme, 2008). 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. Life expectancy is declining in Malawi, from 46 years in 1987 to 40 years in 2005 (World Bank, 2008).

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). 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 programs. 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 facilities[2] 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)

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. 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.

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

Preferences of HIV-tested villagers and their near neighbors

The purpose of the research project was to investigate local supply of and demand for HIV/AIDS services. All interviews were conducted in Chichewa by Malawian research assistants and translated and transcribed into English by the respective interviewers. Interviews took place in respondents' homes and were conducted in private. Interviewers asked questions about personal and family health, experience with HIV testing,[3] knowledge about ART, and local health services. Interviews were semi-structured: interviewers used a guideline of proposed questions, but were instructed not to ask questions in a highly structured format. Rather, I intended for the session to resemble a conversation. Interviews lasted 25 minutes to just over an hour, with transcripts averaging 11 typed single-spaced pages in length.

Interviews were conducted alongside a study on HIV testing and treatment surveillance, led by the University of Pennsylvania and the District Office of the Ministry of Health in Mchinji District. Respondents were drawn from people tested for HIV at two hospitals in Mchinji district and one government clinic; these respondents are hereafter referred to as the Testing Attendee Sample. The sample drew from all clients who were tested in the months of November and December, 2006; the sample was restricted to these two months based on availability of consent for follow-up. The sample was truncated to include only those over 18 years of age, and those with complete identifying information from the clinic survey. We stratified the registers by testing facility, generated random numbers for each respondent, and sorted the three samples; we drew every eighth respondent on the list until we had selected 16 respondents from each facility. The research team attempted to interview a total of 44 respondents sampled from the clinic registers, however, 14 of the 44 sampled respondents could not be interviewed, because they had died, moved, were out of town or hospitalized. The remaining 30 respondents were successfully interviewed, 10 from each facility.

The study also includes a second sample of 19 "near neighbors." These were neighbors of the Testing Attendee Sample and were included so that our sample would contain individuals who were similar to our respondents but would represent something akin to a control group, having not selected into the sample by being HIV-tested. I expected near neighbor respondents to act as benchmarks for village demand for health services, where respondents from the Testing Attendee Sample were more likely than those from the Near Neighbor Sample to state preferences for additional HIV testing services in the district. Furthermore, I expected HIV-positive respondents were more likely than HIV-negative respondents or respondents unaware of their HIV status to have stronger preferences for nearby AIDS treatment services. Near Neighbors were selected during the visit to the respondent from the Testing Attendee Sample: one interviewer located the house of the Testing Attendee Sample respondent, then the other interviewer went to the nearest home in the village that was not part of the same

[3]Interviewers did not ask questions that assumed an HIV clinic visit. Questions were worded such that respondents would say what they knew or, more likely, what they "heard" about HIV testing. It was rare, however, for a respondent to not share his/her own HIV testing experience; the interviews show that those who have been to an HIV clinic tell some friends about it, not just the interviewer. Even when a respondent recounted a personal HIV testing experience, interviewers did not ask for the respondent's test results. However, of the 40 respondents tested for HIV, all but three shared their HIV status with the interviewer.

compound; the interviewer then spoke with either the man or woman of the neighboring house, and asked if they would be willing to chat about health services in Malawi. In the event that there was more than one adult at home, the interviewer asked to speak with the head of the household.

