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National poverty reduction strategies and HIV/AIDS governance in Malawi: A preliminary study of shared health governance

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ABSTRACT

The public health and development communities understand clearly the need to integrate anti-poverty efforts with HIV/AIDS programs. This article reports findings about the impact of the Poverty Reduction Strategy Paper (PRSP) process on Malawi's National HIV/AIDS Strategic Framework (NSF). In this article we ask, how does the PRSP process support NSF accountability, participation, access to information, funding, resource planning and allocation, monitoring, and evaluation?

In 2007, we developed and conducted a survey of Malawian government ministries, United Nations agencies, members of the Country Coordination Mechanism, the Malawi National AIDS Commission (NAC), and NAC grantees ($N = 125$, 90% response rate), seeking survey respondents' retrospective perceptions of NSF resource levels, participation, inclusion, and governance before, during, and after Malawi's PRSP process (2000–2004). We also assessed principle health sector and economic indicators and budget allocations for HIV/AIDS.

These indicators are part of a new conceptual framework called *shared health governance* (SHG), which seeks congruence among the values and goals of different groups and actors to reflect a common purpose. Under this framework, global health policy should encompass: (i) consensus among global, national, and sub-national actors on goals and measurable outcomes; (ii) mutual collective accountability; and (iii) enhancement of individual and group health agency. Indicators to assess these elements included: (i) goal alignment; (ii) adequate resource levels; (iii) agreement on key outcomes and indicators for evaluating those outcomes; (iv) meaningful inclusion and participation of groups and institutions; (v) special efforts to ensure participation of vulnerable groups; and (vi) effectiveness and efficiency measures.

Results suggest that the PRSP process supported accountability for NSF resources. However, the process may have marginalized key stakeholders, potentially undercutting the implementation of HIV/AIDS Action Plans.

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Introduction

Both the public health and development communities are now keenly aware of the need to integrate policies to combat HIV/AIDS and poverty simultaneously. One approach is linking poverty reduction policies such as the Poverty Reduction Strategy Paper (PRSP) process with national HIV/AIDS programs. With a gross national product (GNP) per capita of roughly \$160 in 2004, Malawi ranks among the world's five poorest countries; when global purchasing power parity is taken into account, Malawi ranks second in poverty only to Sierra Leone (World Bank, 2006).

Moreover, Malawi has one of the lowest life expectancies worldwide due primarily to HIV/AIDS, dropping to just 37 years in 1996, and climbing back up to 43 in 2000/1 (National Statistics Office [NSO] of Malawi, 2006). One of the world's poorest countries and one of the most devastatingly stricken by HIV/AIDS, Malawi has HIV prevalence rates of 25% and 11% in urban and rural areas respectively (International Monetary Fund [IMF] & World Bank [WB], 2007), and national adult HIV prevalence rates ranging from 11.8% in 2004 (Government of Malawi [GoM], 2005) to 14.1% in 2005 (USAID, 2009, http://www.usaid.gov/our_work/global_health/aids/Countries/africa/malawi.html) to 11.9% in 2007 (UNICEF, n.d., http://www.unicef.org/infobycountry/malawi_statistics.html). Malawi is thus a prime target for such integrated efforts (IMF & WB, 2000). Malawi's poverty also made it an ideal candidate for external debt relief under the Highly Indebted Poor

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Countries (HIPC) Initiative, the World Bank (WB) and International Monetary Fund's (IMF) international poverty reduction policy to relieve debt and provide low-interest loans to poor countries in return for national governments' commitment to specified economic and governance milestones.

In December 2000, the IMF and WB Executive Boards approved US \$643 million in HIPC debt relief for Malawi. Conditions included: (i) preparing and implementing a full PRSP for one year by 2003 and (ii) "making progress in implementing the National AIDS strategy [NSF], in particular [a] fully staffed, functional and autonomous National AIDS Control Secretariat, and implement[ing] an effective Behavior Change Communication Strategy, among others" (African Development Fund, 2001, p.2). One component of the quid pro quo for Malawi's debt relief was the government's commitment to national policies to address HIV and AIDS country-wide. Malawi's PRSP process was thus to include the government's plan to combat HIV/AIDS. Although PRSP was stipulated as a HIPC requirement, it can also be seen as an opportunity for leveraging the PRSP process to improve HIV/AIDS programming. Significant debt service is a major impediment to adequate investments in health, and debt relief can therefore free up resources to increase public health sector spending. In Malawi, for example, an annual average reduction in debt services obligations of \$52 million (2000–2010) was equivalent to roughly 38% of 1998 social sector spending (Tan, Soucat, & Mingat, 2001). As stipulated in the Malawi Decision Point Document for the Enhanced HIPC Initiative, to receive 100% debt service relief, the Malawi government had to meet certain completion point triggers, which for HIV/AIDS meant advancing the National AIDS Strategy [NSF], including a fully operational and independent national AIDS control body (IMF & WB, 2000). Through the PRSP process, which involves consultation with key stakeholders as the Decision Point Document noted, the Malawi government committed itself to "slowing the spread of HIV/AIDS." (IMF & WB, 2000, p.26).

To provide the prerequisite operational basis for HIPC debt relief, Malawi embarked on the development and implementation of its Poverty Reduction Strategy Paper (PRSP) process. Unlike the Structural Adjustment Programs (SAP) that came before, governments in low-income countries prepare PRSPs through a process engaging domestic stakeholders, related institutions, and external development partners. Their goal is to delineate the "macroeconomic, structural, and social policies and programs" a country will advance to "promote growth and reduce poverty" (IMF, 2009). The approach's five core principles are that it be country-driven, result-oriented, comprehensive, partnership-oriented, and long term. And unlike the SAPs, the PRSP process specifically seeks country-developed and country-led participatory strategies to reduce poverty (IMF, 2009; Peabody, 1996). It views enhanced participation as both normatively superior to prior approaches and potentially more effective in formulating and implementing development projects successfully. It anticipates more solidified national ownership, improved governance of public programs, and increased funding (AFRODAD, 2003). The Malawian government received support especially from the United Nations Development Programme in its effort to allocate 30% of debt relief savings to HIV/AIDS prevention and mitigation strategies (UNDP, n.d.).

The Malawi PRSP was one of the principal development planning instruments in the country, categorizing activities and policies into a "coherent framework for poverty reduction" (Bwalya, Rakner, Svasand, Tostensen, & Tsoka, 2004, p.10). The strategy was constructed around "four strategic pillars": sustainable pro-poor economic growth, human capital development, improvement in the quality of life of the most vulnerable, and good governance (GoM, 2002, p.19). Through its PRSP process, the Malawi government identified HIV/AIDS as a central problem in all four priority

areas that threatened previous development gains while undermining all efforts to fight poverty (GoM, 2002). HIV/AIDS required urgent attention and became a major cornerstone of Malawi's PRSP process with a particular focus on resourcing NSF adequately and implementing the HIV/AIDS action plan successfully (Bor, 2007). The Malawi PRSP included a Thematic Working Group focused solely on HIV/AIDS that covered the following issues: "reducing HIV/AIDS prevalence rates", "reducing HIV transmission through awareness, education, distribution of condoms, etc", "increasing access to appropriate drugs", "improving the lives of those living with HIV/AIDS", and "mainstreaming HIV/AIDS issues" (GoM, n.d.). The PRSP process sought to increase funding for the NSF, the national response to the HIV/AIDS epidemic from 2000 to 2004 (GoM, 2002), and to improve governance and participation deemed critical for NSF implementation.

