

LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

# **Information, Social Interactions and Health Seeking Behavior**

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Thesis submitted to the Department of Economics of the London School  
of Economics and Political Science for the degree of Doctor of  
Philosophy  
London, February 2016

## **Declaration**

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

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## Abstract

This thesis examines the underlying cause of social stigma towards people living with HIV, and the extent to which it discourages HIV testing and treatment. We use a discrete choice model to describe a person's decision to seek treatment for HIV (antiretroviral therapy or ART), and estimate the social cost of seeking treatment using administrative health records from southern Malawi. We show that seeking ART at a clinic where many other community members are present carries a significant cost, even after taking into account clinic quality and location. We investigate the theoretical effects of policy interventions designed to reduce stigma and other barriers to care, and demonstrate important complementarities between such policies. We next evaluate a cluster-randomized information experiment in Zomba, Malawi designed to correct a common misconception: most do not know that ART drugs have a public benefit, that is, the medication prevents HIV transmission between sexual partners. We microfound HIV stigma as sexual discrimination between sexual partners, and model the decision to seek an HIV test (and then, if required, medical treatment) as a signal of infection. We show, theoretically and empirically, that the randomized information intervention reduces this type of stigma and significantly increases the rate of HIV testing. The results demonstrate that social stigma is an important barrier to HIV testing and treatment, that stigma can be due to rational behavior by a misinformed public, and that providing new information can be an effective way to mitigate its effects.

## Acknowledgements

I am deeply grateful to my supervisor, Oriana Bandiera, for her rigorous attention, dependable guidance and encouragement. I am also grateful to my advisor Greg Fischer for his valuable advice and support. This thesis benefited from discussions with faculty at LSE and elsewhere, including Gharad Bryan, Maitreesh Ghatak, Balazs Szentes, Tim Besley, Robin Burgess, Alan Manning, Steve Pischke, Nava Ashraf, Susan Watkins, Siwan Anderson, Victoria Baranov, Nicola Lacetera, Natalie Bau, Kevin Bryan, and Mitch Hoffman.

*Taonga ukongwa* to Yewo Longwe and many others in Mwaya, Malawi for sharing their thoughts on HIV stigma, and for providing the inspiration for this thesis. I wish to thank Joep van Oosterhout, Monique van Lettow, Alfred Matengeni, and Sumeet Sodhi at Dignitas International for their data collection support and ongoing feedback. *Zikomo* to Invest in Knowledge Initiative for their field work support, especially Frank Chikadza, Humphreys Kabota, Sydney Lungu and Augustine Harawa, as well as the entire team of community educators and enumerators. Kate Dovel was a great colleague in Zomba, and shared many ideas from sociology so important for my work.

I have been fortunate to share this graduate experience with wonderful colleagues who offered both intellectual and emotional support. Many of my fellow graduate students were generous with their feedback on my work; Jon De Quidt, Michael Best and Sam Marden taught me most of the economics I now know. Thiemo Fetzer, Erika Deserranno, Munir Squires, Jason Kerwin, and Willa Friedman have all provided useful suggestions which improved this thesis. Ana McDowall is a best flatmate and a best friend, and I am grateful for her kind, fun, open and supportive presence in my life.

This work would not exist without the love and unfailing support of my family: my parents, Carrie and Bob, my sisters Caileigh and Lindsay, and my always encouraging aunt Shelley. Finally, my partner Patrick Blanchenay is a source of calm and strength, and my success in any pursuit is in part owed to his unwavering support and confidence.

I gratefully acknowledge financial support from LSE, STICERD and the Russell Sage Foundation.

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# Chapter 1

## Introduction

A surprising number of deaths are caused by preventable or treatable health conditions. Over one million people in sub-Saharan Africa die of AIDS every year, despite the fact that an effective treatment, antiretroviral therapy (ART) is now widely provided to patients free of charge. The medication has large private benefits for those infected with HIV: it prolongs life by decades and reverses the symptoms of AIDS. It has recently been discovered that ART drugs also have a public benefit: they reduce HIV transmission by 96% (Cohen et al., 2011). This discovery prompted the World Health Organization to advocate a “Treatment for Prevention” strategy to bring an end to the AIDS epidemic. Over the past decade, the supply of free ART has increased dramatically in low-income countries, yet demand for HIV testing and treatment remain low.

Social stigma is often blamed for low HIV testing rates. However, neither the extent nor the underlying cause of stigma is well understood. Many policies which increase HIV testing take stigma into account by affording clients more privacy, as in door-to-door testing, or obscuring the signal, for example, by offering monetary incentives to test (Thornton, 2008). Understanding the extent and the nature of stigma is important in order to better predict the consequences of any policy, including the long-run impact, the population affected, and the effect on take-up of ART. Depending on the root causes of stigma, it may also be possible to design policies which actually reduce the level of stigma in the community, rather than simply helping people to cope with it.

This thesis consists of three parts: we estimate the social cost of HIV treatment using a discrete choice model, we evaluate an information intervention to change beliefs about ART drugs, and we provide empir-

ical evidence for a particular type of HIV stigma explained by statistical discrimination between sexual partners.

We first propose a discrete choice model to describe the decision to seek treatment for HIV in the form of ART drugs. In this model, agents choose between many clinics at varying distances and qualities, or abstain from treatment. We use this model, combined with administrative health data from southern Malawi, to estimate the total cost of treatment, including travel costs and the cost of social stigma. We estimate the cost of stigma, or equivalently, the willingness-to-pay for privacy, by investigating the tradeoff faced by patients who travel to a further clinic in order to avoid seeing members of their community. We also determine the effect of a policy intervention to reduce stigma, reduce travel costs, or increase quality of care, and discuss complementarities between these policies. While the cost of stigma is significant, other barriers to care are larger. In particular, we find that a policy to reduce transport costs is more effective at increasing ART takeup than a policy to reduce stigma.

We next evaluate a carefully designed information experiment to shift beliefs about the public benefit of ART drugs. We conduct community health meetings in 122 villages in Zomba, Malawi, to provide information on the public benefit of ART: a person taking ART is very unlikely to spread HIV to his or her sexual partners. We find that a single community health meeting was highly effective in shifting beliefs about HIV transmission, even as measured five months after the intervention.

Finally, we illustrate this experiment's potential to both detect and reduce one specific type of stigma against those who seek an HIV test: statistical discrimination by potential sexual partners, based on a rational fear of HIV transmission. Those who seek an HIV test are more likely to be infected, and may face rejection from potential partners who fear contracting the virus. The public benefit of ART drugs implies that, in fact, an HIV test should not be viewed as a negative signal, since those who have been tested and treated for HIV are less contagious. We find that providing precise information, at the community level, on the public benefit of ART greatly increases the HIV testing rate within only three months, and we identify a reduction in social stigma as the likely mechanism. These results suggest that stigma is at least in part due to a rational fear of contracting HIV, that this type of stigma is a major barrier to HIV testing, and that correcting wrong beliefs by providing accurate information can mitigate stigma and its effects.

In order to make precise the form of stigma we have in mind, we

model HIV testing as a signalling game between potential sexual partners. The first player decides whether to get tested for HIV, either at a clinic near his home village, or far away. He is then matched with a potential sexual partner. She observes his testing decision with some probability, which depends on his choice of testing location. She forms consistent beliefs about the risk of contracting HIV, and decides whether to reject or consent to the match.

Those who are infected with HIV have more to gain from HIV testing, because it allows them to access ART drugs. This causes a signalling equilibrium to emerge, in which some fraction of the population reject matches who have been tested, because they fear contracting HIV. This behavior contributes to the total level of stigma faced by those who choose to get tested. An upward shift in beliefs about the public benefit of ART alleviates stigma if it is based on a fear of HIV transmission, and leaves other potential forms of stigma unaffected. That is, people are more likely to consent to matches who have been tested and treated, because they know that treatment prevents HIV transmission. This reduction in stigma should, in turn, increase HIV testing.

By mapping the model to an information experiment, we are able to test several theoretical predictions empirically. We randomly assigned 122 villages in Malawi to either treatment or control status. All villages received an intervention in which information about ART was disseminated in public, at community health meetings. In treatment villages, information on both the private and public benefits of ART was provided, in particular, meeting attendees were informed that ART reduces HIV transmission by 96%. In the control group we provided information on only the private benefits of ART.

As the formation of beliefs may depend on endogenous factors such as education and past health seeking behavior, a randomized experiment allows us to measure the causal effect of beliefs. We are also interested in evaluating the information intervention itself, for its potential to inform policy. There is reason to believe that incorrect beliefs might persist in equilibrium. First, ART is under-adopted, which means that first-hand learning is slow. Second, information sharing between social contacts may be strategic and lack credibility; knowledge about ART may be viewed as a signal of HIV status, and a potential sexual partner who claims that ART blocks HIV transmission may have ulterior motives.

Our empirical results are consistent with the theoretical predictions of the signalling model. Survey measures of stigma towards potential sexual

partners who are HIV-positive, but treated with ART, were significantly lower in the treatment group. Health seeking behavior also increased significantly. The HIV testing rate, as recorded over three months of administrative data, was 60% higher in treatment villages. Overall, nearly half of HIV tests take place far away from the HIV testing client's home village, but a large shift in beliefs about the public benefit of ART predicts an increase only in the number of tests sought nearby. The individual testing decision is predicted by one's perception of the community's beliefs about ART, and not by one's own beliefs; if the results were driven by altruism, one would expect the opposite.

This thesis is a study on the cause and effect of statistical discrimination, and its lessons may apply broadly. We show that a technology which benefits a stigmatized group may be underadopted, and that if stigma is based on statistical discrimination, correcting wrong beliefs may diminish stigma and its effects. [Arrow \(1973\)](#)'s seminal work on statistical discrimination shows that a correlation between individual attributes and productivity results in labour market discrimination. The theoretical and empirical effects of this type of discrimination have been investigated in various contexts<sup>1</sup>. Much of the literature on social stigma, both in the context of HIV and more generally, views stigma as an exogenous cost<sup>2</sup>, and investigates the effects of such a social cost. One exception is [Besley and Coate \(1992\)](#), in which the authors model stigma toward welfare recipients as either statistical discrimination or a form of taxpayer resentment, and investigate the theoretical implications of such a model. In this thesis we investigate both the source and effect of stigma, theoretically and empirically, by microfounding stigma as statistical discrimination against HIV-infected sexual partners, and using an experiment to investigate the implications for health seeking behavior.

A lack of accurate information may explain the low adoption rates of many health measures. Providing new, precise information on health risks has been shown to impact some types of behavior<sup>3</sup>. Within the context of HIV, most papers focus on the effect of information<sup>4</sup> on risk-

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<sup>1</sup>See for example, [Altonji and Pierret \(2001\)](#), and [Coate and Loury \(1993\)](#).

<sup>2</sup>In the context of HIV, see [Thornton \(2008\)](#) and [Ngatia \(2011\)](#), and in the context of welfare payments, and [Moffitt \(1983\)](#).

<sup>3</sup>See, for example [Dupas \(2011\)](#), [Kerwin \(2014\)](#), [Bandiera et al. \(2012\)](#), [Madajewicz et al. \(2007\)](#), and [Jalan and Somanathan \(2008\)](#).

