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Cultural obstacles to the rollout of antiretrovirals: language, region and the backlash against AIDS funding

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This paper employs quantitative analysis to explore the issue of cultural barriers to accessing highly active antiretroviral treatment (HAART) in developing countries. It begins with an econometric analysis of potential socio-economic determinants of HAART coverage, i.e. the number of people on HAART as a percentage of the total number needing it. The analysis suggests that language fractionalisation (a widely used indicator of cultural diversity) acts as a barrier to HAART coverage, whereas ethnic fractionalisation is not significant, although politically salient ethnic divisions may be. The most important drivers of HAART coverage are: region (notably, living in the hyper-epidemic region of the Southern part of the African continent); and access to donor funding.

The effect of 'region' may, of course, be proxying for unmeasured 'cultural' variation that is not being picked up by the language and ethnic diversity variables. But it may also be picking up other imperfectly measured variables such as level of economic development and institutional strength or even unmeasured factors such as different variants of HIV. One thus cannot conclude from the fact that regional differences exist, that these have roots in cultural differences.

The question of 'cultural barriers' to HAART is usually interrogated at a domestic or local level where understandings of disease aetiology and healing, stigma, conceptions of masculinity etc can be explored (e.g. Ashforth, 2005; Nattrass 2005; Ashforth and Nattrass, 2005; Nattrass, 2008a; Steinberg, 2008). Similarly, country-level research can help shed light on how political factors, such as government leadership on AIDS and civil society mobilisation in favour of HAART, also affect the pace and level of HAART coverage (e.g. Nattrass, 2007; Robbins, 2009). Political factors are crucial in shaping access to HAART (Bor, 2007; de Waal, 2006; Iliffe, 2006; Nattrass, 2008b) but these are not immutable and can be transformed rapidly through domestic and international pressure. The same is true of cultural understandings of HIV and HAART which can change quickly in the presence of civil society mobilisation and in response to the lived experience of successful antiretroviral treatment.

This paper, by virtue of its focus on cross-country differences in HAART coverage, does not address the kinds of cultural and political obstacles that are more appropriately addressed through ethnographic research. However, the analysis highlights a potentially important over-arching cultural issue which is easily missed by country-level analysis – namely the role of donor attitudes and beliefs in shaping access to HAART. Donor funding is typically seen as an economic issue. But to understand it merely as a resource flow is to miss the importance of 'donor culture' in shaping and sustaining that resource flow.

Global funding for AIDS rose from $1.6 billion in 2001 to $10 billion in 2007 and $13.7 billion in 2009 (UNAIDS, 2008: 188; Sidibé, 2009: 4). Foreign aid through bilateral initiatives, especially the US President's Emergency Plan for AIDS Relief (PEPFAR) and multilateral initiatives such as the Global Fund to Fight AIDS, TB and Malaria, were crucial in driving HIV prevention and treatment efforts – contributing almost half of total resources for AIDS (the rest being made up primarily of government resources and private contributions). This unprecedented international effort, which resulted in the number of people on HAART in developing and transitional countries rising from a few hundred in the early 2000s to over 4 million in 2009 (Sidibé, 2009), was underpinned by a sea-change in donor attitudes. Up until 2002/3 the prevailing view in donor circles was that HAART was 'too expensive' and impossible to administer in developing countries. This orthodoxy was overturned in a remarkably rapid time by civil society mobilisation, the development of generic antiretrovirals (which lowered costs significantly), and by more sophisticated understandings of the benefits of rolling out HAART, both in terms of lives saved, health costs averted and promoting development (e.g. CMH, 2001).

Given the massive flow of international funding for AIDS, it is unsurprising that the cross-country analysis found donor support to be a key determinant of HAART coverage. Yet the very donor culture which made the international HAART rollout possible, is in the process of changing – largely because of the emerging backlash against AIDS funding. In this regard, donor culture is in danger of becoming an important cultural obstacle to HAART coverage, albeit and external one.

The second part of the paper sketches out the key arguments of the backlash, paying particular attention to the claim that 'too much' is spent on HIV and that Africans themselves agree. This assertion about what Africans believe is challenged, once again by employing quantitative analysis, by looking at opinion poll data in Africa. The analysis suggests that high levels of support exist within Africa for continued spending on AIDS, even in the presence of other challenges.