The NSF had three main objectives: (i) reduce HIV and AIDS incidence; (ii) improve the quality of life of HIV-infected individuals; and (iii) mitigate the economic and social consequences of AIDS (GoM, 2002, p.87). The first objective targeted youth, viewing this population as one of the most vulnerable, with a focus on preventing HIV infection among children in school (GoM, 2002). The NSF was to be participatory, especially involving individuals and groups representing people living with HIV and AIDS (PLWHA). The NSF also established the National AIDS Commission (NAC) in 2001 to achieve an expanded multi-sector response to the HIV/AIDS epidemic. The National HIV and AIDS Policy was launched in 2003, with an emphasis on consultation with civil society groups, non-governmental organizations and PLWHA, to offer guiding principles for national HIV/AIDS prevention and treatment programs (UNAIDS, n.d.).

This study sought to examine the PRSP process's impact on the resources for and implementation of the Malawi National HIV/AIDS Strategic Framework and accompanying policies, as well as HIV/AIDS program governance. With an increasingly multi-faceted national response, UNAIDS has identified collective accountability and better engagement of civil society in national policy discussions as two key challenges in Malawi (UNAIDS, n.d.). Specifically, this study sought to assess whether the PRSP supported the NSF by improving resource levels while developing and strengthening good governance and participation (particularly among those most affected and marginalized by HIV/AIDS), all of which are critical for NSF success. Moreover, it sought to address a major controversy in HIPC policy — the concern that additional resources freed up by debt relief will have limited effectiveness due to poorly managed and governed HIV/AIDS programs (Easterly, 2001; Gunter, 2002; Varma, 2006). Particular concerns focus on the lack of integration of HIV/AIDS into PRSPs, a lack of costing and monitoring provisions, and the fact that IMF public spending ceilings imposed on countries limit the increases in funding resulting from PRSPs and donor initiatives (Bonnell, Temin, & Tempest, 2004; Weaver, 2004). We therefore asked respondents directly about their views on the effectiveness and efficiency of HIV/AIDS resource use in Malawi. Previous studies have focused on the relationship between HIV and PRSPs and subsequent impact on the epidemic, and/or the process of integrating HIV into PRSPs. Few, if any, have examined the issue from a governance perspective and as a mechanism for enhancing governance of the HIV response.

Global health governance as shared health governance

In this study we sought to develop and empirically test certain indicators of a new conceptual framework for global health governance called *shared health governance* (SHG). SHG rests on the notion that in a joint enterprise among global, national, and sub-national communities, business as usual — self-interested

maximization through a rational actor model of governance (Ruger, 2007) — is not only normatively unappealing but unsustainable, because it makes cooperation and complementarity difficult. Thus, rather than have a set of competing interests and contrasting goals, SHG puts forth a framework for congruence among the values and goals of different groups and actors. It envisions full knowledge and mutual understanding of objectives, as well as agreement on indicators for evaluating a common purpose. Outcomes that global, national, and sub-national actors achieve depend on their individual actions, which, as argued elsewhere (Ruger, 2007), if informed by self-interest alone rather than common goals, can lead to suboptimal results and wasted resources. Cost management and efficiency are integral parts of good shared health governance. Theoretical and conceptual development of the SHG model and its comparisons with other forms of health governance are beyond the scope of this article and discussed elsewhere (Ruger, 2007, *in press*). Succinctly, however, under the SHG framework, global health policy should reflect (a) a consensus among global, national, and sub-national actors on common goals and measurable outcomes; (b) mutual collective accountability (e.g. for resource use, implementation, and results); and (c) health agency-enhancing processes. The “health agency” concept has been developed and discussed extensively elsewhere and has been defined as the ability to achieve health goals that one values and act as agents of one’s own health either individually or collectively (Ruger, 2008, 2009). Indicators and questions developed to assess these ideas empirically included: (i) goal alignment; (ii) knowledge and mutual understanding of key outcomes and principle indicators for evaluating those outcomes (consensus about the use of indicators and the statistics that measure these indicators and their implications); (iii) adequate levels of resources (human and financial); (iv) effective, efficient resource use for priority areas; (v) meaningful inclusion and participation of key global, national, and sub-national groups and institutions; and (vi) special efforts to ensure participation of key vulnerable groups most affected by policy decisions (e.g. the poor, women, youths, persons with disabilities, and the elderly). We developed a survey to examine these dimensions.

In our study, while we collected “objective” data on resource levels (records of resources), we were particularly interested in survey respondents’ *perceptions* in terms of these indicators. We also designed our survey questionnaire to confirm or update the available documented records. Our questions sought to uncover knowledge and mutual understanding of key outcomes and principle indicators for evaluating those outcomes. Our study thus dovetailed with the distinctions made in the governance and law literature between: (i) *de jure* (e.g. laws, policies, or official rules in writing or “on the books”) and *de facto* (e.g. actual practice, implementation, impact and conditions on the ground) measures of governance, and (ii) polling experts (within and across countries) and representative surveys of key informants. “*De jure*” is rules-based and captures formal rules, institutions, and processes, whereas “*de facto*” is outcomes-based and measures what is relevant and of interest to stakeholders. More informally, the distinction between “*de jure*” versus “*de facto*” can be interpreted as a comparison between “what is supposed to be done” versus “what is actually done.” The *de jure*-*de facto* distinction at least partly, although not perfectly, reflects the difference between the objective and the subjective, and in this study we collected data on both objective and perception-based (subjective) indicators. We surveyed a comprehensive sample of key participants in both the PRSP and NSF processes across the governmental and non-governmental spectrum. Thus, while we captured “*de jure*” elements, our primary concerns were with “*de facto*” measurements.

This study develops and empirically tests several analytical components of a shared health governance model. It also seeks to

understand whether the PRSP process helped to foster the conditions for shared health governance of HIV/AIDS in Malawi. We accomplished these goals by examining key stakeholders’ perceptions about PRSP’s impact to assess whether this process satisfied features of the shared health governance framework we define in this study.

Methods

The project collected data by two methods: (i) a retrospective review of budget allocations and health, social, and economic indicators, and (ii) face-to-face interviews with key informants.

Data sources

Budget allocations and health, social, and economic indicators

Data on budget allocations came from the Government of Malawi *Draft Estimates of Expenditure on Recurrent and Capital Accounts*. Sources included: Budget Document No.4 (Financial Years 1998/99, 1999/2000, 2000/01, 2001/02, 2002/03, 2003/04, 2004/05, 2005/06 and 2006/07) and Economic Reports (1998–2005) from the Ministry of Finance, the Library and Ministry of Economic Planning, and the Resource Center at Capital Hill and Lilongwe, Malawi (GoM, 1998–2009; Ministry of Economic Planning and Development, 1999–2005). Key HIV data came from the databases of the World Health Organization, World Bank, United Nations Children’s Fund, United Nations Joint Programme on HIV/AIDS, United States Agency for International Development, Centers for Disease Control and Prevention, Global Fund for HIV/AIDS, Tuberculosis, and Malaria, and MEASURE. Economic and social data came from the World Development Reports (2000–2005), the Malawi National Economic Council Reports (2000–2005) and the final draft of the Malawi PRSP (2002) itself (WB, 2000–2005; GoM, 1998–2005; GoM, 2002). We collected data to cover the time period before, during, and after the implementation of the PRSP. The face-to-face interviews covered the same time period (2000–2004).