<sup>4</sup>Interventions which provide new, precise information differ sharply from traditional anti-HIV messaging strategies which focus on behavior change directly. [Duflo](#)

taking (Dupas, 2011, Kerwin, 2014, Bandiera et al., 2012). However, the type of information which might increase health seeking behavior is not well understood. Information on the protective benefits of circumcision appears to have no effect on demand for the procedure (Chinkhumba et al., 2012, Godlonton et al., 2011). Health seeking behavior may often be stigmatized, and our results suggest that providing information on the public benefit of health seeking behavior may effectively reduce the level of stigma.

Previous experiments by Thornton (2008) and Ngatia (2011) show that test-seeking responds strongly to small monetary incentives. These experiments also offer effective policy advice in terms of HIV testing. However, providing monetary incentives for ART take-up may prove infeasible. In order to obscure the signal, the entire community, and not only ART patients, would have to be paid to visit the clinic at regular intervals. An intervention that instead reduces the level of stigma in the community is attractive for several reasons. Such an intervention should increase both HIV testing and treatment, and generate persistent effects for a fixed cost. In addition, we show that stigma is likely to be practiced between potential sexual partners, which has important implications for policy. Stigma imposes a high cost on those individuals most concerned with their sexual prospects, the same individuals who are most at risk of HIV infection. Designing policy to increase HIV testing and treatment among this group should be a priority.

The remainder of the thesis proceeds as follows: Chapter 2 provides background information on antiretroviral therapy and HIV related stigma. Chapter 3 estimates the cost of social stigma using a discrete choice model of HIV treatment. Chapter 4 describes an information intervention we conducted in Malawi, and evaluates its effect on beliefs about HIV treatment. In Chapter 5 we present a signalling model of HIV testing as a microfoundation for social stigma, and we test its predictions about HIV testing using the experiment from Chapter 4. Chapter 6 concludes.

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et al. (2012), for example, find that a behavior change program that pushes abstinence fails to reduce risk-taking among adolescent girls in Kenya.

# Chapter 2

## Background

### 2.1 Antiretroviral Therapy

Antiretroviral therapy, or ART, is a combination of drugs which suppress the HIV virus and reverse the progression of AIDS. The medication dramatically reduces the mortality and morbidity associated with HIV infection.

ART was developed in the late 1980's. However, the price of ART was prohibitively high for the low-income countries most affected by the AIDS epidemic. Around 2000, multiple agreements between governments, international organizations, and pharmaceutical companies led to a large reduction in the price of ART in developing countries. Over the next decade, HIV patients in Africa receiving ART drugs increased from 50,000 to 9.7 million, resulting in an approximate 30% decrease in mortality ([WHO, 2013](#)).

While the increased supply of ART has led to a remarkable improvement in outcomes for those infected with HIV, demand for the medication is surprisingly low. In sub-Saharan Africa, half of the population has never been tested for HIV, and only one third of those infected are taking ART drugs ([WHO, 2013](#)). There are more than one million AIDS-related deaths in the region every year, most of which could be prevented by ART ([WHO, 2013](#)).

In addition to providing large health benefits to HIV-positive individuals, ART reduces HIV transmission between sexual partners by reducing an infected person's viral load. A large randomized controlled trial<sup>1</sup>

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<sup>1</sup>This randomized trial was conducted in the field and in low-income countries. The drug reduced HIV transmission by 96%, measured over a period of a few years, among

recently demonstrated that regular ART use by HIV-positive individuals reduces HIV transmission by 96% (Cohen et al., 2011). The World Health Organization and others have called for a “treatment for prevention” strategy, advocating ART use specifically for the purpose of preventing new infections. Epidemiological models suggest that in light of the public benefit of ART, universal testing and treatment could bring an end to the AIDS epidemic within 50 years, and would be cost-effective in the long run (Granich et al., 2009).

In most countries the criteria used to determine whether a person qualifies for ART are based on guidelines from the World Health Organization, which have changed over time. As of 2013 these guidelines stipulate that one should qualify for ART when the disease has progressed beyond a certain point, as measured by the severity of symptoms and a blood test. In addition, pregnant women, children under the age of five, and those with partners who are HIV negative should always qualify<sup>2</sup>.

## 2.2 Stigma Against HIV Testing and Treatment

Social stigma, according to the seminal definition by Goffman (1963), is “the phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute.” There are various potential reasons for such a rejection. Stigma could be based on statistical discrimination, it could be due to a distaste for social interactions with individuals having a particular attribute, or it could arise as an equilibrium of social behavior (Peski and Szentes, 2013).

Because HIV is transmitted through sexual interactions, it is particularly susceptible to many forms of social stigma<sup>3</sup>. This in turn might partly explain why testing levels are low across sub-Saharan Africa, and

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couples who took the drug at home, unobserved, and in general in a similar manner to most ART patients in the developing world. In particular, this reduction in transmission does not hinge on perfect adherence to the medication. It is accurate to say that ART drugs reduce HIV transmission by at least 96% relative to the absolute transmission rate over any time period up to approximately ten years. The absolute transmission rate is low, so the the total reduction in transmission over repeated interactions is approximately linear.

<sup>2</sup>The extent to which these guidelines are put into policy varies. In Malawi, for example, as of 2013 those with partners who are HIV negative did not automatically qualify

<sup>3</sup>See Mahajan et al. (2008) for a review of medical and sociological research on the stigmatization of HIV and AIDS.

in Malawi, where our study takes place. For example, an equilibrium may emerge in which individuals wish to disassociate themselves from others who have engaged in sexual behavior that is deemed socially unacceptable (Ngatia, 2011). Stigma may also take the form of pure statistical discrimination: a person might reject sexual partners who are HIV-positive out of a rational fear of infidelity or HIV transmission. The correlation between HIV status and HIV testing implies that any stigma towards those who are HIV-positive may also apply to test-seekers.

In order to obtain ART drugs, a person must first seek an HIV test. While the results of an HIV test are private<sup>4</sup>, the decision to test may be observable. The availability of ART drugs induces adverse selection among test seekers; for example, in Malawi, true HIV prevalence is 44% higher among those who report having been tested (DHS, 2010). The fact that seeking an HIV test is associated with HIV infection may generate stigma, which in turn discourages HIV testing; in Malawi, 27% of women and 48% of men report never having been tested for HIV (DHS, 2010). In addition, our data shows that 30% of HIV tests do not take place at a nearby health facility, which could be explained by a desire to avoid being seen.

Previous work by Thornton (2008) show that test-seeking responds strongly to small monetary incentives, which conceal a person's true motivation for testing, suggests that stigma may play a role in HIV testing decisions. Ngatia (2011), using a field experiment, finds evidence for a model of HIV testing in which the level of stigma a person faces depends on not only his own testing decision but also on the testing decisions of his social contacts. In that model, stigma is based on social distaste for an underlying risk type, that is, the moral judgment of those who engage in risky behavior. Finally, Hoffmann et al. (2014) use a lab experiment in Kenya to show that people are willing to forgo payment to avoid coming into contact with an object handled by an HIV positive person, and that this behavior is only partly explained by a misunderstanding of contagion risk.

The Malawian Journals Project<sup>5</sup> provides extensive qualitative evidence on the nature of HIV-related stigma. The project has transcribed a vast amount of hearsay data on attitudes towards HIV, and these journals

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<sup>4</sup>In Malawi, non-joint HIV tests are confidential, and a person who tests HIV negative does not receive any written proof of the result. The test is conducted twice with different test kits, so an incorrect diagnosis is unlikely.

<sup>5</sup><http://malawi.pop.upenn.edu/malawi-data-qualitative-journals>



include many examples of stigma towards HIV testing and treatment, especially in the dating market. Many express dismay at the widespread availability of ART, as the medication makes HIV-positive individuals appear healthy and therefore harder to identify. Others report seeking HIV testing and treatment far from home, to avoid being seen and then rejected by potential sexual partners. Consider, for example, the following two quotes from the Malawi Journals Project.

*“Most of the people here in Balaka do prefer to go and get tested at Dream clinic because it is an outskirt place where they cannot be seen by those people who know them.”*

*“It’s better to receive drugs from the hospital of some areas [...] because many people can discover fast that I have virus of AIDS, and some ladies can disagree me so it can be painful in my everyday life.”*

## Chapter 3

# A Discrete Choice Model of Health Behavior

If HIV testing and treatment are subject to social stigma, people who seek HIV-related care will be willing to pay a price to avoid being seen by members of their community. In this chapter, we use a discrete choice model to estimate this cost of stigma and quantify the potential effects of policy interventions designed to reduce stigma and other barriers to treatment.

In Malawi, an HIV positive person taking antiretroviral therapy (ART) must visit a health facility approximately every two months to refill his or her prescription. The patient can choose between many health facilities, both rural and urban, at varying distances from their home village. ART drugs are often distributed through a particular office, and patients must wait in line to see the health worker. If the clinic is frequented by many other village members seeking general medical care, an ART patient risks running into someone he or she knows, and having his HIV status revealed.

In the absence of social stigma, we would expect an ART patient to make his or her choice based on the distance and quality of the health facility. If there is a social cost to seeking HIV-related care, the probability of seeing another person from the same village will enter into a person's choice. The fear of being "found out" will affect both the choice of whether to seek ART drugs, and which clinic to visit.

We propose a discrete choice model of health seeking behavior. Individuals with HIV have a choice of many clinics at varying distances, and choose a particular clinic (or to abstain from treatment) to maximize

utility, taking into account distance, quality, and behavior of other members of the same village. In order to estimate the willingness-to-pay for privacy, we take inspiration from [Kremer et al. \(2011\)](#), who use travel-cost based revealed preference estimates to estimate willingness-to-pay for clean drinking water. We also use our model to examine the effects of several potential policy interventions.

We estimate this model using a large dataset of all existing ART patients from 244 villages in Zomba, Malawi, and administrative data from all 15 ART distributing health facilities within reasonable travel distance from those villages. We show that distance and quality are significant factors in a person's decision to seek treatment. We also show that, on average, patients are willing to pay a significant price to avoid being seen by members of their village who visit the clinic for general health care, consistent with our theory that HIV-related health care is stigmatized.

We find that the overall effect of a policy to reduce stigma is limited due to other substantial barriers to treatment. In particular, a policy to reduce travel costs or improve quality of care would have a large effect on ART uptake, and the largest gains would be made from a policy that reduces stigma while simultaneously removing other barriers to care.

### 3.1 Model of Clinic Choice

We model a situation in which HIV-positive individuals choose whether or not to seek treatment in the form of ART drugs, and which clinic to visit for treatment. Following McFadden's conditional logit model of discrete choice, ([McFadden et al., 1973](#)), for each individual, we define a utility function which depends on both his or her individual characteristics and on the features of the potential choice of clinic. Each person's choice will depend on his or her HIV status (those without HIV cannot choose to seek treatment), the various costs of visiting each clinic, including distance and social stigma, and the benefits of each clinic, including the value of treatment and the quality of the clinic.