Cultural and other determinants of Cross-country HAART Coverage

As of December 2006, about a third of those needing HAART were estimated to be receiving it, although as can be seen in Figure 1, HAART coverage varied significantly across country. Why is this? What factors made it more or less likely that citizens would be able to access to HAART? Cross country regression analysis can help explore the issue by accounting for the extent to which demographic, institutional and other factors 'explain' HAART coverage (see Nattrass, 2006, 2008b).
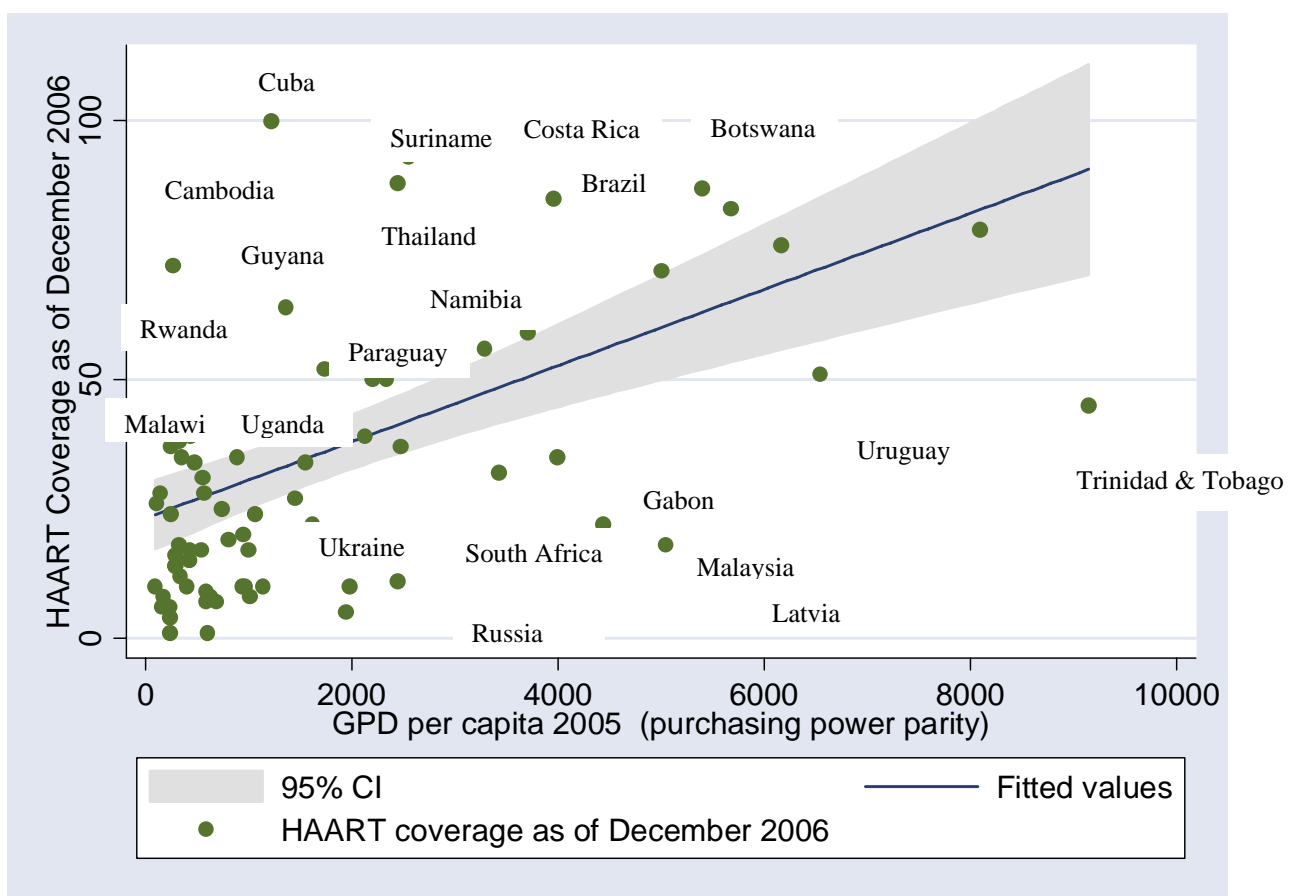