Face-to-face interviews

Rather than conduct a general public opinion survey, we pursued a more targeted approach and sought data from key representatives of governmental and non-governmental organizations involved in (and thus having first-hand knowledge of) the PRSP and NSF processes, and the effect of the former on the latter. Face-to-face interviews with key informants used a standardized questionnaire we developed. Each interview, conducted by an enumerator, sought to confirm or update the available documented records as well as provide information on perceptions of resource levels, participation, and governance for the Malawi HIV/AIDS NSF before, during, and after the implementation of the PRSP (2002). Four enumerators were selected by one of the co-authors based on their previous experience in conducting community surveys and their demonstrated understanding of the study protocol and how to correctly administer the study questionnaire. The enumerators were local Malawians trained in the study protocol, including study aims.

Sample. To minimize selection bias, the sample universe from which we selected our interview subjects encompassed individuals representing the different perspectives on PRSP’s impact on NSF implementation. The sample universe included the following groups: Government of Malawi ministries; all United Nations agencies in Malawi who are members of the Country Coordinating Mechanism (a country-level partnership institutionalized to develop grant proposals to the Global Fund for AIDS, Tuberculosis,

and Malaria (Global Fund) for national priority health care needs); the National AIDS Commission (NAC); and all organizations that received NAC grants since its inception, including organizations supported by the earlier National AIDS Control Programme in the Ministry of Health and Population. Most representatives of these groups held positions of Director (or Deputy or Executive Director), Programme Officer, Chief, Head, or Advisor. We therefore were able to survey respondents representing the different sides or viewpoints in these decision-making and implementation processes. We reiterate, however, that our sample represents only the above delineated universe of groups.

The survey was administered in 2007 to all eligible individuals from this universe for a total potential sample size of 139 people ($N = 139$), out of which there were 125 respondents, a survey response rate of 90%. Informants were included as respondents if they answered at least one question on the questionnaire. The sample was not randomly selected.

Questionnaire. The study questionnaire consisted of three parts designed to cover 2000–2004 and was completed by an enumerator in a face-to-face interview with the respondent. Part I asked informants about the period prior to PRSP implementation. Section 1 of Part I asked about the alignment of goals and objectives between the respondent's ministry/agency/organization's HIV/AIDS Action Plan and the Malawi NSF. Section 2 asked respondents whether, in their view, the human and financial resources allocated for their ministry/agency/organization's HIV/AIDS Action Plan were adequate to implement it successfully. We were then able to compare these responses to the actual cost figures obtained from the final PRSP. Section 3 asked about key HIV and economic and social indicators – both HIV indicators and major general economic and social indicators for the period of 2000–2002. These indicators included: poverty headcount based on the poverty line, GDP per capita, literacy rate, life expectancy, maternal mortality, infant mortality, HIV prevalence rate, the percentage of HIV-infected women and men aged 15–24, the percentage of HIV-infected adults and children still alive 12 months after initiation of anti-retroviral therapy, the percentage of young people aged 15–24 reporting consistent use of condoms with non-regular partners, the number of people counseled and tested for HIV including provision of HIV test results, the number of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce mother-to-child transmission (PMTCT), and the number of people benefiting from community-based programs. These questions sought to uncover knowledge and mutual understanding of key outcomes and principle indicators for evaluating those outcomes. Part III of the survey, which referred directly to the post-implementation period of the PRSP, asked these questions again. Parts I and III aimed to elicit respondents' perceptions of the changes in the goals, objectives, priorities, resources and major indicators in the pre-and post-implementation phases of the PRSP process.

Part II of the survey focused on the PRSP process itself and on identifying critical linkages between PRSP development and the NSF. Question 1 of Part II collected data on access to information and asked interviewees whether, in their opinion, their ministry/agency/organization's access to information necessary for effective participation in the PRSP process was adequate or inadequate, and whether there was a change in such access to information. Question 2 concerned inclusion and participation, and asked interviewees whether they thought their ministry/agency/organization's inclusion and/or participation in PRSP development was adequate or inadequate, and whether or not there was a change in participation in the course of the PRSP process. Question 3 sought responses about vulnerable populations and asked interviewees if, in their opinion, participation of key groups vulnerable to HIV infection and

affected by AIDS (for example, the poor, women, youths, the elderly, or people with disabilities) was adequate or inadequate and whether their participation had changed as a result of the PRSP process. Question 4 sought feedback from respondents on prioritization and resource allocation and asked them whether, from their perspective, resourcing for NSF-defined priorities had improved, deteriorated, or experienced no change as a result of the PRSP process.

Finally, Section 4 of Part III of the questionnaire consisted of three questions. Question 1 asked respondents whether, after PRSP implementation, they thought the effectiveness and efficiency of resources expended for key HIV/AIDS priorities under the NSF improved, stayed the same, or deteriorated. Question 2 asked whether, in their view, the NSF goals had been met. Question 3 focused on accountability, asking respondents whether they thought that, after PRSP implementation, accountability for resources and results had improved, stayed the same, or deteriorated.

For each section of the questionnaire, the interviewer asked respondents whether they wished to elaborate or comment on these quantitative assessments. In many cases, the qualitative evaluations added context and depth to the responses. The questionnaire was not terribly long and was also quite straightforward, which, in addition to personal recruitment and follow-up of study personnel and participants, may have contributed to the high response rate (90%) for this study.

Key HIV, economic, and social indicators used in the questionnaire were drawn from the same international organizations and Malawian government sources listed under the previous section.

Ethical approval for this study was obtained on March 8, 2007, from Yale University School of Medicine, Human Investigation Committee, Protocol Exemption HIC#0702002327.

Analysis

The study examined budget allocations for HIV/AIDS and the principal health and economic indicators during 1999–2004 through basic univariate and bivariate analysis. It investigated perceptions of resource levels, participation, and governance at baseline (the period before the PRSP 2002), at midpoint (during the development of the PRSP 2002), and at endpoint (after the implementation of the PRSP 2002).

Results

The adult HIV prevalence rate in Malawi in 2005 was 14%, a slight decline from 14.4% in 2003 and 15% in 1999 (Table 1). Total HIV/AIDS expenditure and financing increased from Malawi Kwacha (MK) 2,536,868,803 [29,294,097 US\$] in 2002/03 to MK

Table 1
Malawi National Adult HIV/AIDS prevalence and expenditures.

	1999/2000	2000/1	2001/2	2002/3	2003/4	2004/5
Malawi adult HIV prevalence (%)	15	15	15	14.4	14.4	14
HIV/AIDS expenditure ('000 Malawi Kwacha)	n/a	n/a	n/a	2,536,868	6,296,486	7,527,323

Adult prevalence data is available for 1999, 2001, 2003, and 2005 from National AIDS Commission of Malawi (2007).