The prevalence of HIV in village  $j$  is denoted  $\bar{h}_j$ , and the population prevalence is denoted  $\bar{h}$ . Each individual  $i$  in village  $j$  has private type  $h_{ij} \in \{0, 1\}$  (with  $\mathbb{E}(h_{ij}) = \bar{h}_j$ ) which represents his or her HIV status. Those with  $h_{ij} = 0$  do not have the choice of seeking treatment for HIV. Those with  $h_{ij} = 1$  have the choice of visiting one of  $K$  clinics to seek ART drugs, or abstaining from treatment. The fact that individuals have

different choice sets marks a departure from McFadden's model.

A patient  $i$  from village  $j$  who chooses clinic  $k \in 1, \dots, K$ , or chooses to abstain from treatment,  $k = 0$ , receives utility

$$u_{ijk} = V_{ijk} + \epsilon_{ijk}. \quad (3.1)$$

where  $V_{ijk}$  captures all of the observable costs and benefits of seeking treatment at clinic  $k$ , relative to abstaining from treatment, and  $\epsilon_{ijk}$  is an error term. In particular, for  $k > 0$ ,

$$V_{ijk} = \beta^V + \beta^D D_{jk} + \beta^G N_{jk}^G + \beta^A N_{jk}^A + Q_k + \beta^{\chi T} \chi_{ijk} \quad (3.2)$$

where  $\beta^V$  is a constant representing the perceived value of receiving treatment.  $D_{jk}$  is the distance in kilometers between village  $j$  and clinic  $k$ , and the coefficient  $\beta^D$  captures the utility cost of travel.  $Q_k$  is a dummy variable which represents the quality of clinic  $k$ .  $\chi_{ijk}$  is a vector containing other regressors which could include individual or village characteristics, or interactions such as whether a village has a formal relationship with a particular clinic.

The terms  $N_{jk}^G$  and  $N_{jk}^A$  represent the expected number of *other people from the same village* visiting clinic  $k$  on a given day for general health care or ART drugs respectively. The coefficients  $\beta^G$  and  $\beta^A$ , if negative, capture the cost of social stigma, that is, the cost of being seen at the clinic by a (general or ART) patient from one's own village. If positive, these coefficients capture the benefit of going to the clinic on the same day as other community members.

For a person who does not seek treatment ( $k = 0$ ),

$$V_{ij0} = 0. \quad (3.3)$$

### 3.1.1 Distributional Assumption

The error term  $\epsilon_{ijk}$  (for  $k = 0, 1, 2, \dots, K$ ) is assumed to be independently and identically distributed with an extreme value distribution:

$$F(\epsilon_{ijk}) = e^{-e^{-\epsilon_{ijk}}}. \quad (3.4)$$

This is the assumption behind the multinomial logit model, and generates a closed-form solution for the likelihood function. This assumption

also normalizes the variance of the error term to  $\pi^2/6$ , which in turn normalizes the overall scale of utility.

### 3.1.2 Choice Behavior

An HIV-negative person must choose  $k = 0$ . An HIV-positive person will choose option  $k$  if it generates the largest possible utility out of all options (including the option to abstain,  $k = 0$ ). The probability that an HIV-positive person chooses  $k$  is equal<sup>1</sup> to

$$\mathbb{P}(u_{ijk} \geq u_{ijk'} \forall k' | h_{ij} = 1) = \frac{e^{V_{ijk}}}{\sum_{k'=0}^K e^{V_{ijk'}}}. \quad (3.5)$$

Therefore, the unconditional probability that a person chooses to seek ART at clinic  $k$  is equal to

$$p_{ijk} = \bar{h}_j \frac{e^{V_{ijk}}}{\sum_{k'=0}^K e^{V_{ijk'}}}. \quad (3.6)$$

The unconditional probability that a person in village  $j$  does not seek ART is equal to the probability that he is HIV-negative,  $1 - \bar{h}_j$ , plus the probability that he is positive,  $\bar{h}_j$ , but that abstaining from treatment maximizes his utility:

$$p_{ij0} = (1 - \bar{h}_j) + \bar{h}_j \frac{1}{\sum_{k'=0}^K e^{V_{ijk'}}}. \quad (3.7)$$

## 3.2 Empirical Estimation

In this section, we describe our estimation of the multinomial logit model using administrative health records from Malawi.

### 3.2.1 Setting and Data

Our empirical setting is Zomba District, Malawi. In Southern Malawi, HIV prevalence is approximately 14.5% (DHS, 2010). Antiretroviral therapy (ART) is available at more than 20 rural clinics, and is provided free

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<sup>1</sup>This probability is obtained by integrating the indicator function  $I(u_{ijk} \geq u_{ijk'} \forall k')$  times the probability density function of the extreme value distribution.

of charge. Clinics which dispense ART also treat patients for a wide variety of general health conditions. The study area covers two areas, TA Chikowi and TA Mwambo, within Zomba District. These areas are served by 15 ART-dispensing health facilities, and the average distance from a rural village to an ART-dispensing clinic is approximately 5 kilometers. In Malawi, ART is only provided to pregnant women, symptomatic patients, and patients with a high viral load (as measured by a CD4 count). However, these requirements rarely bind, as the vast majority of new ART patients are well beyond the CD4-count thresholds put forth in the Ministry of Health guidelines.

We use administrative data<sup>2</sup> from all 15 ART-dispensing clinics, containing the universe of ART patients in 2013. For each patient, we can identify the patient's age, gender, choice of clinic (with GPS coordinates), and home village. We restrict attention to the 244 villages with unique names in the District, as identified by the Malawian National Census. We combine the National Census data with the health administrative data to construct a dataset of all adults in those 244 villages, including gender, whether or not the person was taking ART drugs in 2013, and if they were, their choice of clinic, and the straight-line distance between the village and the clinic.

In order to measure general patient clinic attendance, we visited each ART dispensing clinic and digitized the general out-patient registers, which include a patient's home village. We collected two months worth of data: November and March.

### 3.2.2 Summary Statistics

The prevalence of HIV in Southern Malawi is approximately 14.5%, and the rate of infection is higher among women (17%) than men (12%) (DHS, 2010). However, only 4.8% of the adult population in our data were ART patients in 2013. ART use is nearly three times higher among women (7.4%) than men (2.6%), a fact which is not fully explained by the difference in prevalence, but may be explained by health policy: pregnant women are encouraged to get tested and treated for HIV because ART prevents transmission from mother to child.

The majority of ART patients do not attend the nearest clinic to their

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<sup>2</sup>This data was digitized as part of the routine data collection practices of Canadian NGO Dignitas International.

village: 62% of men and 52% of women travel further than necessary to seek ART. This may be explained by differences in clinic quality, but ART-related care is highly standardized across Zomba District. According to the medical team at health care NGO Dignitas International, ART is the one medication which is never out of stock at any dispensing clinic in Zomba. For this reason, we view the extra distance traveled as suggestive of social stigma. The fact that so many are willing to travel further than necessary for ART motivates the analysis that follows, in which we more carefully disentangle clinic quality from stigma.

### 3.2.3 Estimation

We use simulated maximum likelihood to estimate the vector of parameters  $\beta$  and clinic fixed effects  $\{Q_k\}$  in equation 3.2. The only additional regressor,  $\chi_{jk}$  is an indicator for whether village  $j$  is in the catchment area of clinic  $k$ , that is, whether clinic  $k$  is formally recommended to villagers for health programming, pre-natal visits, etc. We also estimate the village-level HIV rates  $\bar{h}_j$ , applying the constraint<sup>3</sup>  $\frac{1}{J}\sum_j \hat{h}_j = \bar{h} = 0.145$ , where  $\hat{h}_j$  is the maximum likelihood estimate of  $\bar{h}_j$ , and  $\bar{h} = 0.145$  is the HIV prevalence in Zomba district (DHS, 2010). We also constrain  $\hat{h}_j \in [0, 1]$  for all  $j$ .

From our administrative data on ART patients, we are able to calculate the approximate daily rate of ART visits at clinic  $k$  attendance from village  $j$ ,  $N_{jk}^A$ . From the general patient rosters, we are able to calculate the approximate daily rate of general clinic  $k$  attendance from village  $j$ ,  $N_{jk}^G$ .

## 3.3 Results

### 3.3.1 The Costs of Treatment and Travel

The results of the simulated maximum likelihood estimation are displayed in Table 3.1. The value of seeking treatment,  $\beta^V$ , is positive and significant. This is not an obvious result. While ART drugs offer large benefits, those benefits are only apparent once a person has started to experience the symptoms of AIDS. This takes approximately ten to fifteen

<sup>3</sup>By the law of large numbers, the average village-level rate of HIV should equal the population prevalence. This constraint helps us interpret our parameter estimates  $\hat{h}_j$  correctly within the model.

years from the time of HIV infection. On the other hand, a person taking ART drugs bears costs not captured in the time it takes to reach a clinic. Even if the clinic is in the patient's village, he or she will need to visit the clinic every two months, and wait to see and speak to a health worker. He will be under pressure from that health worker to remember to take the medication every day <sup>4</sup>. ART drugs carry some side effects, which are mild relative to the symptoms of AIDS, but are still a burden.

As expected, the utility from a clinic visit is significantly decreasing in distance. Utility is significantly lower if the village is not in the clinic's catchment area, even controlling for distance, which suggests that formal policy links with a clinic are important.

### 3.3.2 The Cost of Stigma

Interestingly, there does not appear to be social stigma among ART patients. In fact,  $\beta^A$  is positive and significant, suggesting that ART patients from the same village prefer to visit the same clinic. This result may be subject to Manski's reflection problem: it could be that some common shock encourages villagers from the same village to choose the same ART clinic. However, this shock would need to be village-clinic specific, since we control for clinic quality in our specification and we estimate the total rate of ART use in the village, and would have to be unrelated to formal policy links between villages and clinics, as we control for clinic catchment area.

We find that social stigma from general clinic patients is important:  $\beta^G$  is negative and significant. The magnitude of the coefficient suggests that a patient is willing to travel 2.76 extra kilometers to avoid seeing one additional member of their village who is at a clinic for general health care.

We use the results of the incentive experiment conducted by Thornton (2008) to estimate willingness-to-pay for privacy. In Thornton (2008), individuals in Malawi were offered incentives of varying amounts to collect HIV test results at randomly-placed centers near their villages. Thornton (2008) argues that those receiving any incentive were not subject to social stigma, since the incentives provided clear plausible deniability: even those who were unlikely to have HIV would visit the clinic to collect their

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<sup>4</sup>Proper adherence to ART is encouraged in order to prevent the emergence of ART-resistant strains of the virus.