Figure 1. HAART Coverage and Per Capita Income (Source: Nattrass, 2008b)

The key economic factor constraining governments in their attempt to rollout HAART is *per capita* income, i.e. the overall level of economic development. As can be seen in Figure 1, there is a positive (but weak) relationship between *per capita* income and the level of HAART coverage. Countries above the

regression line are doing better in terms of HAART coverage than would be expected if *per capita* income was the only factor driving HAART coverage (and *vice versa* for those below the line). The recognized poor performers (e.g. Russia, Ukraine and South Africa) fall substantially below the line (suggesting that they should have achieved higher levels of coverage given their level of development), and the poster children for good performance (Cambodia, Cuba, Brazil, Malawi, Namibia, Rwanda, Thailand, Uganda) fall substantially above it. Even after controlling for other relevant epidemiological and institutional constraints, these countries retain their outlier status, thereby indicating the importance of political leadership and other country-level factors in driving HAART coverage (Nattrass, 2008b).

This section of the paper explores the extent to which HAART coverage can be 'explained' by cultural factors, such as ethnic and language fractionalization, controlling for other relevant factors. The empirical strategy is to control for the epidemiological challenges facing the countries, the economic resources available, the reach of the health sector, and institutional capacity – and then see if these broad cultural indicators matter and to what extent. A recent analysis by Lieberman (2009) argues that race and ethnicity matter profoundly with regard to AIDS policy. His over-arching theoretical hypothesis is that in the presence of politically salient ethnic boundaries, governments are less aggressive on AIDS policy because HIV prevalence may be concentrated amongst politically marginalised groups and/or because the ruling elite may not wish to draw attention to the presence of an HIV epidemic amongst its own supporters. His empirical analysis suggests that the sharper the ethnic boundaries, the worse countries perform on AIDS policy, including the HAART rollout.

A common measure of cultural diversity in cross-country analysis is 'ethnic fractionalisation' which measures the probability of two randomly selected members of a population belong to different ethnic groups. The simple linear regression model 1 presented in Table 1 of ethnic fractionalization on the (log of) HAART coverage in 77 developing countries,[1] suggests that a negative

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[1] Angola, Argentina, Barbados, Belize, Benin, Bolivia, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Chile, China, Colombia, Congo, Costa Rica, Cote d'Ivoire, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guatemala, Guinea, Guyana, Honduras, India, Indonesia, Iran, Jamaica, Kazakhstan, Kenya, Latvia, Lesotho, Madagascar, Malawi, Malaysia, Mali, Mauritania, Mexico, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Russia, Senegal, South African Sri Lanka, Suriname, Swaziland, Thailand, Togo, Trinidad and Tobago, Uganda, Ukraine, Tanzania, Uruguay, Uzbekistan, Vietnam, Zambia, Zimbabwe.

relationship exists, i.e. that the greater the degree of ethnic diversity, the lower the level of HAART coverage:

Table 1. Preliminary Regression Models on (Log of) HAART Coverage

Log HAART coverage (std)	*Model 1* Coefficient (Robust std error)	*Model 2* Coefficient (Robust std error)
Ethnic Fractionalisation (std)	-0.1841** (0.914)	0.1367 (0.1087)
Language Fractionalisation (std)		-0.4933*** (0.0924)
R-squared	0.0339	0.1744
Prob>F	0.0475	0.0000
Number of observations	77	77

* Statistically significant at the 10% level, ** at the 5% level and *** at the 1% level
Language and ethnic fractionalization from Allesina, both available from:
http://ksghome.harvard.edu/~pnorris/Data/Data.htm.

As the above variables are both standardized, the regression tells us that a one standard deviation increase in ethnic fractionalization is associated with a 0.184 standard deviation decrease in predicted log HAART coverage (and that this is statistically significant at the 5% level). However, as Model 2 shows, adding language fractionalization (the probability of two randomly selected people speaking different languages) renders ethnic fractionalization statistically insignificant. This suggests that it is language diversity rather than ethnic diversity per se which is important for HAART coverage – perhaps because it makes communication about AIDS treatment that much more complex for policy makers and health practitioners. The regression model predicts that controlling for ethnic fractionalization, a one standard deviation increase in language fractionalization leads to a 0.493 standard deviation decrease in the log of HAART coverage (and that the estimate is statistically significant at the one percent level).