Forty-nine interviews were conducted in all: 30 from the Testing Attendee Sample and 19 Near Neighbors. The study's sample was geographically representative of the district as a whole: some respondents lived in peri-urban areas, though most were located in a variety of rural areas of the district. Table 2 below presents some characteristics of the respondents in the sample. The overwhelming majority of respondents were married (81.6%). Women also dominated the sample (79.6%). Routine testing of pregnant women attending antenatal clinics contributes to a greater number of women HIV-tested compared to men in Malawi,[4] and because the majority of Near Neighbor respondents were women of childbearing age, our study group over-represents the population in Malawi ever tested for HIV.[5] Roughly a third of the sample was HIV-positive, almost half were HIV-negative, and as for the remainder, their serostatus remains unknown.[6]

Table 2: Characteristics of Interview Respondents

		Count	Percent
Sample	Testing Attendee	30	61.2%
	Near Neighbor	19	38.8%
Sex	Women	39	79.6%
	Men	10	20.4%
Marital Status	Married	40	81.6%
	Divorced/Separated	4	8.2%
	Single	4	8.2%
	Widowed	1	2.0%
HIV Status	Ever Tested	40	81.6%
	HIV+	16	32.7%
	HIV-	23	46.9%
	Unknown	10	20.4%

N=49. Average age of respondent was 29 years old, with a median of 26, ranging from 18 to 62.

Respondents were asked what should be done to improve the health of their village. In

[4]For example, in 2006, of the 661,400 HIV testing encounters in Malawi, 289,000 were among males and 372,400 among females (Ministry of Health HIV Unit [Malawi] et al., 2007, 12).

[5]Whereas 81.6% of our sample reports to ever having an HIV test, according to the most recent Malawi Demographic and Health Survey, only 10% have been tested for HIV and know their results (National Statistical Office [Malawi], 2005).

[6]These remaining 10 respondents are from the Near Neighbor sample; of these, nine reported not having been HIV tested, and one reported having been tested but did not share his/her test results with the interviewer.

the sample, even HIV-positive respondents who had not yet been successful in acquiring AIDS treatment did not always express preferences for additional HIV/AIDS services in the district. When asked what the government could provide to make her village healthy, one HIV-positive woman said, "The most problem which we have in the village is water... If they could give us boreholes that means we can be protected" (Interview #24NN). Across the district, respondents remarked on water-borne disease as a major health problem facing their villages. When asked if the government had to choose between clean water or HIV/AIDS services in their village, these respondents all chose clean water. When asked how to improve the health of those in his village, a Near Neighbor respondent said, "Here at [respondent village], water is the main problem. We would like the government to help us. When you are used to drinking water from the borehole and then all of a sudden you start having water from the river it is so difficult... We get diseases and it is not good" (Interview #21NN).

Respondents also wanted to increase availability of clinic services in their villages. However, when asked to choose between a clinic providing HIV/AIDS services or a clinic providing general services not including HIV/AIDS services, the majority of respondents chose a general services clinic. "I can choose a hospital which gives different services on different sickness because anyone who is HIV positive or negative they both get sick with malaria so we need a hospital which can help anyone in the village" (Interview #4 - HIV-positive female not yet receiving AIDS treatment). An HIV-positive man remarked the HIV/AIDS clinics "don't give any help but are only telling us results" (Interview #20).

The interview study alerts us to the other pressing concerns faced by rural Malawians experiencing the AIDS epidemic. 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, the interview study was not meant to draw inferences about policy preference rankings during an epidemic. Rather, the findings from this pilot study informed the construction of a closed-ended survey question that asked villagers to force-rank their public policy preferences.

Villagers' public policy preferences

As part of a larger project on the consequences of HIV/AIDS in Malawi,[7] 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, Rumphi, and Balaka districts and the sample included 3,384 women and 2,631 men, of which 4,052 (67%) were

[7]The 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. The MLSFH is a five-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. The MLSFH has gathered 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`.

successfully visited by the field team. The analytical sample size for this chapter is 3,892, reduced to include only those respondents who completed the survey and had village-identifying data. 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; suspected HIV infection or AIDS deaths of people known to the respondent; and perceived risk of future HIV infection. I describe each of these "HIV-affected" metrics in turn.