Table 3.1: Clinic Choice for ART Patients

	Utility function parameters
$\beta^V$ (value of ART)	1.500*** (0.295)
$\beta^D$ (distance to clinic)	-0.138*** (0.016)
$\beta^A$ (number of ART patients from same village)	1.795*** (0.252)
$\beta^G$ (number of general patients from same village)	-0.381** (0.162)
$\beta^X$ (outside catchment area)	-1.480*** (0.266)
Clinic ( $k$ )	Predicted Share - Actual Share
No treatment ( $k = 0$ )	-0.0005
BLM ( $k = 1$ )	0.0000
Chamba ( $k = 2$ )	-0.0001
Lambulira ( $k = 3$ )	-0.0001
Likangala ( $k = 4$ )	-0.0001
Magomero ( $k = 5$ )	0.0000
Makwapala ( $k = 6$ )	0.0000
Matawale ( $k = 7$ )	0.0000
Matiya ( $k = 8$ )	-0.0001
Mayaka ( $k = 9$ )	0.0000
Namikango ( $k = 10$ )	0.0000
Nasawa ( $k = 11$ )	0.0001
Police College ( $k = 12$ )	0.0000
Pirimiti ( $k = 13$ )	0.0006
Thondwe ( $k = 14$ )	0.0001
Zomba Central Hospital ( $k = 15$ )	0.0002
Clinic fixed effects	Yes
Obs (Individuals)	53,230

Administrative data from 15 health facilities offering ART. Patient data from 244 villages in Zomba District includes all existing ART patients in 2013 and two months of data for general health patients. Estimation is constrained simulated MLE. Standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

payment. Conditional on any incentive offered, the marginal effect of increasing the size of the incentive by \$0.41 USD<sup>5</sup> was found to equal the marginal disincentive of needing to travel one additional kilometer to reach the center. In that paper, the cost of travel was slightly lower than our estimates (though almost identical to the estimates we will obtain for general health patients, in Section 3.4.1). This may be because ART patients find it harder to travel, or because they recognize some switching costs: traveling to a distant clinic once for ART means having to keep traveling that distance every couple of months. We adjust our cost estimate to take this difference in travel costs into account, and set one kilometer of travel for ART equal to \$0.53.

Applying those estimates to our setting, we find that on average, an ART patient is willing to pay \$1.47 to avoid seeing one person from their own village on a given visit. For the average person considering ART treatment, there will be average of 0.21 others from their village seeking general health care at the nearest clinic on a given day. The total cost of stigma faced by the average person at their nearest clinic is therefore \$0.31. Because ART patients need to visit the clinic approximately 6 times per year, this works out to an annual cost of \$1.86, or approximately 3 days' income<sup>6</sup>. This may help explain why most ART patients do not choose the nearest clinic for treatment.

Our estimates may understate the level of stigma for two reasons. First of all, we base the rate of general clinic attendance on only two months' worth of data, so the regressor is measured with error. Second, Zomba Central Hospital in the city of Zomba is the most preferred option, and is not the nearest clinic to any village. One reason the hospital may be preferred is the perceived anonymity of receiving health care in a big hospital in a city. In addition, HIV testing and treatment are conducted in a separate wing of Zomba Central Hospital, which may afford more privacy than a rural clinic. These effects are difficult to disentangle from other measures of quality.

### 3.4 Policy

In the previous section, we calculated the private cost of HIV-related stigma on ART patients. However, ART use has many positive externali-

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<sup>5</sup>Dollar amounts are adjusted to 2014 USD.

<sup>6</sup>According to the World Bank, Malawi's GNI per capita was \$250 in 2014.

ties, including economic externalities generated by a healthy and productive person living with HIV, as well as epidemiological externalities: ART drugs prevent both mother-to-child HIV transmission and HIV transmission between sexual partners.

For these reasons, policy makers may be interested in increasing the total rate of ART use in the population. In this section, we will investigate the effect of policies which reduce costs associated with ART use, including stigma and travel costs. We are able to use our estimated utility function (Table 3.1) to make predictions about the effects of policy changes that affect the parameters  $\beta$  and  $\{Q_k\}$ . By calculating the predicted share of the population that chooses  $k = 0$  under various counterfactuals, we can investigate the effect of a policy change on rates of ART use.

In order to conduct policy experiments related to travel costs and improvements in clinic quality, we must recognize that such policy changes will impact both the decision to seek ART and the decision to seek general health care. For this reason, we expect to find a complementary effect between a reduction in stigma and a reduction in travel costs. To this end, we must begin by examining the decision to seek general health care.

### 3.4.1 General Health Care Choices

In order to understand how a person chooses whether and where to seek general health care, we again turn to McFadden's conditional logit model. We estimate clinic quality for general health care (which may be different from clinic quality for ART), and the effect of distance. We estimate the model using data from general patient rosters at the same set of clinics we used in the ART analysis, as described in Section 3.2.1. Full details of the model and estimation are available in the Appendix (3.A), and the results appear in Table 3.2.

Table 3.2 shows that in a given two month period, most people do not need to visit a clinic for general health care (the average value of care is negative), that people are significantly more likely to visit a clinic if their village is in the catchment area, and that travel costs are significant. Any policy to reduce travel costs will therefore increase visits for general health care, and therefore increase stigma.

Table 3.2: Clinic Choice for General Patients

	Utility function parameters
$\beta^V$ (value of health care)	-0.829*** (0.222)
$\beta^D$ (distance to clinic)	-0.105*** (0.019)
$\beta^X$ (outside catchment area)	-2.069*** (0.162)
Clinic fixed effects	Yes
Obs (Individuals)	53,230

Administrative data from 18 health facilities offering general care. Patient data from 244 villages in Zomba District includes two months of data for general health patients. Estimation is simulated MLE. Standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

### 3.4.2 Elimination of Stigma

A natural first counterfactual to investigate is the elimination of social stigma. Of course, the elimination of stigma is not in and of itself a policy. However, policymakers spend considerable energy devising programs which are more or less effective in this endeavor. There is evidence, for example, that monetary incentives reduce stigma (Thornton, 2008). In Chapter 5, we show that information on the public benefits of ART can also significantly reduce stigma. While programs to improve patient privacy do not reduce the level of stigma itself, they are designed to reduce its cost. In this section, we investigate the maximum potential gain from such policies.

If ART patients did not experience social stigma from other village members, they would not face a cost from seeing other village members at the clinic, and the coefficient  $\beta^G$  would equal zero. In order to calculate the rate of ART use in the absence of social stigma, we must recalculate the predicted share of the total population that would seek ART drugs, using estimates  $\beta^G = 0$  and the new predicted values of the variable  $N_{jk}^A$ , which represents the number of other ART patients from the same village, at the same clinic on a given day.

The elimination of stigma on its own does not cause a large increase in ART use. In fact, with no other policy changes in place, the rate of ART use among HIV positive people would increase from 33% to 35%, a 6% proportional increase. This effect size is fairly small for two reasons. First, while the cost of stigma at the nearest clinic is high for many people, many have the option of traveling to another clinic which is not much further but at which the cost of stigma is low. Second, as we shall see in the following sections, travel costs are much larger barriers to ART use, and reducing both travel costs and stigma would be more effective than reducing only one or the other.

### 3.4.3 Travel Costs

A reduction in travel costs should affect ART use through several channels. First, lower travel costs should increase treatment directly, by making it easier for patients to reach the clinic. They should also increase ART use indirectly, as patients prefer to travel to the clinic together.

Travel costs may also decrease ART use due to stigma: lower travel costs will increase attendance at clinics for general health care. However, this is mitigated by the fact that it is now easier for patients to travel further to avoid stigma from other community members.

Let us investigate a policy which reduces travel costs by fifty percent. This policy increases total general health clinic visits by 13%, and will therefore surely lead to an increase in the cost of social stigma. In fact, the total effect on ART use is positive: ART use from 33% to 56%, a 70% proportional increase. Even in the presence of stigma, reducing travel costs has a much larger effect on ART use than a policy to reduce stigma.

We might expect to find a complementarity between reducing travel costs and reducing stigma. Because lower travel costs increase the burden from stigma, a policy which both reduces stigma and travel costs would be more effective than a policy that does only one or the other.

Suppose we implement a policy that both eliminates social stigma and reduces travel costs by 50%. This will increase general health care visits, but such visits will no longer impose a negative externality on ART patients. From a baseline level of 33%, such a policy would increase ART use to 58% of the HIV positive population. The effects of stigma and transport cost reduction are approximately additive.

### 3.4.4 Clinic Quality

We investigate a policy which improves clinic quality for all patients, and increases the benefit to patients by \$2 (approximately 3 days' income)<sup>7</sup>.

Reducing wait times, providing a greater variety of good medication, and increasing the number or skills of staff would all qualify as increases in clinic quality. Some other policies would have an identical effect to an increase in clinic quality. For example, increasing information about the benefits of health care, and in particular, the benefits of ART would be isomorphic to an increase in the quality of service.

If the quality of general care increases by \$2, as measured by increased utility for the patient, general health care attendance at clinics will increase by 40%. If the quality of ART provision increases by the same amount, the total increase in ART use may be expected to increase due to the direct effect of quality, but may also decrease due to stigma from additional general care patients at the clinic. We estimate ART use to increase from 33% to 53%.

In contrast, if only the level of ART service increases, while general health care quality stays constant, ART rises slightly higher to 54% because there is no additional stigma burden from an increase in general health patients.

Finally, there is a complementarity between eliminating stigma and increasing clinic quality. If we increase clinic quality for *either* ART patients *or* all patients, and at the same time eliminate social stigma, ART use will increase from 33% to 56%.

The complementarity between stigma and clinic quality is stronger than the complementarity between stigma and travel costs. When travel costs decrease, ART patients face a higher stigma burden from the corresponding increase in general health care patients, however, this is mitigated by the fact that it is now easier to travel even further to avoid seeing neighbors from the same village. Clinic quality improvements also increase the stigma burden, but do not make it any easier to travel far for ART drugs.

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<sup>7</sup>We again use the calibration from (Thornton, 2008) in which one additional kilometer of travel for general health care is worth \$0.41, and use this calculation to add \$0.68 in utility to overall clinic quality.

### 3.A Appendix: Discrete Choice Model for General Care

In this appendix, we estimate a discrete choice model of general health seeking behavior.

In Malawi, general health care is provided at many rural and urban health facilities. Services include pre and post-natal exams and advice, infant health care, prescriptions for pain medication, antibiotics and contraception, anti-malarial treatment, wound care, and many other services. Each village is in the catchment area of one particular clinic, yet village members are free to visit any health facility. Within the geographic areas included in this study (TA Mwambo and TA Chikowi in Zomba District), there are 17 rural health facilities and one urban hospital: Zomba Central Hospital.

In our discrete choice model, each person can choose between many clinics at varying quality and distance, and if in need of health care, may choose a particular clinic to maximize utility. We estimate the model using a dataset of general health patients from 244 villages in Zomba, Malawi, and administrative data from all 18 health facilities<sup>8</sup> in the area. We find that distance and quality are significant factors in a person's decision to seek general health care. We model a situation in which individuals choose whether or not to seek health care, and which clinic to visit for treatment. As in Chapter 3, we follow McFadden's conditional logit model of discrete choice, (McFadden et al., 1973). For each individual, we define a utility function which depends on the features of the potential choice of clinic and the person's home village.