HIV/AIDS expenditure data is also from National AIDS Commission of Malawi (2007); conversion rate on 12/15/02 (midpoint for 2002/3) is 1 USD to 86.6 MK. Conversion rate on 12/15/04 is 1 USD to 105.8 MK. Conversion rates available at <http://www.greenwichmeantime.com/time-zone/africa/malawi/currency.htm>.

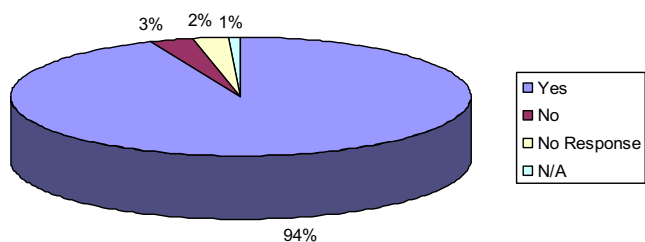


Fig. 1. Alignment of Action Plans* with Malawi NSF Pre-PRSP implementation. *Respondents' ministry/agency/organization's Action Plans.

7,527,323,449 [71,146,725 in US\$] in 2004/05 (see Table 1 for currency conversion rates). Previous HIV/AIDS expenditures under the Ministry of Health's National AIDS Program were undifferentiated from other health expenditures in the Malawian health budget, and were therefore unavailable as a separate expense category.

Period prior to PRSP development and implementation

Roughly 94% of respondents believed that their ministry/agency/organization's HIV/AIDS Action Plans were in line with the goals and objectives of the NSF (Fig. 1), but approximately 69% of respondents thought that resources (financial and human) allocated to their HIV/AIDS Action Plans prior to PRSP development and implementation were inadequate to successfully implement the plans (Fig. 2).

PRSP process

At the advent of the PRSP process in October 2000, 58% of the respondents thought that they had enough information about PRSP objectives, the implications of external donor financing, and the impact of HIV/AIDS resource levels to participate in the development of the PRSP (Fig. 3). Once the process was under way, however, the percentage of respondents who thought there was adequate inclusion and participation in PRSP development was 52% (Fig. 3).

Well less than half (45%) of the respondents believed that those most vulnerable to and/or marginalized by HIV/AIDS had adequate participation in PRSP development. Additionally, 32% of respondents said there was no change in their perception of the adequacy of inclusion and participation in the PRSP process, and 20% of respondents thought levels of participation were inadequate (Fig. 3). Respondents from the leading People Living with HIV and AIDS (PLWHA) advocacy organizations in Malawi reported that they were not given the opportunity to participate in initial PRSP deliberations. Respondents from women's organizations also indicated their inadequate representation. The majority of Malawian representatives in the PRSP process, especially during important decision points, came from urban areas, even though

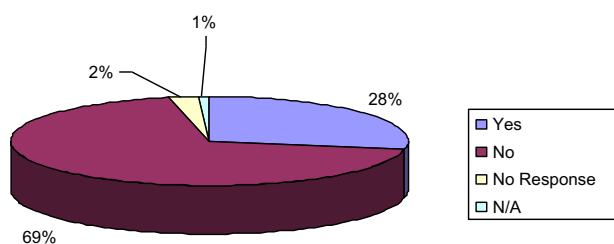


Fig. 2. Was resource allocation for Action Plans* adequate for pre-PRSP implementation? *Respondents' ministry/agency/organization's Action Plans.

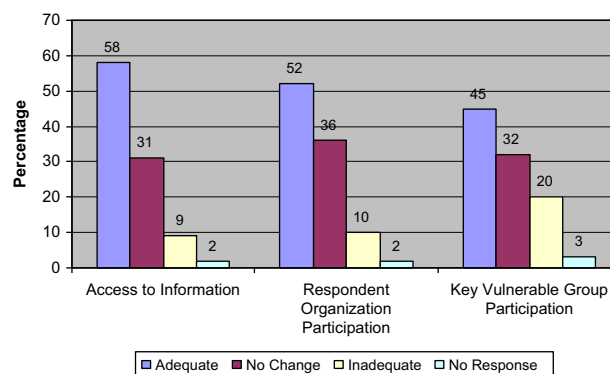


Fig. 3. Access to information and group participation in the PRSP process.

approximately 80% of the Malawian population is rural (Central Intelligence Agency, 2009).

Half of the respondents perceived improvement in the resources necessary to implement the NSF successfully. A nearly comparable 40% felt that PRSP 2002 had no influence on substantive resource allocations for the NSF. Only 5% of the respondents thought that PRSP had reduced resource levels (Fig. 4).

Post-implementation of PRSP

Participants were asked about goal alignment and resource levels for their ministry/agency/organization's HIV/AIDS Action Plans after PRSP implementation. Post-PRSP, 90% of respondents felt their ministry/agency/organization's goals were aligned with the NSF, a 4% decline from the pre-PRSP period (Figs. 1 and 5), whereas only 6% felt that their goals diverged from those of the NSF (Fig. 5). 38% of participants saw an improvement, 46% saw no change, and 10% saw a deterioration in their ministry/agency/organization's resource levels post-PRSP (Fig. 6). Additionally, 67% of respondents reported improved efficiency and effectiveness of public HIV/AIDS expenditures post-PRSP (Fig. 7).

The assessment of NSF achievement is more mixed. While 64% of the respondents believed that overall NSF goals were met (Fig. 8), 34% of respondents, many of whom were in the coordinating body and key implementing organizations, thought that NSF efforts had fallen short, especially in its HIV/AIDS prevention strategies (see below). In terms of accountability, 74% of respondents felt that the level of accountability for public resources expended on the NSF – and for results of these expenditures – had improved (Fig. 7).

HIV, social, and economic indicators

Many respondents from key NSF coordinating and implementing organizations thought NSF had fallen short of its goals. Major NSF indicators concern HIV prevalence, condom use, HIV testing,

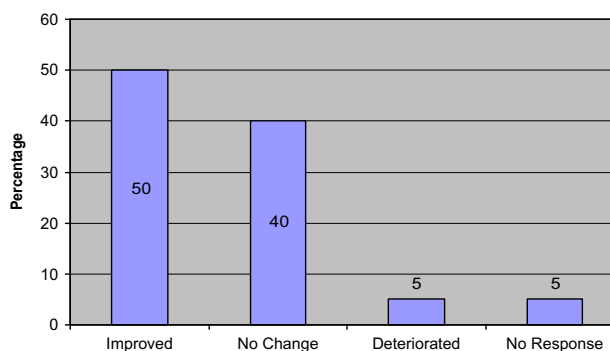


Fig. 4. Resourcing for NSF as defined by PRSP (2002).

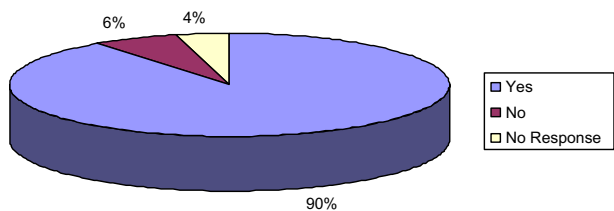


Fig. 5. Alignment of Action Plans* with Malawi NSF post-PRSP implementation. *Respondents' ministry/agency/organization's Action Plans.

prevention of mother-to-child HIV transmission (PMTCT), and antiretroviral therapy (ART). In 2003 and 2004, HIV prevalence rates among those with secondary-level education and post-secondary-level education were higher than those who had either no formal education or had attained only primary-level education (Ministry of Health & National AIDS Commission of Malawi, 2003; GoM, 2005).