The extent to which countries are able to rollout HAART obviously depends on other factors which also need to be included in the model. The regressions in Table 2 include population size, the number of HIV positive people and the percentage of HIV positive people in urban areas (to account for the fact that it is easier to rollout HAART to concentrated urban populations). The regressions also control for resource availability by including *per capita* income, the share of government spending going on health, and dummy variables for whether a

country is a PEPFAR focus country or was a recipient of a (first round) Global Fund grant.

Table 2. Regression Models on (Log of) HAART Coverage

Log HAART coverage (std)	*Model 3* Coefficient (Robust std error)	*Model 4* Coefficient (Robust std error)
Ethnic Fractionalisation (std)	-0.1110 (0.1198)	
Ethnic Boundary Index (std)		-.230966** (0.0932)
Language Fractionalisation (std)	-.3558137*** (0.1226)	-.2353201** (0.1172)
Log HIV positive population (std)	.4645577** (0.1797)	.4846413*** (0.1714)
Log population (std)	-.5453785*** (0.1397)	-.435324*** (0.1325)
% HIV population urban (std)	.1929673** (0.0732)	.1348581* (0.0746)
Log GDP per capita (std)	.1150163 (0.1823)	.2664845 (0.1902)
Pepfar focus country	.5143164** (0.2002)	.7344242*** (0.2068)
Global Fund recipient (first round)	.3409289 (0.2271)	.2500061 (0.1978)
% Govt spending on health (std)	.1986344** (0.0790)	.1839019** (0.0760)
Log non-AIDS DALYs (std)	-.1399058 (0.1867)	.095338 (0.1581)
% births skilled attendant (std)	.0333612 (0.1398)	.2258631* (0.1214)
Government effectiveness (std)#	.1240261 (0.1170)	-.0181073 (0.1185)
Southern part of Africa	-.6839112* (0.3615)	-.8948067* (0.3311)
R-squared	0.6225	0.6907
Prob>F	0.0000	0.0000
Number of observations	77	67

* Statistically significant at the 10% level, ** at the 5% level and *** at the 1% level
Ethnic and Language fractionalization from Allesina; Government effectiveness from Kaufman, both available from http://ksghome.harvard.edu/~pnorris/Data/Data.htm. Other data from data available on www.unaids.org; www.worldbank.org.

HIV is, of course, not the only health challenge facing developing countries. Countries with a heavy burden of other diseases should not be expected to have as great a HAART rollout as countries with fewer competing health challenges. In order to account for this, the number of disability adjusted life years (DALYs) lost due to non-AIDS-related reasons were included as a proxy for non AIDS-related demands on the health budget. As state capacity to deliver health services is also important, the percentage of women giving birth in the presence of skilled health professionals is included as an indicator of the capacity and reach of the health sector. Kaufman's index of government effectiveness was also added to control for overall government capacity. Finally, the models in Table 2 control for being in the hyper-epidemic region of the broadly Southern part of the African continent (South Africa, Swaziland, Namibia, Lesotho, Botswana, Mozambique, Madagascar, Malawi, Zambia, Democratic Republic of Congo, Tanzania and Angola) which have been had to cope with a long-running epidemic, with multiple clades of HIV infection and a shared history of trade and migration (Iliffe, 2006).

The regressions in Table 2 show that language fractionalization remains statistically and substantive significant after controlling for these other variables. However, other variables, notably being in the Southern part of Africa, having a large population, many HIV positive people and being a PEPFAR focus country have larger effects on predicted HAART coverage. Other statistically significant variables in both models 3 and 4 include the proportion of HIV positive people in urban areas and the proportion of government spending on health. Note that *per capita income* is not a significant determinant of HAART coverage once other variables are controlled for, and neither were either of the proxies for state capacity. This highlights once again the importance of donor funding in driving the HAART rollout.