#### 3.A.1 Model

A person  $i$  from village  $j$  who chooses clinic  $k \in 1, \dots, K$ , or chooses to abstain from medical care,  $k = 0$ , receives utility

$$u_{ijk} = V_{ijk} + \epsilon_{ijk}. \quad (3.8)$$

where  $V_{ijk}$  captures all of the observable costs and benefits of seeking general health care at clinic  $k$ , relative to not seeking care, and  $\epsilon_{ijk}$  is an

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<sup>8</sup>There are 18 health facilities in the area, 15 of which distribute ART.

error term. In particular, for  $k > 0$ ,

$$V_{ijk} = \beta^V + \beta^D D_{jk} + Q_k + \beta^{\chi^T} \chi_{ijk} \quad (3.9)$$

where  $\beta^V$  is a constant representing the perceived value of receiving treatment.  $D_{jk}$  is the distance in kilometers between village  $j$  and clinic  $k$ , and the coefficient  $\beta^D$  captures the utility cost of travel.  $Q_k$  is a dummy variable which represents the quality of clinic  $k$ .  $\chi_{ijk}$  is a vector containing other regressors which could include individual or village characteristics, or interactions such as whether a village has a formal relationship with a particular clinic.

For a person who does not seek general health care ( $k = 0$ ),

$$V_{ij0} = 0. \quad (3.10)$$

The error term  $\epsilon_{ijk}$  (for  $k = 0, 1, 2, \dots, K$ ) is again assumed to be independently and identically distributed with an extreme value distribution:

$$F(\epsilon_{ijk}) = e^{-e^{-\epsilon_{ijk}}}. \quad (3.11)$$

An person will choose option  $k$  if it generates the largest possible utility out of all options (including the option to abstain,  $k = 0$ ). The probability that a person chooses  $k$  is equal<sup>9</sup> to

$$\mathbb{P}(u_{ijk} \geq u_{ijk'} \forall k' | h_{ij} = 1) = \frac{e^{V_{ijk}}}{\sum_{k'=0}^K e^{V_{ijk'}}}. \quad (3.12)$$

The probability that a person chooses option  $k$  is equal to

$$p_{ijk} = \frac{e^{V_{ijk}}}{\sum_{k'=0}^K e^{V_{ijk'}}}. \quad (3.13)$$

### 3.A.2 Empirical Estimation

In this section, we describe our estimation of the multinomial logit model using administrative health records from Malawi.

In order to measure general patient clinic attendance, we visited all eighteen health facilities in the study area and digitized the general outpatient registers, which include a patient's home village. We collected

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<sup>9</sup>This probability is obtained by integrating the indicator function  $I(u_{ijk} \geq u_{ijk'} \forall k')$  times the probability density function of the extreme value distribution.



two months worth of data. The average rate of clinic attendance among adults is 4.5% per month. 62.5% of patients attend either their nearest clinic or the clinic whose catchment area they belong to.

We use simulated maximum likelihood to estimate the vector of parameters  $\beta$  and clinic fixed effects  $\{Q_k\}$  in equation 3.9. The only additional regressor,  $\chi_{jk}$  is an indicator for whether village  $j$  is in the catchment area of clinic  $k$ , that is, whether clinic  $k$  is formally recommended to villagers for health programming, pre-natal visits, etc.

### 3.A.3 Results

The results of the estimation appear in Chapter 3, in Table 3.2. The average value of care is negative, since in a given two-month period most people do not require medical care. People are significantly more likely to visit a clinic if their village is in the catchment area, and travel costs are significant.

## Chapter 4

# An Information Intervention

In response to the AIDS epidemic, international organizations have put much effort into spreading information about HIV prevention, focusing on abstinence, faithfulness, and condom use as effective measures. Education efforts worldwide have exaggerated the risk of transmission in an effort to encourage a reduction in risk-taking (Kerwin, 2014). Perhaps as a result, misconceptions about HIV transmission are widespread. The rate of HIV transmission, for example, is often overestimated by the general population. The true incidence is less than 1% per sexual interaction, yet average beliefs have been measured as higher than 80% in both Malawi and Burundi (Kerwin, 2014, Sterck, 2013).

In this section, we focus on a second misconception. We find that in our sample of Malawian adults, most respondents are unaware of the fact that a person who is successfully treated for HIV is unlikely to spread the virus to sexual partners. In particular, antiretroviral therapy (ART) reduces HIV transmission by upwards of 96% (Cohen et al., 2011). Providing information about this link between ART and HIV prevention may increase demand for HIV testing and treatment through various channels. An altruistic person who is likely to have HIV would have a greater incentive to seek testing and treatment in order to protect his or her partner or the wider community. The fact that ART prevents HIV transmission may result in a reduction in stigma at the community level (discussed in more detail in the following chapter). Finally, a person who is likely to have HIV may experience an increase in pressure from sexual partners or other members of the community to seek treatment in order to prevent HIV transmission.

In this chapter, we describe an information intervention to change

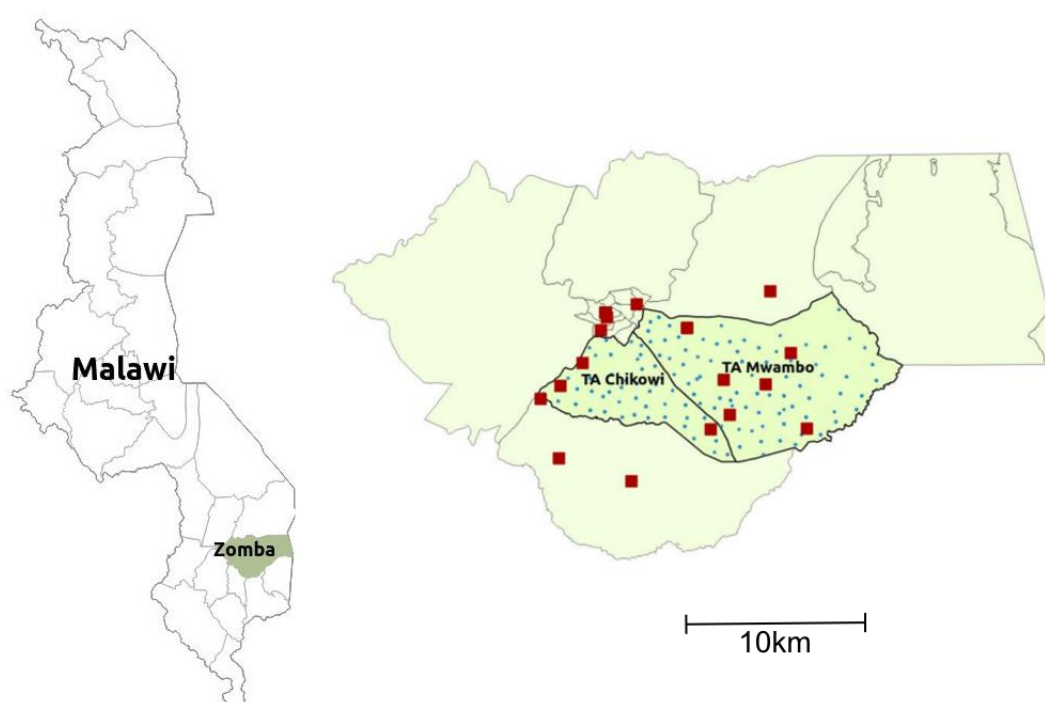
beliefs about the effect of ART on HIV transmission. We use data from a follow-up survey five months after the intervention to evaluate its effect on beliefs, and show that a single community health meeting is sufficient to change beliefs related to HIV transmission. We will also investigate the spread of information within communities. We discuss whether characteristics of the health educator, such as gender, background, education and identity are important in their ability to transmit knowledge. Finally, we will investigate heterogeneous effects of the information campaign based on education, gender, age and income.

## 4.1 Setting and Randomization

This chapter evaluates an experiment which took place in Zomba District, Malawi. Malawi is representative of Southern Africa in terms of its relatively high rate of HIV infection, and recent but widespread access to ART drugs. In Zomba District, HIV prevalence is approximately 14.5% (DHS, 2010), and both HIV testing and antiretroviral therapy (ART) are available for free at more than 20 rural clinics.

The study area covers two areas, TA Chikowi and TA Mwambo (see Figure 4.1), within Zomba District. We include only villages with unique names in the district, which enables us to identify the study villages in administrative clinic data. From this set, we selected a random sample of 122 villages, which we randomly assigned to either the treatment or control group, stratifying on population and nearest health facility. The sample is balanced on observable village characteristics (see Table 4.1).

Figure 4.1: Study area



The study included 122 villages in Zomba District, Malawi, represented by blue dots. Administrative data was obtained from 18 health facilities, represented by red squares.

Table 4.1: Balance on Village-Level Covariates

	(1) Control	(2) Treatment	(3) (1) vs. (2), p-value
% of target <sup>†</sup> group tested for HIV pre-intervention	1.302	0.902	0.152
% of men in target <sup>†</sup> group tested for HIV pre-intervention	1.149	0.801	0.239
% of target <sup>†</sup> group tested jointly pre-intervention	0.252	0.126	0.145
% of target <sup>†</sup> group tested far away pre-intervention	0.548	0.403	0.327
% of target <sup>†</sup> group tested positive pre-intervention	0.205	0.137	0.223
% tested for HIV pre-intervention	1.213	1.050	0.308
% initiated ART pre-intervention	1.010	0.894	0.540
% already taking ART pre-intervention	2.582	1.884	0.166
Village in TA Chikowi region	0.400	0.424	0.839
Village distance to health centre	4.489	5.111	0.259
Village distance to Zomba Town	17.490	17.037	0.995
% houses brick <sup>‡</sup>	0.450	0.465	0.566
% houses with livestock <sup>‡</sup>	0.589	0.615	0.346
% primary school educated <sup>‡</sup>	0.289	0.305	0.790
% secondary school educated <sup>‡</sup>	0.103	0.100	0.763
% employed <sup>‡</sup>	0.207	0.246	0.264
Stratification variables			
Indicators for nearest health facility			
Village population			
Observations	60	59	119

All p-values are for a regression of the covariate on village treatment status, controlling for stratification variables. The pre-intervention period is 2.5 months. The post-intervention period is 3 months for HIV testing, and 10.5 months for ART initiation. <sup>†</sup>Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. <sup>‡</sup>This measure is based on the selected sample of surveyed meeting attendees; this selected sample should be the same in treatment and control.

The average village population is 440, with approximately half between the ages of 15 and 49. All villages are within 11 kilometers of a health facility, and the average distance is 5 kilometers.

## 4.2 Intervention

An information intervention took place in each of the 122 study villages, in the form of a community health education meeting sanctioned by the Malawi College of Medicine and the village chief, and conducted by ten community educators<sup>1</sup>. The target population consisted of men and women aged 15 to 49.

Although we use the labels “treatment” and “control” to refer to the two arms of the experiment, we in fact held information meetings in both types of villages in order to isolate the treatment effect of one particular piece of information: the public benefit of ART drugs. In control villages we provided information on the private benefits of ART drugs, while in treatment villages we provided information on both the private and public benefits of ART. In this way, we avoid conflating the effect of beliefs about the public benefit of ART with the effect of information on the existence, private benefit, or availability of ART drugs.

In control villages, community educators started the meeting by eliciting a rough measure of initial beliefs: a show of hands to determine whether meeting attendees were aware of the private benefits of ART. 75% of attendees believed that ART allowed HIV-positive individuals to lead a long and healthy life. Educators then informed meeting attendees that ART increases life expectancy, hides the symptoms of AIDS, and is free at local clinics. They emphasized the importance of correct adherence, and that condom use and abstinence were good methods of HIV prevention. They did not discuss the link between ART use and HIV transmission. Educators used an infographic depicting a reduction in viral load to explain how ART alleviates the symptoms of AIDS (Figure 4.2).