In HIV prevention strategies, condom use among sexually active 15–49 year-olds varied by gender and location. Women's condom use in 2004 varied from 25% in rural areas to 44% in urban areas, while men's condom use varied from 44% in the rural areas to 57% in urban areas (Fig. 9).

Utilization of voluntary confidential counseling test sites increased from 40,806 in 2001 to 482,364 in 2005 (Table 2).

Preventing mother-to-child transmission was one of NSF's principal strategies. Data show an increase in the percentage of women receiving Nevirapine to prevent parent-to-child transmission, from less than 1% in 2002 to about 6% in 2005. The number of sites administering Nevirapine also increased from 7 sites in 2002 to 60 sites in 2006 (Table 2).

In contrast to concerns about prevention outcomes, treatment for HIV/AIDS has been one of NSF's key successes. Antiretroviral therapy (ART) grew from 3,000 patients in 2003 to over 85,000 in 2006 (Table 2). The number of patients alive on ART increased from roughly 11,000 in 2004 to approximately 60,000 in 2006, and the number of public and private facilities providing ART increased from 9 to 141. Even though the benefits of ART were seen after the end of NSF (2004), the key infrastructure that supports ART (health personnel, laboratory diagnostics, patient information systems, drug logistics) developed at the beginning of NSF.

In terms of poverty and death rates, poverty declined from 52% in 2004 to 45% in 2006 (NSO, 2006). Life expectancy fell from 48 years in 1990 to 37 years in 1996, then increased to 45 years in 2003 (NSO, 2006). Infant mortality rates decreased from 131 per 1,000 in 1990 to 76 per 1,000 in 2006 (WHO, 2008). Maternal mortality rates in Malawi, on the other hand, increased from 620 per 100,000 in the early 1990s to 984 per 100,000 by the end of 2005 (NSO, 2006).

Discussion

This study sought to examine PRSP's impact on resources for and implementation of the National HIV/AIDS Strategic Framework and on the governance of HIV/AIDS in Malawi from a shared health

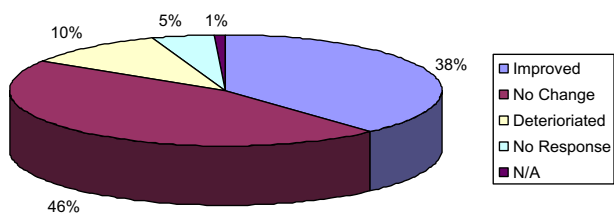


Fig. 6. Resourcing of Action Plans* Post-PRSP implementation. *Respondents' ministry/agency/organization's Action Plans.

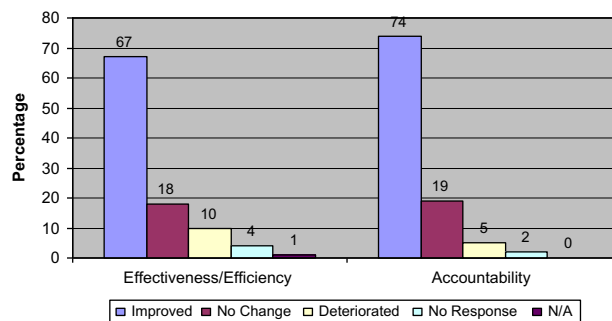


Fig. 7. Effectiveness/efficiency and accountability of NSF expenditure and results Post-PRSP.

governance perspective. In essence this study raised an important question at the crux of the health and development nexus, and that is whether the increased involvement of the international actors helped or hindered the Malawi government in its task of health governance and in its ability to facilitate the contributions of all actors and attract resources, while maintaining accountability and allowing political space for criticism. In sum, did the PRSP process support and enable the "shared health governance" of HIV/AIDS as shown by Malawi's NSF?

Our results are both interesting and mixed. Respondent perceptions of PRSP and NSF governance efforts were quite positive. PRSP implementation, according to survey participants, did result in greater efficiency as well as improved accountability for the resources used in the national HIV/AIDS response. Goal alignment between the respondent's ministry/agency/organization and the NSF was also good both before and after the PRSP process. Perceptions of resourcing, information access, and inclusion, however, were less favorable. While our findings revealed that almost all respondents believed their organizational HIV/AIDS Action Plans supported and/or complemented the NSF, their perceptions of the adequacy of resources and information are notably more negative. More than two-thirds of respondents thought resources were insufficient for successful Action Plan implementation, while only slightly more than half of the respondents thought they had adequate information to participate effectively in the national plan's development.

This study found that key stakeholders – PLWHA, rural women, and parliamentarians – believed they were excluded from the PRSP process. Respondents from PLWHA organizations and parliamentarians indicated that they felt side-lined during PRSP deliberations, which is consistent with findings from other types of global health policy, namely involvement in the population policy agenda (Luke & Watkins, 2002). Parliamentarians did not have the opportunity to review, debate, and make decisions on the proposed budgets. Respondents from the leading PLWHA advocacy organizations in Malawi were keen to point out that they were not given the chance to participate in important initial PRSP deliberations. Many thought that PLWHAs were included too late in the process,

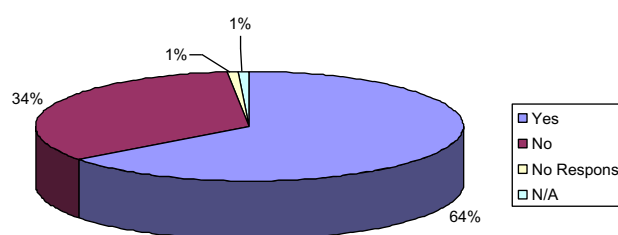


Fig. 8. Were Malawi NSF goals met?

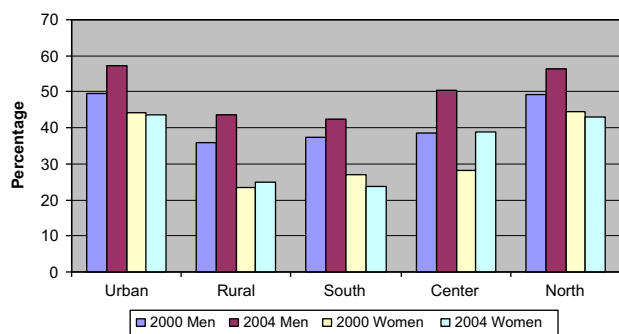


Fig. 9. Trends of condom use at last high-risk sex, among men and women aged 15–49, by location (National AIDS Commission of Malawi, 2005–2006).

especially since HIV/AIDS is a pervasive challenge across the national poverty reduction agenda, and some PLWHAs felt they were simply rubber stamping an agenda that did not address their needs comprehensively. Respondents from women's organizations also expressed their frustrations, citing inadequate and mismatched representation. For example, women are the primary caregivers of those afflicted with AIDS, and while approximately 87% of births occur in rural areas (GoM, 2005) and rural women are critical for supporting Malawi's agro-based economy, the majority of representatives in the PRSP process, especially during important decision points, came from urban areas. These results are consistent with other findings suggesting that those directly affected by programs—villagers, for example—often are unable to obtain needed and long term funding due to a lack of input (Swidler & Watkins, 2009).