Model 4 uses Lieberman's 'ethnic boundary index' instead of ethnic fractionalisation because this measure is sensitive to his assessment of the level of institutionalization of ethnic boundaries rather than variations in demographic diversity *per se*. As can be seen in Table 2, this variable, in contrast to ethnic fractionalisation, is statistically significant. However, its size impact is relatively small (it ranks six out of nine of the statistically significant variables in terms of the size of its impact on HAART coverage). Note also that Lieberman's measure is not available for all the countries in the sample (no measure is provided for Iran, Barbados, Belize, Kazakhstan, Egypt, Ukraine, Uzbekistan, Latvia, Russia and Suriname) – hence the number of observations falls when his variable is included. The other variables retain their importance (and the proxy for health

sector capacity, i.e. percentage of births attended by a skilled professional) becomes significant in this regression.

The above empirical analysis is, of course, far from exhaustive. Although the variables included in models 3 and 4 'explain' about two-thirds of the total variation in cross-country HAART coverage, there are clearly factors that have not been accounted for. While the attempt to measure the impact of culture is suggestive only (and very incomplete) we can be reasonably confident of the regression result that domestic government spending on health and donor support (especially PEPFAR) are crucial factors driving the HAART rollout. This brings us to the second part of the paper, namely donor culture and the current backlash against AIDS funding which appears to be changing donor attitudes and may well undermine the HAART rollout in the future.

Donor and African priorities for AIDS Funding

The HAART rollout over the past half decade has involved an unprecedented increase in donor support for health interventions, particularly AIDS. Initially motivated by concerns that AIDS would undermine development and even threaten global security (CMH, 2001), the AIDS response became increasingly shaped by solidaristic internationalist ideals. Most notably, the Global Fund for AIDS, TB and Malaria broke with the old aid paradigm that insisted aid flows be 'sustainable' (i.e. in line with what developing country governments could afford to assume responsibility for in the near future) by allocating resources in line with need (Ooms, 2008). Similarly, the World Health Organisation and UNAIDS successfully drove an international agenda for 'universal access' to HAART – a truly bold and innovative project, unprecedented in scale, scope and long-term resource commitments from rich to poor countries (Lieberman, 2009). Both UNAIDS and the Global Fund transformed development practice further by involving NGOs, civil society and patient stake-holder groups in decision-making at all levels – most notably through the country co-ordinating mechanisms through which Global Fund grants are channelled (UNAIDS, 2008; Global Fund, 2009).

In short, what we have witnessed is an important change in global development discourse and practice; or to put it differently, an important donor cultural shift which has forged new forms of global solidarity, involving and empowering a wider set of players. Yet this new culture is fragile and under threat. A counter-hegemonic discourse is on the rise which is threatening to undermine, and in important respects already has, the global AIDS response (Nattrass and

Gonsalves, 2009). This 'backlash' against AIDS-related funding claims that too many resources have been allocated to AIDS programs, particularly HAART (see e.g. Garrett, 2007, England 2007a, 2007b, 2008). Proponents claim that health systems have been harmed, money wasted and that Africans themselves believe that AIDS resources should have gone to other development initiatives (e.g. Easterly, 2006: 258).

These claims are severely over-blown (Nattrass and Gonsalves, 2009) but nevertheless appear to be hardening into stylised facts in donor circles – notably the International Health Partnership of 16 countries which channels resources for health to developing countries. Donors are increasingly arguing for the need to put resources into 'sector-wide approaches' and to reallocate foreign aid to the other millennium development goals. Although international experience has shown that the AIDS response can and has in many cases strengthened developing country health systems (e.g. Yu *et al*, 2008; El-Sadr and Abrams, 2007; Global Fund, 2009; Nattrass and Gonsalves, 2009) and that the relationship between AIDS funding and health sector impact is complex and varies across country (WHO MPSCG, 2009), the simplistic backlash against AIDS funding has not abated in donor circles. Indeed, the backlash is an emerging cultural obstacle which needs to be taken into account when thinking about the HAART rollout in developing countries.

One of the key questions is whether this external attitudinal shift meshes with opinion 'on the ground', particularly in Africa where the epidemic is concentrated. Does the backlash reflect real African priorities, or is it, once again, another donor vision imposed on recipients?