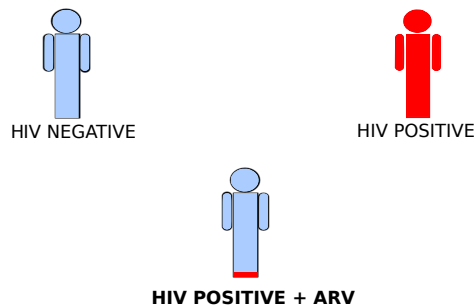
In treatment villages, community educators provided information on both the private and public benefits of ART drugs. First, they provided the same basic information they provided in control villages. Next, they elicited a measure of initial beliefs about the public benefit of ART: a show

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<sup>1</sup>These meetings took place in November and December, 2013. The educators had official identification badges from the Malawi College of Medicine which were meant to increase their credibility.

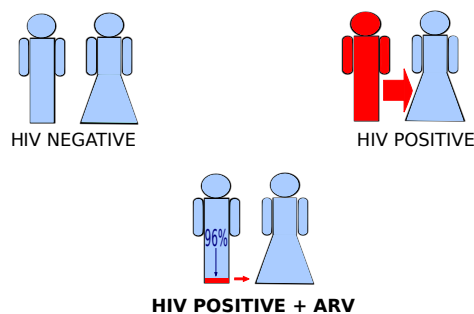
of hands indicated that the public benefit of ART was initially unknown to most community members; on average, only 5% of meeting attendees believed that ART drugs had any effect at all on HIV transmission. Educators then explained the magnitude of the public benefit: that ART reduces the probability of HIV transmission by 96%. They also used an infographic depicting not only the fact that ART reduces a person's viral load, but that this reduction in viral load leads to a reduction in transmission risk (Figure 4.3). The community educators emphasized that this reduction in HIV risk was based on correct adherence to ART as prescribed.

Figure 4.2: Infographic used during intervention: control



Similar infographics with an HIV-positive woman were also shown at each meeting.

Figure 4.3: Infographic used during intervention: treatment



Similar infographics with an HIV-positive woman were also shown at each meeting.

A detailed description of the information provided in treatment and control villages is shown in Table 4.2. Educators followed a carefully worded script, and answered questions only by repeating information already provided. Unanswered questions were referred to the nearest health facility. The meetings were balanced in terms of length (approximately 45 minutes) and community participation; treatment and control villages had different show-of-hands questions and infographics. The information content of the meetings was identical, except for the crucial discussion about ART and HIV transmission.

The community educators first conducted meetings in the control villages, which took place over ten days. At the end of these ten days, training on the treatment village information campaign took place, and the meetings in treatment villages took place over the following ten days. We conducted the control and treatment interventions sequentially in order to prevent information spillovers due to the conduct of the community educators. The team of educators traveled together to a different geographical section of Zomba District on each day, and within that area they were randomly assigned to different villages. Small villages were assigned one educator, while in villages with over 100 households work was done in pairs. Educators disseminated information through a combination of the meeting organized by the village chief and door-to-door campaigning. The educators knew they were to receive large incentives based on knowledge retention in the specific treatment and control villages they had visited, according to data from a survey five months after the intervention<sup>2</sup>. While educators knew the maximum size and timing of the incentive, the exact relationship between the survey questions and the size of the incentive were left intentionally undefined in order to avert any attempt to “teach to the test.”

Attendance levels at community health meetings were high. An average of 67% of the target population was reached in each village, and approximately two thirds of attendees were women. It does not appear as though the community educators learned to attract more meeting attendees over time; the average attendance level was insignificantly lower in the treatment group (65%) than in the control group (68%). The topic of

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<sup>2</sup>The maximum incentive was approximately 100 USD. These incentives were paid to community educators in May, 2014, and the size of the incentive was based on the percent of community meeting attendees in treatment villages who believed that ART prevents HIV transmission, and the percent of community meeting attendees in control villages who believed that ART had private benefits, as recorded in the survey.



Table 4.2: Intervention

Topic	Script	Control	Treatment
Initial beliefs about private benefits of ART	<i>Raise your hand if you believe that a person with HIV can live a long and healthy life with ART.</i>	X	
Private benefits of ART	<i>A person who has HIV can live a long, healthy, normal life, as long as he or she takes ART properly.</i>	X	X
ART mechanism: reduction in viral load	<i>If a person with HIV takes ART he will still have HIV, but he will have a lower viral load, so the symptoms may disappear.</i>	X	X
Infographic (control)	Figure 4.2	X	
Initial beliefs about public benefit of ART	<i>Imagine a couple. One person is HIV positive and the other one is HIV negative. If the HIV-positive person takes ART, does that reduce the chance that the virus is passed to his or her partner? Raise your hand if you think the answer is yes.</i>		X
Public benefit of ART	<i>Actually, it is true that if a person with HIV takes ART, it can greatly reduce the chance of spreading HIV. Imagine a certain area where no one takes ART. In that area, 100 people got HIV from their partners last year. If those partners had been taking ART, only 4 people would have gotten HIV. 96 of them would have remained HIV negative.</i>  <i>If a person with HIV takes ART he will become 96% less contagious. This is true for both men and women. This is because ART reduces the amount of virus in the body. When there is very little virus in the body, it is much less likely that the virus will be transmitted from one person to another.</i>		X
Infographic (treatment)	Figure 4.3		X
Other information about ART	<i>Only HIV-positive people should take ART. The person who is taking ART must adhere properly, taking the pills every day, exactly as instructed. If he or she forgets to take the pills, the viral load will go back up.</i>	X	X
Other HIV prevention methods	<i>For maximum protection from HIV, you should be faithful to one partner and use condoms.</i>	X	X
Availability of ART	<i>Health clinics offer free HIV testing and ART.</i>	X	X
Questions	<i>For other questions, ask at the health clinic.</i>	X	X

the meeting was not announced ahead of time, so the sample of meeting attendees should be similar in treatment and control villages. Village chiefs received small gifts of soap and salt for organizing and advertising the meetings, but attendees did not receive any incentive for attendance.

### 4.3 Empirical Estimation

As a first step, we ascertain whether the information campaign achieved its goal of shifting beliefs about the public benefit of ART, and whether other types of beliefs were affected. We also investigate the effect of the intervention on survey measures of stigma.

#### 4.3.1 Survey data

We conducted a survey approximately five months after the intervention. A total of 1,357 individuals were interviewed. The purpose of this survey was to collect individual data on beliefs, attitudes towards HIV, health seeking behavior, and sexual behavior. The survey also provided data on village-level covariates which were not available from census data, such as wealth and education.

The interviewers selected respondents by conducting a random walk within each village<sup>3</sup>. The survey was administered only to those who attended the community health meeting<sup>4</sup>.

The interviewers were hired from a pool of candidates who were not socially connected to the community educators employed for the intervention. Interviewers had no information on the purpose of the original intervention, nor the identities of the treatment and control villages. Out of 122 study villages, 119 were successfully surveyed. In one treatment village and two control villages, village authorities denied permission for a survey to take place due to the recent death of a village leader.

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<sup>3</sup>Two interviewers were assigned to each village; one began the random walk at the center and the other at an outer edge of the village.

<sup>4</sup>This results in selection bias among those interviewed relative to a random sample of the village as a whole, but this selection should be the same in both treatment and control villages.

### 4.3.2 Regression equation

In order to investigate the effect of the information treatment on the beliefs of meeting attendees, we regress each belief measure captured in the survey on the treatment status of the village. Because the information treatment was randomly assigned, this allows us to estimate the causal effect of the information treatment on beliefs.

$$\text{Belief}_{ij} = \alpha + \beta T_j + \delta^T \chi_{ij} + \epsilon_{ij} \quad (4.1)$$

Here,  $\text{Belief}_{ij}$  is a belief measure elicited from respondent  $i$  in village  $j$  and  $T_j \in \{0,1\}$  is the treatment status of village  $j$ .  $\chi_{ij}$  is a set of individual- and village-level covariates<sup>5</sup>. Standard errors are clustered at the village level. Because  $T_j$  is randomly assigned, we expect  $\mathbb{E}(\epsilon_{ij}|T_j) = 0$ , so the OLS estimate  $\hat{\beta}$  is unbiased.

## 4.4 Results

### 4.4.1 Beliefs about the Public Benefit of ART

Eliciting beliefs about the public benefit of ART was a primary goal of the survey, conducted approximately five months after the intervention. Five different measures were collected. We also elicited two of these measures for a subset of community members who did not attend the meeting, in order to gauge the spread of information. Finally, because the information we provided is somewhat complicated and may require a certain level of numeracy to properly explain or understand, we look at heterogeneous effects by respondent's education and community educator's education level.

In our first survey measure, respondents were presented with a list of possible HIV prevention methods, including the use of condoms, mosquito nets, circumcision, abstinence, and ART. They were asked to select those which reduce the probability of transmitting HIV. Most respondents in the treatment group and only 19% in the control group chose ART as a prevention method (see Column 1 of Table 4.3).

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<sup>5</sup>Individual-level controls include age, gender, whether the person is pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, and has a brick house. Village-level controls consist of covariates listed in Table 4.1 and community educator fixed effects.

Next, respondents were asked to agree or disagree (on a Likert five-point scale) with the following statement: *ART reduces the probability that an HIV-positive person will spread the virus to his or her partner.* The information treatment had a significant effect; the average response in the control group was “disagree”, while in the treatment group the average response was “agree” (this measure is in Column 2 of Table 4.3, rescaled).