More importantly, the exclusion of key stakeholders arguably had real impact on NSF policy outcomes. Survey participants noted that the convergence of stakeholders' HIV/AIDS Action Plans with the NSF contributed to the successful scale up of antiretroviral therapy (ART). For example, the Christian Health Association of Malawi (CHAM), the second largest health care provider after the Government, incorporated testing, counseling, treatment, and prevention for HIV/AIDS into its health offerings, efforts that certainly increased the number of people helped by HIV/AIDS programs. In contrast, the marginalization of rural women in the PRSP process may well have hindered PMTCT efforts. Particularly consequential for PMTCT effectiveness is the setting in which

Nevirapine can be administered to newborn infants and birthing women. It is therefore essential to consider birthing conditions when evaluating program effectiveness. Several respondents explained that home births typically occur in more remote rural areas, where capacity shortfalls inhibit PMTCT efforts. These remote settings help explain the low success rate of Malawi's PMTCT programs. In Thailand and Cambodia, for example, trained health volunteers have proven invaluable to quality rural health care delivery. There is an urgent need to train and utilize traditional birth attendants to meet Malawi's capacity shortfall. This issue might have received greater attention had rural women been adequately included in the PRSP process. There may also be a link in statistical reporting between maternal mortality and AIDS. Some of the reported maternal mortality may be masking death from AIDS; it was noted that some families may report deaths of women of childbearing age as maternal mortality rather than death due to HIV/AIDS. HIV/AIDS stigma and discrimination may thus impact the reporting of maternal mortality due to AIDS.

Nevertheless, PRSP implementation, according to survey participants, resulted in more favorable outcomes. Just over two-thirds of the respondents said public expenditure for HIV/AIDS programming was more effective and efficient after PRSP implementation. This improvement was due in part, respondents noted, to more rapid review of proposals and, for proposals approved for support, more expeditious release of funds. Many respondents attributed such improvements to commitments and political will for action from the Office of the President and Cabinet and to the formation of the semi-autonomous Malawi National AIDS Commission (NAC). The NAC was formed as a public trust, and its Trust Deed gave the NAC the autonomy to appoint its own staff and manage its own affairs independent of the terms of public service, even while operating under the Minister of Health; it is charged with coordinating the national HIV/AIDS response (National AIDS Commission of Malawi, 2003).

Assessments of NSF goals and objectives varied. Even though 64% of respondents thought that the overall goals of the NSF were met, 34% of respondents, many of whom were in the NAC and key implementing organizations, disagreed. For instance, principal NSF prevention goals — increasing the utilization of Voluntary Confidential Counseling and Testing (VCCTs), ensuring GIPA (Greater Involvement of People Living with HIV/AIDS) and effectively scaling up PMTCT activities — were not adequately met. In 2005, only about 6% (up from 1% in 2002) of women eligible to receive Nevirapine at childbirth were administered it. Still, the number of clients tested in HIV testing and counseling centers increased roughly twelve times between 2001 and 2005. Moreover, between 2003 and 2006 the number of public and private facilities providing ART increased 15 fold, the number of new patients starting ART quadrupled, the number of cumulative patients on ART increased 2838% and the number of patients alive on ART increased approximately 600%. Respondents attributed the rapid ART scale up under NSF to the NAC's stewardship and the key policy guidance provided by the Office of the President and Cabinet. Praise also went to the convergence of stakeholders' HIV/AIDS Action Plans with the NSF, although as the data suggest, this high perceived alignment was present pre-PRSP as well, so it is hard to say that the PRSP alone demonstrably increased it. Still, the preparation for the PRSP, which coincided with the pre-PRSP period in our study, may have been significant.

Most respondents placed a high value on the rapid ART scale up, but noted this achievement may have crowded out a focus on key prevention strategies of testing, condom use, and education. Respondents expressed concern regarding the lack of HIV/AIDS prevention strategies geared toward youth and students, in particular. Fig. 9 and the previously mentioned differences in

Table 2
HIV/AIDS trends 2001–2006.

	2001	2002	2003	2004	2005	2006
Number of clients tested for HIV	40,806	86,631	154,707	221,071	482,364	661,400
Number of testing and counseling sites	14	70	118	146	250	351
Percentage of women on Nevirapine	n/a	0.9	2	2.3	6	n/a
Number of PMTCT sites	n/a	7	17	31	40	60
Number providing ART services	n/a	n/a	9	24	83	141
New patients started on ARTs	n/a	n/a	n/a	10,183	25,634	46,351
Cumulative patients on ART	n/a	n/a	3,000	13,183	37,840	85,168
Patients alive on ART	n/a	n/a	n/a	10,761	29,087	59,980

Data for clients and sites of HIV testing adapted from National AIDS Commission of Malawi (2005–2006), (2007).

Data for women on Nevirapine and PMTCT sites adapted from National AIDS Commission of Malawi (2006), (2007) and UNAIDS & WHO (2008).

Data for ART adapted from National AIDS Commission of Malawi (2006) and UNAIDS & WHO (2008).

prevalence rates between levels of education present an alarming picture for youth. When viewed alongside a study done by the University of Malawi, these data highlight the need for effective prevention interventions for youth (aged 15–24), who are particularly vulnerable to and/or marginalized by HIV infection and suffer the highest prevalence rates (IRIN, 2007). HIV prevalence measures should be assessed with caution, however, as they continue to reflect rates of infection occurring in previous periods.

Variance among education levels is worrisome, as is the specific concern that HIV/AIDS prevention messages and treatment strategies were not reaching post-secondary groups. Some respondents recalled that in the 1990s, condoms and prevention literature were available in discreet bathroom locations on University campuses, but that, at the time of the survey, there really were no HIV/AIDS prevention programs geared toward students, only token speeches by high-level University officials. While it is unclear whether the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) had a significant impact during our study period, the disappearance of condoms and prevention materials described above is suggestive of an effect and parallels trends in other countries, specifically Zambia (Kreha, n.d.). Other countries, such as Thailand, have instituted condom use policies among certain segments of the population to prevent HIV/AIDS transmission. Again on the prevention side, concern emerged regarding VCCT use rates. In 2004, only around 17% of all Malawians were aware of their sero-status (Angotti et al., 2009; GoM, 2005). Logistical difficulties, such as inconvenient hours, locations, and cost, are important barriers to VCCT in Malawi and elsewhere in the region; they can be mitigated by the provision of free, mobile, rapid, and anonymous testing services (Angotti et al., 2009; Morin et al. 2006). Other noted barriers included access to information, cultural beliefs, gender-based power relations, and general misconceptions, particularly within high-risk groups (Kaler, 2004). HIV related stigma and discrimination are also important barriers to testing and prevention.