The 2005 *Afrobarometer* survey of 18 African countries asked respondents what they considered to be the three most important problems facing the country. Table 3 shows that most people cited poverty and income-related issues, with health/sickness/AIDS typically coming in third (in the total sample, poverty/famine was mentioned 18% of the time, unemployment/income 17% followed by health/sickness/AIDS 12% of the time). This tells us is that Africans worry primarily about income and food security, especially in low-income and high-unemployment situations. It does not tell us anything about their preferences for government or donor spending. To conclude that, one would need responses to a different set of questions which would probe, in addition to the scale of the problem, the relative efficacy of different interventions. The only question which probed funding priorities was the following:

"Question 66: Which of these statements is closest to your view?
- A: The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education.
- B: There are many other problems facing this country beside AIDS; even if people are dying in large numbers, the government needs to keep its focus on solving other problems."
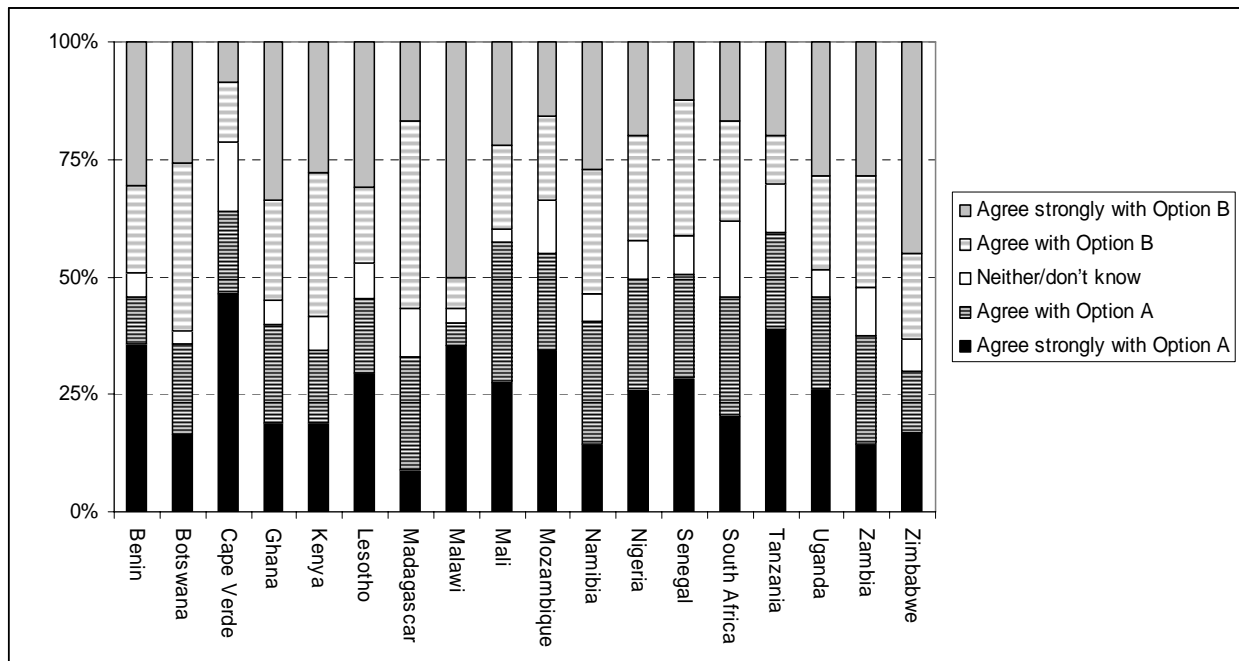

Figure 2. Responses to the Afrobarometer Survey (2005) to Question 66.

The results, depicted in Figure 2, show that most countries favoured option A (government should allocate more resources for AIDS), but that in Botswana, Ghana, Kenya, Madagascar, Malawi, Namibia, Zambia and Zimbabwe, more than 50% of respondents agreed with option B (more resources for other problems). Note that this does not mean that respondents in these countries would prefer resources currently allocated to AIDS to be removed and reallocated to other projects. That was not the question posed. Respondents were asked whether they would like *many more* resources to be devoted to AIDS (and at the cost of other programs) or if they think that the government should focus on the many other problems besides AIDS (even in the face of high mortality). This is a difficult choice and it is unsurprising that 8% of respondents overall said they supported neither option (or did not know).