In 2008, 4.2% of the respondents who completed surveys tested positive for HIV. This is likely an underestimate of HIV prevalence in our sample as 6.7% of respondents completing surveys refused to be HIV-tested. Of the 200 respondents completing the survey but refusing to be HIV tested in 2008, 16 (8%) tested positive for HIV in a previous round of the longitudinal study.[8] 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 4.5% of the respondents 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 measured as 1 for having ever tested positive in MLSFH biomarker collection.

In most cases, married respondents are linked in the data; in fewer cases, respondents are also linked to parents or adult children.[9] Because of marital and inter-generational linkages in the data, we can utilize the HIV biomarker data to ascertain a greater population of the HIV-affected by denoting all those who are linked by familial connection in the dataset to someone who has tested HIV-positive. Spouses, parents, or children of respondents who tested HIV-positive make up XX% of our sample.

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 759 respondents who reported a household death in the last two years, 83 (10.9%) 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 2.1% of our sample. In our sample, 3662 respondents (94.2%) report having known someone to have died of AIDS, and 2830 (69.8%) report having known someone to have died of AIDS in the last 12 months. Over half of our respondents (2374 or 58.6%) report having a relative who is sick with AIDS or who has died of AIDS; 2936 respondents (72.5%) report knowing someone who is HIV-positive. HIV prevalence is lower than the

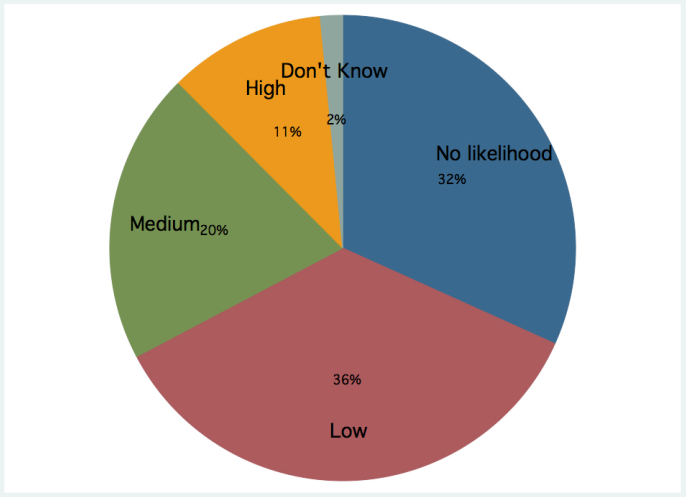
[8] It is probable that additional respondents refusing to be tested in 2008 also know themselves to be HIV-positive, but were made aware of their status not by the longitudinal study; among individuals who know their status, HIV-positive individuals are four times as likely to refuse HIV testing than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

[9] In 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. [Need to ascertain whether parents who were already in the study are also linked or were overlooked.]

national average in our study population and reported household AIDS deaths also affect only a small group. However, considering the number of respondents who report knowing someone to be infected with or having died from AIDS, the AIDS-affected population in rural Malawi is as significant as one could expect in the country whose HIV prevalence ranks eighth in the world.

Another likely predictor of demand for HIV/AIDS services is perceived risk of future HIV infection: I expect respondents who are more worried about becoming infected with HIV in the future will be more likely to prioritize HIV/AIDS services. Respondents were asked, "In your opinion, what is the likelihood (chance) that you will become infected with HIV/AIDS in the future?" Figure 1 shows the distribution of 3,886 responses to the survey question.

Figure 1: Perceived Risk of Future HIV Infection



Question: "In your opinion, what is the likelihood (chance) that you will become infected with HIV/AIDS in the future?" N=3,886. Source: MLSFH (2008).

Table 3 provides summary statistics of all available measures of the HIV- and AIDS-affected populations in the MLSFH study.

We asked respondents to rank five public policy priorities: clean water, health services, agricultural development, education, and HIV/AIDS services. Table 4 summarizes the responses. Most notably, nearly half of the respondents ranked HIV/AIDS services as the least important public policy intervention among the five options.

Biomarker data allows us to test H1 and see if HIV serostatus can predict preferences for HIV/AIDS services. I find XXXXX.