Another key area of our study involved respondents' perceptions of their ability to actively press for and obtain resources. Achieving NSF goals and objectives is largely dependent on adequate, timely, and equitable funding for specified NSF activities. Respondents did not view the PRSP as pivotal in informing budget allocations; 38% of respondents, after PRSP implementation, thought there were improvements in resources for their HIV/AIDS Action Plans. Several key respondents from implementing organizations expressed concern that, in retrospect, they had not been conversant with the PRSP process. As a result, these organizations thought they lost an opportunity to secure additional critical financing for NSF-consistent HIV/AIDS interventions. As for accountability in HIV/AIDS governance, our study found that the Malawi PRSP process did contribute to the perception of improved accountability for resources in the national HIV/AIDS response. Respondents were quick to commend the Office of the President and Cabinet and NAC for the improved stewardship of resources now available. NAC reviews proposals and monitors results for each grant recipient; it uses findings to inform additional funding requests and to take any corrective action to ensure effective and efficient expenditures. Respondents said that such corrective actions are undertaken swiftly. Several civil society organizations that actively participated in the PRSP process, such as the Malawi Economic Justice Network, helped hold the government, NAC, and implementing agencies accountable for both expenditures and results. These and other efforts have led to perceptions of increased accountability and improved governance.

As a preliminary examination of shared health governance, this inquiry found that in this particular case of governance of HIV/AIDS in Malawi, roughly half of the aspects of strong shared health governance identified in this study have been realized and about

a third to a half of the positive outcomes aimed for by the exercise have been achieved. Thus, there are both successes and shortcomings from which to learn in this application of the shared health governance model. More specifically, we found the following: (i) goal alignment between organizations and the NSF was good before and after the PRSP process (which implies the PRSP process was supportive but not determinative in this respect); (ii) strong perception among informants that resources were insufficient for implementing NSF-related action plans (which implies the PRSP process did not increase HIV resource allocations to sufficient levels and may have been constrained in some respects by development policy, for example, IMF ceilings on public sector spending); (iii) some key stakeholders were excluded from the PRSP process (which may or may not have had an impact on HIV policy and strategy); (iv) strong perception that public expenditure for HIV was more effective and efficient post-PRSP largely due to the formation of the NAC, greater political commitment and increased civil society involvement in holding the NAC to account (but we were unable to analyze other factors which may have influenced efficiency, so we cannot say that the PRSP process was causally linked to efficiency improvements).

This study has several limitations. First, the retrospective nature of the study relies on previously collected estimates and documentation of HIV/AIDS expenditures for objective data. This data was not readily available for review, as oversight of the national HIV/AIDS response moved from the Ministry of Health to the Office of the President and Cabinet, making data retrieval significantly more complicated. Second, the retrospective study design of our survey and face-to-face interviews required respondents to report on events that occurred between 2000 and 2004. There is thus significant potential for memory and recall bias and confusion of time periods. Third, due to existing sentiments and actions toward participation and inclusion as part of the NSF process itself, it may have been hard for respondents to distinguish between PRSP and NSF efforts, although these processes were distinct and presented that way. Fourth, there is a lack of well-designed, medium-term studies that specifically evaluate the impact of the development process on national HIV/AIDS responses. This makes comparison of this study's design and results to other studies difficult. Fifth, due to time and resource constraints and subjects' refusal to participate, the sample did not include all implementing partners of HIV/AIDS funding from bilateral and multilateral donors. Sixth, because interviewees were drawn from those involved in the processes or receiving/having received funding, we are unable to report results from the perspective of those excluded. Seventh, during 1999–2002, HIV/AIDS expenditures were undifferentiated as part of the Malawian health budget. Key respondents from the Ministry of Finance and the Ministry of Health tried to reliably differentiate HIV/AIDS expenditures during this period, but these efforts proved impracticable. Eighth, it is possible that there were other factors occurring in Malawi— for example, the increased spending by the Global Fund, USAID or the Government of Malawi and/or increased political commitment or strong civic activism by PLWHA— that could have brought about the changes described in this study. Since we are unable to control for these factors, we state them as potential omitted bias as a study limitation. Ninth, the data on reductions in HIV incidence and increased ART coverage should not be interpreted in a causal capacity as they are not intended to support causal claims about the impact of the PRSP process on HIV and AIDS endpoints.

Since 2000, more than 32 sub-Saharan African countries have developed and implemented national Poverty Reduction Strategy Papers. Many of these countries are also facing development challenges posed by the HIV/AIDS epidemic. In the last two years, many sub-Saharan countries have been in the process of

developing next-generation PRSPs that will inform future HIV/AIDS budgeting. Our study highlights the importance of involving stakeholders through the PRSP process – when planning, budgeting for, and implementing HIV/AIDS prevention and treatment strategies – especially those most vulnerable to and/or marginalized by HIV infection and AIDS, specifically, the poor, women, youth, persons with disabilities and the elderly.

The experiences and lessons drawn from the Malawi PRSP process can be invaluable for countries developing next-generation PRSPs. Efforts to build mechanisms of accountability, participation, and efficient resource allocation through the PRSP process are now being tested and evaluated. Lessons learned from the Malawi experience can shed light on challenges and shortcomings relevant to understanding how to strengthen shared health governance in Malawi and elsewhere, and to producing more effective and sustainable outcomes in Malawi's national HIV/AIDS response particularly.