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Those who did respond with a choice were effectively primed to take at least two factors into account: the scale/urgency of the 'other problems' facing the country (famine would obviously trump AIDS as it has a more immediate impact on survival) and the pressure on the government budget. As all the countries in the sample (with the exception of Lesotho and Cape Verde) were by 2005 already receiving high profile support for AIDS projects from either or both of the Global Fund and PEPFAR, it is possible (and likely) that respondents took this into account when thinking about whether their *government* should allocate more money to AIDS. If so, then respondents could have selected option B on the grounds that donors were looking after the AIDS response. In other words, support for Option B in the context of serious other problems and donor support for AIDS should *not* be interpreted crudely as support for the backlash claims that poor people think that 'too much money' in total has been or is being spent on AIDS.

Consider the case of Botswana, which, through the assistance of donors, notably PEPFAR, was by 2005 well on the way to achieving universal HAART coverage. This, coupled with persistently high levels of poverty and unemployment (see Table 3), would make it rational and understandable for respondents to direct the government to focus on other problems in the future – notably those related to poverty and unemployment. Indeed, what is, in fact, striking about the Botswana opinion data is that over a third of respondents actually selected Option A: i.e. that government should continue to allocate substantial resources to AIDS even at the cost of other programs. This probably speaks to the terrible toll the epidemic has had on the country (which has seen life expectancy decline by 31 years between 1982 and 2002 in that country).

The scale of 'other problems' is also obviously crucial in affecting the choice of option A or option B. Thus in Zimbabwe, where by 2005 the country was already in macroeconomic melt-down with high and rising unemployment, inflation and poverty, it is surprising that anyone prioritised AIDS. Yet even in the face of such a disastrous situation, where macroeconomic management, poverty and unemployment dominated the perceived problems facing the government, health/sickness/AIDS still figured in 15% of answers, and 30% of respondents selected option A (with more than half of these respondents reporting a strong preference). Again, this probably speaks to the human toll that AIDS has exacted on Zimbabwe – and to the strong desire of Zimbabweans to address health issues, even in the presence of economic collapse.

Table 3: Most Important Problems Facing Governments (Afrobarometer 2005)

Country GDP per capita, HIV prevalence (2005), total AIDS spending per HIV positive person (2007)	Most important problem (average of three responses)							Agreed with option B Quest. 66
	Poverty/ Famine (% below poverty line)*	Unemployment/ income (unemployment rate)*	Health/ sickness/ AIDS	Water supply	Economic management	Infra-structure	Education	
Benin $1,130 HIV: 1.8%, $410	8.0% (33%)	11.5% (n/a)	15.3%	10.0%	5.3%	10.4%	10.7%	49.1%
Botswana $12,154 HIV: 24.1% ; $770	15.3% (47%)	27.1% (24%)	16.4%	7.8%	1.6%	3.0%	8.9%	61.5%
Cape Verde $5,831 HIV: <1%	13.9% (30%)	29.1% (21%)	9.9%	6.3%	1.4%	3.8%	6.6%	21.5%
Ghana $2,480 HIV: 2.3%, $90	7.9% (31%)	18.9% (20%)	10.6%	8.3%	5.6%	8.9%	15.3%	54.9%
Kenya $1,240 HIV: 6.1%	14.5% (50%)	14.4% (40%)	11.4%	7.8%	5.9%	6.7%	8.7%	58.5%
Lesotho $3,384 HIV: 23.2% , $90	18.9% (49%)	23.9% (45%)	6.9%	9.8%	0.8%	8.4%	3.5%	47.0%
Madagascar $924 HIV: 0.5% , $1,200	18.3% (50%)	14.2% (n/a)	10.1%	4.0%	6.3%	10.7%	5.6%	56.6%
Malawi $669 HIV: 14.1% , $60	30.6% (55%)	5.1% (n/a)	7.5%	9.6%	3.2%	4.4%	6.2%	56.6%
Mali $1,034 HIV: 1.7%, $270	36.4% (30% urban)	6.4% (15% urban)	12.0%	9.8%	1.1%	4.8%	6.6%	40.0%
Mozambique $1,034 HIV: 16.1%, $40	14.5% (70%)	17.4% (21%)	17.2%	9.5%	2.1%	4.3%	10.6%	33.6%
Namibia $7,634 HIV: 19.6% , $620	8.2% (50%)	26.4% (35%)	11.9%	5.7%	2.5%	2.2%	11.6%	53.7%
Nigeria $1,095 HIV: 3.9% , $360	23.9% (60%)	18.7% (n/a)	4.9%	3.7%	6.2%	4.5%	7.3%	42.3%
Senegal $1,780, HIV: 0.9%, $180	17.1% (54%)	13.4% (48%)	18.0%	4.7%	3.8%	4.4%	7.9%	41.2%
South Africa $11,187 HIV: 18.8%, $110	10.5% (50%)	23.4% (26%)	13.0%	6.1%	1.9%	5.4%	4.3%	38.0%
Tanzania $707 HIV: 6.5% , $230	10.3% (36%)	6.1% (n/a)	16.7%	10.0%	2.8%	12.2%	9.5%	30.4%
Uganda $1,454 HIV: 6.7%, $220	19.9% (35%)	7.9% (n/a)	15.5%	10.3%	2.7%	5.8%	11.2%	48.5%
Zambia $1,023, HIV: 17.0%,$170	22.3% (86%)	19.8% (50%)	9.7%	8.2%	2.4%	6.2%	12.8%	52.3%
Zimbabwe $2,065 HIV: 20.1%, $100	28.9% (70%)	15.2% (70%)	7.4%	2.5%	15.2%	0.6%	2.5%	63.4%