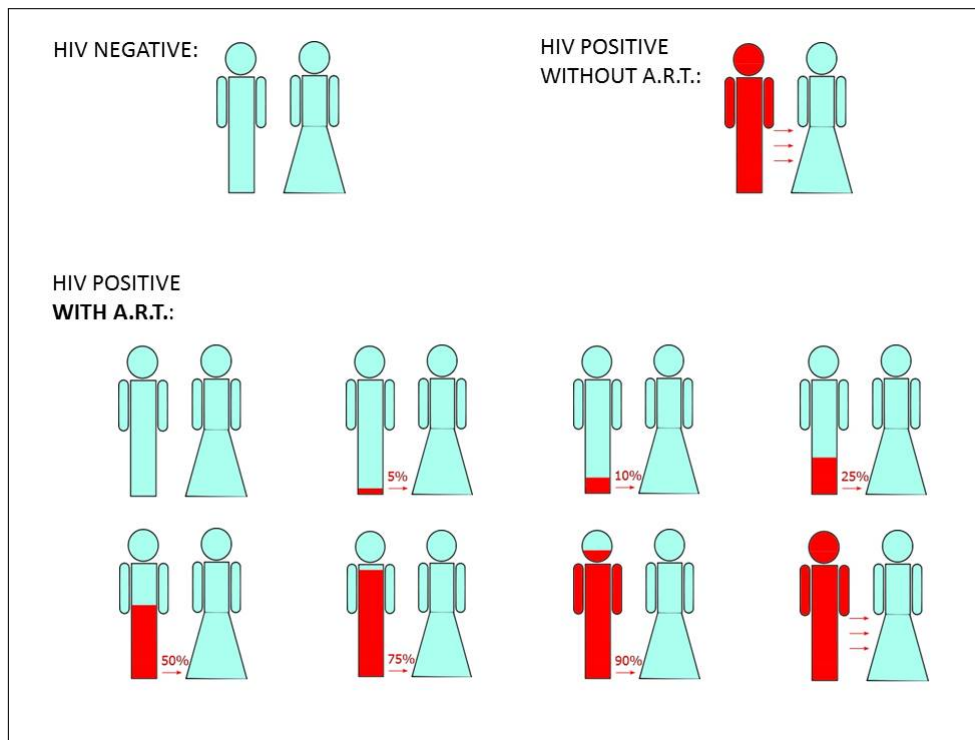
Respondents then ranked the following two types of potential sexual partners according to HIV transmission risk: a person who has never been tested for HIV, and a person who is HIV positive and taking ART correctly. Column 3 of Table 4.3 shows that in the control group, respondents said, on average, that a person who has never been tested for HIV is less risky, while in the treatment group, most said that a person taking ART is a safer sexual partner. This suggests that many who attended the community meeting understood an important implication of the information provided: that a partner who has never been tested might in fact be more risky than a partner who is infected but treated.

In order to elicit beliefs about the rate of HIV transmission with and without ART drugs, we took inspiration from the bean-counting subjective beliefs measure advocated by [Delevande and Kohler \(2009\)](#). Respondents were shown ten bottle caps. Each bottlecap was meant to represent a serodiscordant couple: an HIV-positive person and his or her HIV-negative spouse. Respondents removed one bottle cap for each person who they believed would contract HIV within one year, assuming no one was taking ART. The process was then repeated, under the alternative assumption that all HIV-positive individuals took ART drugs as prescribed. Using these two measures of absolute and relative transmission rates, we calculate the beliefs about the relative reduction in risk associated with ART use. In Column 4 of Table 4.3, we see that based on this measure, individuals in the treatment group believe that the relative reduction in HIV transmission risk is approximately 53%; this is much higher than in the control group (9%) but still well below the true value  $\rho = 0.96$ .

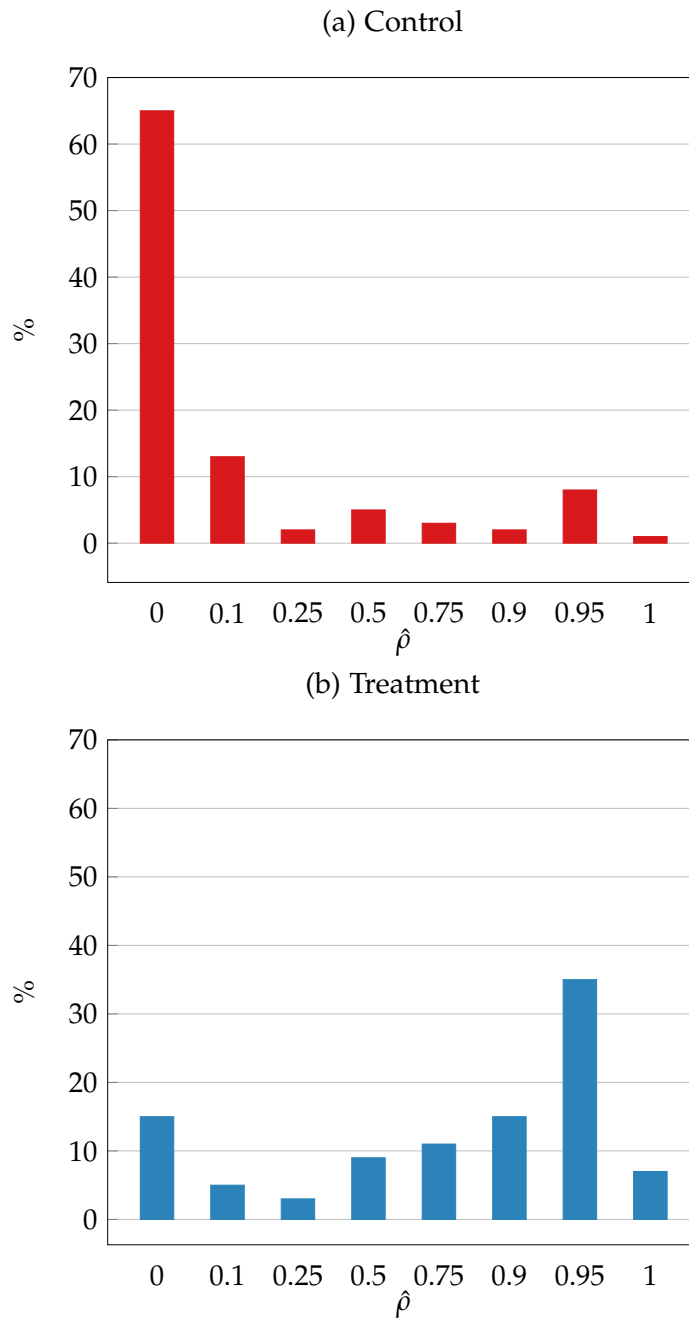
We also capture beliefs about the ART prevention parameter  $\rho$  using an infographic similar to the one displayed at the community health meetings (Figure 4.4). This measure was elicited last to ensure that respondents were not visually reminded of the information campaign before discussing their beliefs. Histograms in Figure 4.5 show that the distribution of beliefs about  $\rho$  is uniformly higher in the treatment group. In Column 5 of Table 4.3, we see that average beliefs  $\hat{\rho}$  are significantly higher in the treatment group, but below the true value  $\rho = 0.96$ . It is

reassuring that the measures in Columns 4 and 5 are somewhat similar.

Figure 4.4: Infographic used to elicit beliefs



Respondents were asked to state their beliefs about the relative rate of HIV transmission for a person taking ART drugs by selecting one of eight options. The top left corresponds to the belief that an infected person taking ART drugs is not at all contagious. The bottom right corresponds to the belief that an infected person taking ART drugs and an infected person not taking ART drugs are equally contagious.

Figure 4.5: Beliefs  $\hat{\rho}$  (ART prevention parameter)

Beliefs were elicited using the infographic in Figure 4.4.

Table 4.3: Survey Measures of Beliefs about  $\rho$ : Does ART reduce HIV transmission?

	(1) Selected ART from list of HIV prevention methods		(2) Likert scale (rescaled 0-1)		(3) Partner taking ART is less risky	(4) Relative reduction: $\hat{\rho}$	(5) Infographic: $\hat{\rho}$
	<i>non- attendees</i>		<i>non- attendees</i>				
T	0.645*** (0.059)	0.020 (0.015)	0.371*** (0.035)	0.111** (0.044)	0.261*** (0.068)	0.439*** (0.050)	0.472*** (0.052)
(T)*(primary school educ.)	0.015 (0.044)		0.048* (0.028)		-0.029 (0.070)	0.077* (0.042)	0.053 (0.036)
(T)*(educator educ.)	-0.116* (0.069)		-0.043 (0.043)		0.078 (0.083)	-0.041 (0.057)	-0.006 (0.065)
Educator educ.	0.072 (0.054)		0.022 (0.030)		-0.061 (0.059)	0.044 (0.035)	0.053 (0.047)
Mean of dep var in control	0.19	0.01	0.44	0.44	0.43	0.09	0.18
Individual controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Village-level controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Obs (Individuals)	1343	536	1340	510	1341	1310	1340

Survey to meeting attendees ((1b) and (2b) to non-attendees) in all villages.  $\rho = 0.96$  the relative reduction in HIV transmission with ART drugs. (1) Selected ART as method of preventing HIV from list. (2) Likert-scale measure, rescaled to (0,1): *Do you agree or disagree? If a person who is HIV positive takes ART it will reduce the chance that he transmits HIV to his or her partner.* (3) Used ten bottle caps to show beliefs about absolute transmission probability with/without ART. These were used to calculate relative reduction in risk. (4) Believes that a person on ART drugs is less likely to transmit HIV than a person who has never been tested. (5) Selection from Table 4.4, rescaled into a measure of  $\rho$ . T = respondent's village is in treatment group. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. Village-level controls: Table 4.1. Robust standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

## 4.4.2 The Role of Education

The ability to understand relative rates of HIV transmission with and without ART drugs might depend on numeracy skills. For this reason, in order to benefit from the information campaign, one might require an education. Surprisingly, Table 4.3 shows that while two of the five belief measures seem to show that more educated respondents better understood the information campaign, the effect of the intervention is still large and highly significant for uneducated respondents (those who had not completed primary school).

We also investigate the effect of the community educator's education. Five community educators had completed only secondary school, while the other five had completed some type of post-secondary degree or diploma. Table 4.3 shows that both types of educators were equally able to transmit the intended information. This is useful from a policy point of view, as in Malawi and many other sub-Saharan African countries, a secondary education is relatively common while post-secondary is not.

## 4.4.3 The Spread of Information

There are reasons to believe that, while the information provided at the community health meetings was useful and important, it may not have been shared with non-attendees. Speaking about HIV may be viewed as a signal of infection, and a person who claims that a treated, infected partner is not contagious may be disbelieved and viewed with suspicion.

While the goal of the survey was primarily to interview those who attended community meetings, we also conducted short interviews of 536 non-attendees in an effort to gauge the spread of information within each village. We asked only two questions, corresponding to the first two measures of beliefs about the public benefit of ART. As shown in Columns 1 and 2 of Table 4.3, while information may have spread to some community members who did not attend a meeting, the effect of the campaign on non-attendees was small.

## 4.4.4 Beliefs about the Private Benefits of ART

Both treatment and control villages received basic information about the private benefits of ART drugs, and indeed, Column 1 of Table 4.4 shows that respondents' beliefs do not differ between the treatment and control



groups. Respondents were asked to agree or disagree, on a five-point Likert scale, with the statement *An HIV-positive person can live a long and healthy life if he takes ART*. This statement closely matches the intervention script. In both treatment and control villages, the average respondent strongly agreed with the statement.

#### 4.4.5 Beliefs about HIV Transmission and Prevalence

The information campaign could have affected several beliefs about HIV. The knowledge that ART reduces HIV transmission may cause individuals to update their beliefs about the overall HIV prevalence in their community. In addition, while the absolute transmission rate was not mentioned during the information campaign, attendees may have formed some correct or incorrect beliefs about this rate based on the information that was provided. However, Table 4.4 shows that there were no significant changes in these beliefs.

As mentioned above, we elicited beliefs about the absolute transmission rate using ten bottle caps. We asked respondents how many HIV-negative individuals with infected, untreated partners would contract the virus over the course of one year. The respondent removed one bottle cap for each case of HIV transmission. We also used bottle caps to measure beliefs about prevalence. Ten bottle caps represented ten randomly selected members of the community, and the respondent was to remove one bottle cap for each member who was HIV positive.