To test H2, I utilize links to HIV-positive respondents to test whether those related to someone with HIV will have a stronger demand for HIV/AIDS services. I find XXXXX. Using reports of recent household deaths attributable to AIDS provides another test of H2. I find XXXXX. Another test of H2 involves the larger sample of AIDS-affected: all respondents who report having known someone to have died of AIDS in the last twelve months. I find

Table 3: HIV- and AIDS-affected respondents in the MLSFH

AIDS-Affected Variable	Count	Percent	Analytical Sample Size
Ever Tested HIV-Positive	175	4.5%	3,888
Spouse Ever Tested HIV-Positive	83	4.1%	2,032
Child Ever Tested HIV-Positive	40	8.9%	449
Parent Ever Tested HIV-Positive			
Recent Household Death Likely AIDS	83	2.1%	3,888
Knew Someone Who Died of AIDS	3662	94.2%	3,888
Knew Someone Who Died of AIDS (last 12 months)	2823	72.6%	3,888
Knew Someone Who Is HIV-Positive	2930	75.3%	3,888
Relative Sick With or Died of AIDS	2369	60.9%	3,888
Suspects High Chance of Future HIV Infection	424	10.9%	3,886

Source: MLSFH 2008

XXXXX.

To test H3, I look at whether respondents' worry about future HIV infection can predict preferences for HIV/AIDS services. I find XXXXX.

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 village's needs. A considerable number of duties have been delegated to village headmen with the implementation of Malawi's Decentralization Policy.[10] To deal with the limitations of the short-sightedness of villager preferences, I surveyed 122 village headmen across three districts of Malawi: Mchinji in the center, Rumphi in the north, and Balaka in the south. 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 public goods 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 MLSFH sample. 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

[10]For 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.

Table 4: Public Policy Rankings

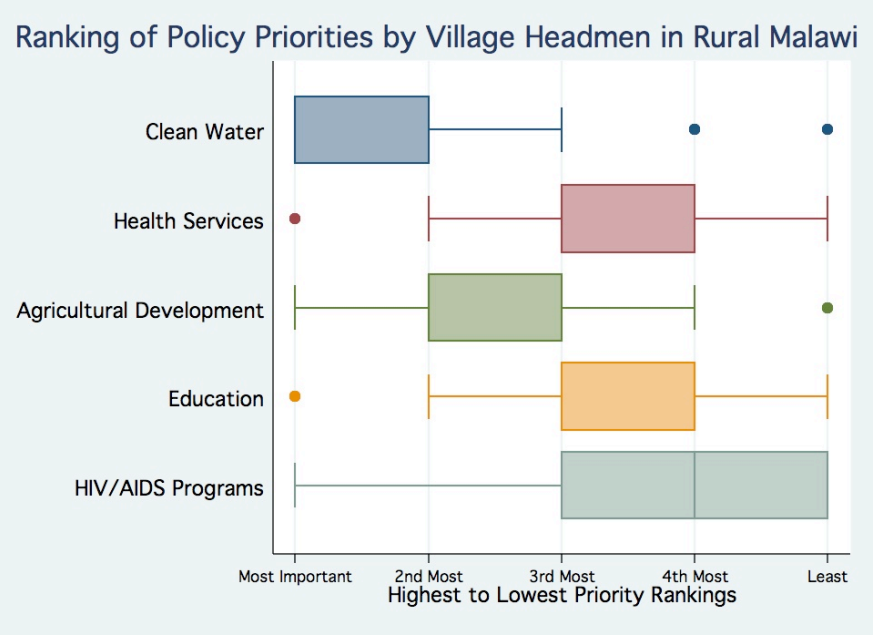
Clean Water	Count	%
Most Important	1789	46.0
Second Most Important	1002	25.7
Third Most Important	580	14.9
Fourth Most Important	328	8.4
Least Important	193	5.0
Health Services	Count	%
Most Important	569	14.6
Second Most Important	878	22.6
Third Most Important	1143	29.4
Fourth Most Important	769	19.8
Least Important	528	13.6
Agricultural Development	Count	%
Most Important	928	23.9
Second Most Important	1059	27.2
Third Most Important	834	21.4
Fourth Most Important	696	17.9
Least Important	372	9.6
Education	Count	%
Most Important	274	7.1
Second Most Important	503	12.9
Third Most Important	808	20.8
Fourth Most Important	1315	33.8
Least Important	985	25.4
HIV/AIDS Services	Count	%
Most Important	328	8.4
Second Most Important	449	11.5
Third Most Important	531	13.7
Fourth Most Important	776	20.0
Least Important	1804	46.4