Source: Afrobarometer (2005). Available on http://www.afrobarometer.org/data.html; data on spending per HIV positive person (2007) from UNAIDS (www.unaids.org)
*CIA Factbook (2005): http://www.umsl.edu/services/govdocs/wofact2005/

The highest level of support for Option B was in Malawi, a country plagued by poverty, famine and unsafe water supplies (Dionne *et al*, 2009). This was reflected in the *Afrobarometer* finding that poverty and famine was the overwhelmingly largest concern (30%), followed by water supply (10%) and health/sickness/AIDS (8%). Does this mean, that we can conclude, as does a recent paper, that 'Malawians, like the critics of AIDS exceptionalism, would prefer fewer resources be allocated to AIDS and more to other critical day-to-day problems' (Dionne *et al*, 2009: 11)? No. Respondents were not asked if the AIDS response should be scaled down. They were only asked about their priorities, and they may well have taken the current level of spending on AIDS as a given. At most, the data can be seen as indicating that at the margin, Malawians would prefer additional resources to be spent on providing safe water, food security etc. The data probably tell us more about the scale of other problems in Malawi than they tell us about whether 'too much' or 'too little' is spent on AIDS.

Indeed, given that AIDS-related spending (from all sources) per HIV positive person in Malawi is the third lowest in Africa (Chad and Mozambique are the only countries with lower levels), it would be bizarre to conclude that 'too much' is spent on AIDS in Malawi. According to the most recent UNAIDS estimates, the average spending from all sources on AIDS per HIV positive person in Malawi was $60, less than a quarter of the average for Sub-Saharan Africa (www.unaids.org) - see Table 3. Rather, the development challenge is to find additional development resources for the country rather than to cut the already relatively low levels of AIDS spending in the country.

Conclusion

There are obviously many cultural obstacles to the rollout of HAART. These include rival conceptions of illness and healing, stigma, shame – all of which undermine both the demand for HAART and appropriate adherence to treatment regimens. This paper has not reviewed such obstacles. Rather, it attempted to explore the relative importance of measurable cultural factors in shaping cross-country HAART coverage. The paper found that donor funding was a crucial factor, and hence drew attention to the recent backlash against AIDS funding – arguing that it poses an important 'external' cultural threat to the HAART rollout. Despite claims to the contrary, the paper shows that although Africans face many problems, particularly pertaining to food security and poverty, health remains high on the agenda, especially in the hyper-epidemic countries of Southern Africa.

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