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References

- African Development Fund. (2001, January). *Malawi-HIPC approval document: Decision point under the enhanced framework*. Retrieved October 13, 2009, from <http://www.afdb.org/fileadmin/uploads/afdb/Documents/Financial-Information/ADB-BD-WP-2001-08-EN-HIPC-MALAWI-BOARD-APPROVAL-DOCUMENT-REV-ECA-JAN-17.PDF>.
- African Forum and Network on Debt and Development. (AFRODAD). (2003, April). *Prospects for poverty reduction in Malawi: A critical analysis of the Poverty Reduction Strategy Paper (PRSP) process and outcomes (Poverty Reduction Strategy Paper series)*. Retrieved October 14, 2009, from http://www.sarpn.org.za/documents/d0001722/P2052-Malawi_PRSP_Afrodad_April2003.pdf.
- Angotti, N., Bula, A., Gaydosh, L., Kimchi, E., Thornton, R., & Yeatman, S. (2009). Increasing the acceptability of HIV counseling and testing with three C's: Convenience, confidentiality and credibility. *Social Science & Medicine*, 68, 2263–2270.
- Bonnel, R., Temin, M., & Tempest, F. (2004). *Poverty Reduction Strategy Papers: Do they matter for children and young people made vulnerable by HIV/AIDS? Results of a joint UNICEF and World Bank review*. In *African Region Working Paper Series No.78*. Washington, DC: World Bank. Retrieved January 2, 2010, from <http://www.worldbank.org/afr/wps/wp78.pdf>.
- Bor, J. (2007). The political economy of AIDS leadership in developing countries: An exploratory analysis. *Social Science & Medicine*, 64, 1585–1599.
- Bwalya, E., Rakner, L., Svasand, L., Tostensen, A., & Tsoka, M. (2004). *Poverty reduction strategy processes in Malawi and Zambia (CMI Reports R 2004:8)*. Bergen, Norway: Chr. Michelsen Institute. Retrieved October 14, 2009, from <http://www.cmi.no/publications/file/?1829=povrty-reduction-strategy-processes-in-malawi-and>.
- Central Intelligence Agency. (2009). Malawi. *The world factbook*. Retrieved October 28, 2009, from <https://www.cia.gov/library/publications/the-world-factbook/geos/mi.html>.
- Eastery, W. (2001). Think again: Debt relief. *Foreign Policy*, 127, 20–26.
- Government of Malawi. (n.d.). Malawi Poverty Reduction Strategy Paper (PRSP): HIV/AIDS. Retrieved October 13, 2009, from http://www.finance.gov.mw/prsp/hiv_aids.htm.
- Government of Malawi. (1998–2005). *Economic report*. National Economic Council.
- Government of Malawi. (1998–2009). *Budget document No.4, draft estimates of expenditure on recurrent and capital accounts (output based)*. Zomba, Malawi: Government Printer.
- Government of Malawi. (2002, April). *Malawi Poverty Reduction Strategy Paper: Final draft*. Retrieved October 13, 2009, from <http://www.imf.org/external/np/prsp/2002/mwi/01/043002.pdf>.
- Government of Malawi. (2005). *Malawi demographic and health survey 2004*. Zomba: National Statistics Office.
- GreenwichMeanTime.com. (n.d.). Malawi currency converter. Retrieved February 1, 2010, from <http://www.greenwichmeantime.com/time-zone/africa/malawi/currency.htm>.
- Gunter, B. (2002). What's wrong with the HIPC initiative and what's next? *Development Policy Review*, 20(1), 5–24.
- International Monetary Fund. (2009, August 14). *Poverty Reduction Strategy Papers (PRSP): Factsheet*. Retrieved October 16, 2009, from <http://www.imf.org/external/np/exr/facts/prsp.htm>.
- International Monetary Fund, & World Bank. (2000, December). *Malawi: Decision point document for the enhanced heavily indebted poor countries initiative*. Retrieved October 13, 2009, from <http://www.imf.org/external/NP/hipc/2000/mwi/Malawidp.pdf>.
- IRIN. (2007). *Africa-Asia: Youth and HIV/AIDS – The most vulnerable face the toughest challenges*. Retrieved February 1, 2010, from <http://www.irinnews.org/InDepthMain.aspx?InDepthId=28&ReportId=69981>.
- Kaler, A. (2004). AIDS-talk in everyday life: The presence of HIV/AIDS in men's informal conversation in Southern Malawi. *Social Science & Medicine*, 59, 285–297.
- Kreha, V. (n.d.). Zambia: Country profile. Retrieved February 1, 2010, from <http://projects.publicintegrity.org/aids/country.aspx?cc=zm>.
- Luke, N., & Watkins, S. (2002). Reactions of developing-country elites to international population policy. *Population and Development Review*, 28(4), 707–733.
- Ministry of Economic Planning and Development of Malawi. (1999–2005). *Economic report*. Lilongwe, Malawi.
- Ministry of Health, & National AIDS Commission of Malawi. (2003). *HIV sentinel surveillance report 2003*. Lilongwe, Malawi.
- Morin, S., Khumalo-Sakutukwa, G., Charlebois, E., Routh, J., Fritz, K., Lane, T., et al. (2006). Removing barriers to knowing HIV status: Same-day mobile HIV testing in Zimbabwe. *Journal of Acquired Immune Deficiency Syndromes*, 41(2), 218–224.
- National AIDS Commission of Malawi. (2003). *Strategic management plan 2003–2008*. Lilongwe, Malawi.
- National AIDS Commission of Malawi. (2006). *Antiretroviral therapy 4th quarter report 2006*. Lilongwe, Malawi.
- National AIDS Commission of Malawi. (2005–2006). *Malawi HIV and AIDS monitoring and evaluation report 2005*. Lilongwe, Malawi.
- National AIDS Commission of Malawi. (2007). *Malawi HIV and AIDS monitoring and evaluation report 2007*. Lilongwe, Malawi.
- National Statistics Office of Malawi. (2006). *Welfare monitoring survey*. Zomba, Malawi.
- Peabody, J. (1996). Economic reform and health sector policy: Lessons from structural adjustment programs. *Social Science & Medicine*, 43(5), 823–835.
- Ruger, J. (in press). *Global health justice and governance*. Oxford: Clarendon Press.
- Ruger, J. *Global health governance as shared health governance*. Paper presented at the Values and Moral Experiences in Global Health conference, 25–26 May 2007, Harvard University, Cambridge, MA.
- Ruger, J. (2008). Ethics in American health 2: An ethical framework for health system reform. *American Journal of Public Health*, 98(10), 1756–1763.
- Ruger, J. (2009). *Health and social justice*. Oxford: Clarendon Press.
- Swidler, A., & Watkins, S. (2009). “Teach a man to fish”: The sustainability doctrine and its social consequences. *World Development*, 37(7), 1182–1196.
- Tan, J., Soucat, A., & Mingat, A. (2001, March). *Enhancing human development in the HIPC/PRSP context: Progress in the Africa Region during 2000 (Africa Region Human Development Working Paper Series)*. Washington, DC: World Bank. Retrieved October 13, 2009, from http://siteresources.worldbank.org/AFRICAEXT/Resources/hipc_prsp.pdf.
- United Nations Children's Fund (UNICEF). (n.d.). Malawi: Statistics. Retrieved February 1, 2010, from http://www.unicef.org/infobycountry/malawi_statistics.html.
- United Nations Development Programme (UNDP). (n.d.). Factsheets: Malawi. Retrieved October 16, 2009, from <http://www.undp.org/hiv/docs/olpubs/malawi.pdf>.
- United Nations Joint Programme on HIV/AIDS (UNAIDS). (n.d.). Malawi country situation analysis. Retrieved October 13, 2009, from <http://www.unaidsrsta.org/countries/malawi>.
- United Nations Joint Programme on HIV/AIDS, & World Health Organization. (2008). *UNAIDS/WHO epidemiological fact sheets on HIV and AIDS: Malawi, 2008 update*. Geneva: UNAIDS & WHO.
- USAID. (2009, June 2). *HIV/AIDS: Malawi*. Retrieved February 1, 2010, from http://www.usaid.gov/our_work/global_health/aids/Countries/africa/malawi.html.
- Varma, S. (2006). Debt relief, debt sustainability, and growth in low-income countries. In V. Bhargava (Ed.), *Global issues for global citizens* (pp. 91–104). Washington, D.C.: World Bank.
- Weaver, R. (2004). Poor relations? PRSPs and the response to HIV/AIDS and children (Tearfund HIV/AIDS Briefing Paper 2). Teddington, UK: Tearfund. Retrieved February 1, 2010, from http://tilz.tearfund.org/webdocs/Website/Campaigning/Policy%20and%20research/AIDS_briefing_2_PRSPs_final.pdf.
- World Bank. (2000–2005). *World development report*. Retrieved from <http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTWDRS/0,contentMDK:20227703~pagePK:478093~piPK:477627~theSitePK:477624,00.html>.
- World Bank. (2006, April 18). GNI per capita 2004, Atlas method and PPP. World development indicators database. Retrieved October 16, 2009, from <http://www.pdwb.de/archiv/weltbank/gnipc04.pdf>.
- World Health Organization. (2008). *World health statistics 2008*. Geneva: WHO.