N=3892; Source: MLSFH 2008

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. Responses were preliminarily coded into 20 possible categories. In summary, what we take away from the coding of the open-ended responses to the question about what are the most important issues facing your village is that water is the biggest issue. 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 the boxplots in Figure 2.

Figure 2: Headmen's Policy Priorities



MLSFH Headmen Survey (2008); N=122

Access to clean water was the primary concern of headmen in our study, whereas HIV/AIDS ranked last among the five possible policy priorities. Health services ranked fourth most im-

portant. 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.[11] Thus, if headmen thought there were few people with HIV in their villages, they would not prioritize HIV/AIDS services. We asked headmen to estimate how many adults in his village are 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 is a non-negligible group of headmen who can attribute 100% of the deaths in the past year to AIDS.

To test H4, I studied whether there was any relationship between the headmen's estimates of HIV prevalence or AIDS deaths and the prioritization of HIV/AIDS services. There were only six village headmen that ranked HIV/AIDS services as the most important public policy priority. All six headmen's estimates of village HIV prevalence and AIDS-related eaths were below the average values in the sample; village experience with AIDS does not predict these headmen to highly prioritize HIV/AIDS. Looking at all headmen in the sample, I find XXXXX.

3.2 Demand across Africa for devoting resources to AIDS

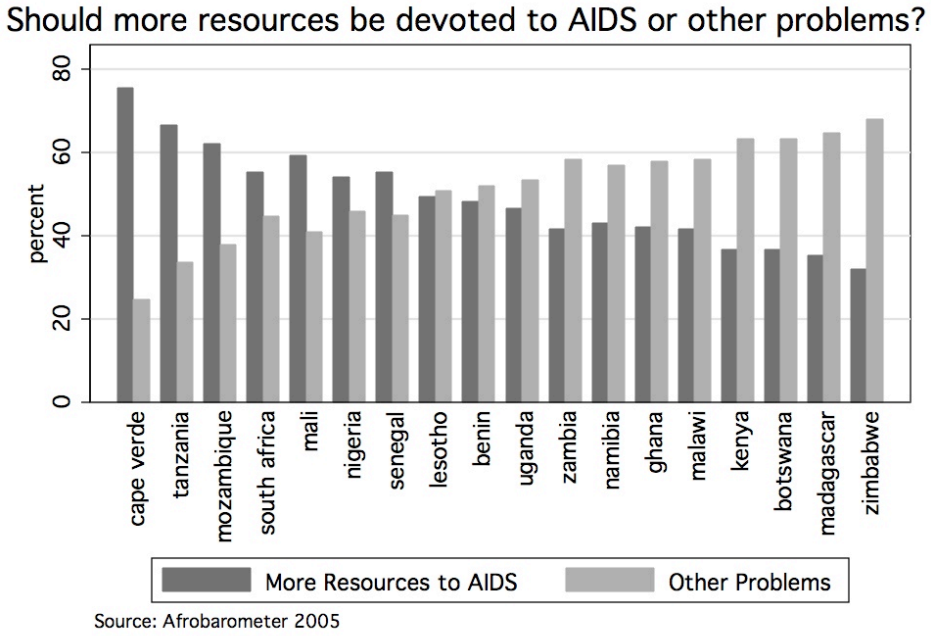
Low prioritization of AIDS services is not peculiar to rural Malawi. Data from the Afrobarometer[12] in 2005 show that citizens are still mixed on whether to demand more government resources be devoted to AIDS (see Figure 3). A few countries had respondents who demanded more resources devoted to combating AIDS, as depicted by the tall dark columns. However, countries in Southern Africa that have some of the highest HIV prevalence rates in the world — namely Zimbabwe, Botswana, and Malawi — had many more respondents state preferences for resources to be channeled to problems other than AIDS.

With the exception of South Africa, the countries with the highest HIV prevalence rates demanded resources be devoted to problems other than AIDS. Figure 4 plots the proportion

[11] The national HIV prevalence in Malawi is estimated at 12%, but rural prevalence is estimated at 8%.

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

Figure 3: Should Government Devote More Resources to AIDS?



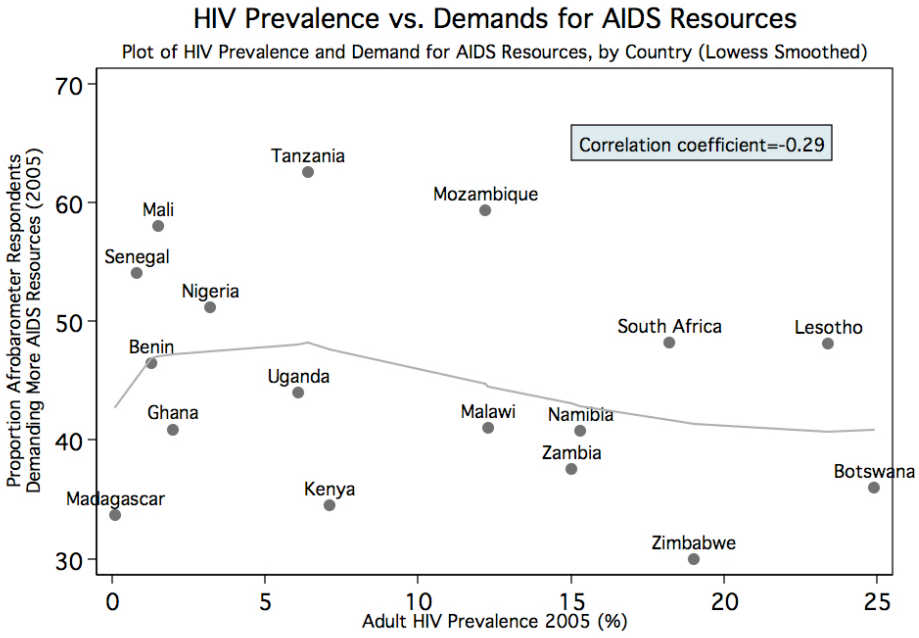
of Afrobarometer respondents supporting more resources be devoted to AIDS in each country against national HIV prevalence. Higher HIV prevalence rates do not predict prioritization of AIDS resources. Data aggregated to the national level, then, fails to confirm H1 that higher HIV prevalence rates should predict greater demand for HIV/AIDS services.

Afrobarometer data also allow us to test H2 if we operationalize whether an individual 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 H2 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. Respondents reporting someone close to them to have died of AIDS were more likely to demand resources be devoted to problems other than AIDS in each of the countries surveyed by the Afrobarometer (not shown).[13]

Using Afrobarometer survey, I find that even in countries with high national HIV prevalence, HIV/AIDS services have mixed demand, contradicting the expectations of H1. Additionally, the individual-level data contradict the expectations of H2: those who know

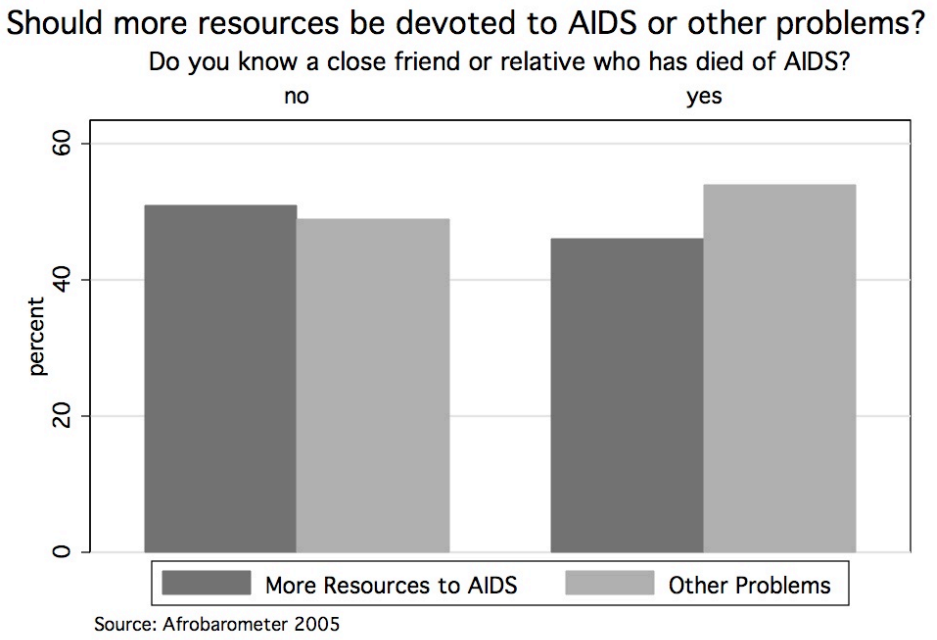
[13]In some cases, country-level analysis shows a pattern similar to the aggregated data for respondents who report not having someone close to them to have died of AIDS; in others not; in Tanzania, for example, respondents not knowing someone close to them to have died of AIDS were more likely to prefer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

Figure 4: HIV Prevalence and Demand for AIDS Resources



Source: Afrobarometer (2005) and UNAIDS (2008)

Figure 5: Should Government Devote More Resources to AIDS?



someone to have died of AIDS are less likely to prefer more resources be devoted to AIDS.

4 Discussion

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; in the rush to stem the tide of the AIDS pandemic, many international actors forget about 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 rural Malawians fail to prioritize HIV/AIDS services despite the high HIV prevalence in the country? The reader should not to 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. Of the 2,522 MLSFH respondents reporting in 2008 to having ever been tsted for HIV, 90% shared their results with their partner and 54% shared results with friends, relatives, and others. Could the respondents merely be unenlightened (Bartels, 2005), not knowing that AIDS is fatal or unaware of their risk in contracting HIV? 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 their quality and length of life. Perhaps the West should not think of AIDS as a special kind of illness, but a heightened sense of other deprivations of poverty.

The study also points out an important quality of village headmen: their congruence with villagers in policy preference rankings. Whatever our normative judgments about the

[14]For 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).

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. Headmen 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.

Even the treatment of HIV/AIDS services as excludable goods fails to show a strong demand for HIV/AIDS services among the populations that would stand to benefit the most: those who have been personally affected by HIV. The study raises important questions about the misalignment of policy preferences for AIDS intervention in Africa. First, what are the practical implications of misaligned policy preferences? Will we see diversion of resources earmarked for HIV/AIDS at the local level because 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? Second, when there is a misalignment of priorities, whose preferences should take precedence in an intervention: those of international donors, or ordinary citizens? 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 (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. In another chapter focusing on interstitial elites involved in the AIDS intervention, initial analysis suggests district officers are aware that HIV/AIDS ranks low among the public but that provision of HIV/AIDS programs and services is dictated by the interests of international donors supplying resources for development. 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. From the perspective of African policymakers, international 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.

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