Columns 2 and 3 of Table 4.4 show that neither beliefs about the absolute transmission rate, nor beliefs about HIV prevalence were affected by the information campaign. We might expect beliefs about prevalence to be lower in the treatment group, as respondents are aware that ART should slow the spread of HIV in the population. While this coefficient is negative, it is small and insignificant. This may be explained by fact that ART has only been available for the past few years, and adoption has been low, so a reasonable update in beliefs about the spread of HIV might be quite small.

Beliefs about HIV transmission and prevalence are incorrect in both treatment and control villages. In particular, beliefs about the absolute probability of HIV transmission are much higher than the true value, which, according to the Malawi National AIDS Commission, is approximately 10% per year. These beliefs are consistent with the overestimates of HIV transmission rates measured by Kerwin (2012) in Malawi, and may

Table 4.4: Survey Measures of Other Beliefs about HIV

	(1) ART leads to a long and healthy life: Likert scale (rescaled 0-1)	(2) Absolute transmis- sion probability (one year)	(3) HIV prevalence in community
T	0.007 (0.008)	-0.009 (0.009)	0.011 (0.012)
Mean of dep var in control	0.95	0.96	0.54
Individual controls	Yes	Yes	Yes
Village-level controls	Yes	Yes	Yes
Obs (Individuals)	1340	1330	1224

Survey to meeting attendees in both treatment and control villages. (1) A Likert-scale measure, rescaled to (0,1): *Agree or disagree with the following statement: an HIV-positive person can live a long and healthy life if he or she takes ART properly..* (2) The respondent used ten bottle caps to show their beliefs about the one-year probability of HIV transmission for a serodiscordant couple who are not using condoms or taking ART. (3) The respondent used ten bottle caps to show their beliefs about the HIV prevalence in the village. T = respondent's village is in treatment group. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. Village-level controls: Table 4.1. Robust standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

be explained by a health education policy which purposely overstates the risk of contracting HIV in an effort to discourage risk taking behavior.

## Chapter 5

# Stigma as Statistical Discrimination

In this chapter, we present evidence for a particular mechanism through which HIV may be stigmatized: the rational fear of HIV transmission between sexual partners. This type of stigma, when combined with a signalling model of HIV testing, provides an economic microfoundation for social stigma in the context of HIV testing and treatment. We undertake a clean empirical test of the underlying mechanism, making use of the information experiment described in Section 4.2.

In the model, a person seeks an HIV test only if he is likely to be HIV positive, and thus benefit from access to antiretroviral therapy (ART). This leads to adverse selection among those seen to seek an HIV test: they are more likely than the average person to be HIV positive. Society will view HIV testing as a signal of transmission risk, and some fraction of the population will reject potential partners seen or known to have been tested for HIV. This strategy in turn discourages members of the community from getting tested, as they realize they will face a penalty in their personal lives.

This signalling equilibrium is based on a misconception: in fact, a person who has been tested and treated for HIV is a relatively low-risk sexual partner, because of the capacity for ART drugs to greatly reduce HIV transmission (Cohen et al., 2011). For this reason, the information intervention discussed in Chapter 4 is a useful test of this theory of stigma. By investigating the effect of the intervention on health seeking behavior, we will present evidence for fear of contagion as a source of stigma, and show that it is a significant barrier to HIV testing.

## 5.1 Theory

We define HIV-related stigma as a phenomenon whereby individuals who are suspected of having HIV are excluded from social interactions<sup>1</sup>. This chapter focuses on one potential source of stigma, and one particular type of social interaction. Individuals who are likely to be HIV positive may be excluded from sexual interactions due to a rational fear of contagion. If HIV testing is a signal of underlying risk, that is, high-risk individuals are more likely to seek an HIV test, then those who do so may face statistical discrimination by potential sexual partners. Other types of stigma, and other barriers to HIV testing<sup>2</sup> may exist, and are included in the model in reduced form<sup>3</sup>. Comparative statics will show that the information experiment reduces stigma if and only if it is due to a fear of HIV transmission; other forms of stigma and costs of testing remain unaffected.

### 5.1.1 Environment

We model the HIV testing decision as a one-sided signalling game between two players, over two periods. In the first period, the first player decides whether to seek an HIV test based on his private type, which corresponds to his HIV risk. In the second period, he is matched at random to a potential sexual partner, who might observe whether or not he has been tested for HIV. Based on this signal, the second player decides whether or not to consent to a sexual relationship.

Consider a continuum of agents  $\mathcal{A} = [0, 1]$ , and another continuum of equal measure  $\mathcal{B} = [0, 1]$  which represents potential sexual partners for agents in  $\mathcal{A}$ . A fraction  $\bar{h}$  of individuals  $a \in \mathcal{A}$  are HIV positive, while every  $b \in \mathcal{B}$  is HIV negative<sup>4</sup>. We denote HIV status by  $h_a \in \{0, 1\}$ .

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<sup>1</sup>This is derived from the seminal definition by Goffman (1963), who defines stigma as “The phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute.”

<sup>2</sup>HIV testing has increased significantly over the past decade, in part due to increased supply of HIV testing services and ART. We do not wish to suggest that stigma is the only potential barrier to HIV testing.

<sup>3</sup>For ease of exposition, we include only stigma from potential sexual partners. Allowing for stigma from the general population does not produce a substantially different model or predictions.

<sup>4</sup>We shall refer to  $a$  as “he” and  $b$  as “she” for clarity, but the model is not meant to be gender specific.

We assume that individuals possess asymmetric information about their own HIV risk, as they have full knowledge of past risk-taking behavior and current symptoms. In the first period, each agent  $a \in \mathcal{A}$  privately observes his type  $\theta_a$ . This represents his probability of being infected, which takes one of two values:

$$\theta_a \in \{\theta_L, \theta_H\}$$

with  $0 < \theta_L < \theta_H < 1$ . We refer to these two types as low-risk and high-risk types, respectively.

The agent  $a$  then decides whether or not to seek an HIV test, and if so, whether to test at a far away clinic  $t_a^F \in \{0, 1\}$  or nearby  $t_a^N \in \{0, 1\}$ , such that  $t_a^N + t_a^F \in \{0, 1\}$  (agents cannot test in both locations). HIV testing is beneficial to those who are infected, as it provides immediate access to ART drugs<sup>5</sup>. ART drugs yield total payoff  $v$  every period if the test result is positive, and 0 otherwise.

The cost of traveling to a nearby clinic is  $c$ , while traveling to a far away clinic costs  $c + d$ . These costs are not necessarily monetary: they include the opportunity cost of time, the probability that the clinic is closed, and the psychic cost of learning one's HIV status.

We assume that for low-risk types, the direct cost of HIV testing is higher than the expected benefit of access to medication, as the test result is unlikely to be positive. Meanwhile, for high-risk types, the expected benefit is higher than the direct cost.

$$\theta_L v(1 + \delta) < c < \theta_H v(1 + \delta) \quad (5.1)$$

Here  $\delta$  denotes the discount factor between periods 1 and 2. We also assume that the cost of traveling to a far away clinic is bounded in the following way<sup>6</sup>.

$$\frac{d}{1 - \phi} < \theta_H v(1 + \delta) - c \quad (5.2)$$

Agents  $a \in \mathcal{A}$  receive the following payoff at the end of the first period.

$$u_1^a(n, f) = (t_a^N + t_a^F)(h_a v - c) - t_a^F d \quad (5.3)$$

In the second period, each agent  $a \in \mathcal{A}$  is matched at random with a

<sup>5</sup>In this model, if we allowed those who tested positive to forgo ART, a person who knows he would do so would have no motivation to test in the first place.

<sup>6</sup>If this does not hold, then no equilibrium will exist in which agents test far away.

potential sexual partner  $b \in B$ . While  $b$  is aware of the population HIV prevalence  $\bar{h}$ , she does not observe  $a$ 's risk type directly, and she does not observe whether or not he is HIV positive.

Agent  $b$  may, however observe  $a$ 's testing decision. If  $a$  tested nearby, he is observed with probability one, while if he tested far away, he is observed with probability  $\phi \in (0, 1)$ . This is modeled by a signal  $\sigma_a \in \{0, 1\}$  with  $\mathbb{P}(\sigma_a = 1) = t_a^N + \phi t_a^F$ . Agent  $b$  uses this signal to form beliefs about the probability that her partner  $a$  is HIV positive; we denote these beliefs by  $\hat{\theta}_b(\sigma_a)$ .

Agent  $b$  then decides whether to consent to a sexual relationship with her match,  $m_b \in \{0, 1\}$ . If  $b$  consents,  $a$  and  $b$  obtain relationship benefits  $y_a \sim G$  and  $y_b \sim G$  respectively<sup>7</sup>, where the distribution  $G$  has positive support.

Consenting to the relationship comes with a cost to agent  $b$ ; she risks becoming infected with HIV. Because ART drugs reduce HIV transmission, the probability of contracting HIV from an infected partner depends on whether or not he has been tested and treated. The relative reduction in HIV transmission risk associated with ART use is denoted by  $\rho$ , and the true value is approximately 0.96 (Cohen et al., 2011). We denote the absolute transmission rate by  $\tau$ ; this is the probability that an infected person transmits HIV to his sexual partner if he is not taking ART. The cost of contracting HIV is  $s$ .

We also allow for other forms of stigma. Agent  $b$  may experience disutility from a relationship with an HIV-positive person distinct from the possibility of contracting HIV. This could be, for example, because of  $a$ 's propensity for infidelity, because of social norms, or because of a taste parameter. We capture all of these costs in reduced form, denoted by  $s_0$ .

If  $b$  chooses to consent, the second-period payoff to agent  $a$  consists of the benefit of the relationship and, in the case where he has tested positive for HIV, the value of ART drugs .

$$u_2^a(m_b) = m_b y_a + (t_a^N + t_a^F)(h_a v) \quad (5.4)$$

The second-period payoff to agent  $b$  depends on both the benefit of the relationship and the risk of contracting HIV.

$$u_2^b(m_b) = m_b \left[ y_b - h_a \left( s\tau \left( 1 - \rho(t_a^N + t_a^F) \right) + s_0 \right) \right] \quad (5.5)$$

<sup>7</sup>We have assumed that  $a$  always obtains net benefit from the relationship. We do not model his consent decision.

In calculating the payoff to agent  $b$  we make use of our assumption that everyone who seeks an HIV test receives ART immediately. This allows agent  $b$  to conclude that an HIV-positive individual who has been tested is less contagious, as captured by the term  $(1 - \rho(t_a^N + t_a^F))$ .

We now make two additional assumptions. First,

$$\mathbb{P}(y_b > \bar{h}(s\tau + s_0)) = 1; \quad (5.6)$$

the net payoff from a sexual relationship with the average, untreated member of the population is always positive. Second,

$$\mathbb{P}(y_b < s\tau + s_0) = 1; \quad (5.7)$$

the net payoff from a sexual relationship with an untreated, HIV-positive match is always negative.

### Heterogeneous beliefs about the effect of ART

In order to illustrate the link between the model of stigma and the experiment we use to test it, we assume that agents differ in their perception of the risk of HIV transmission. Specifically, agents in  $\mathcal{B}$  have heterogeneous beliefs about the extent to which ART drugs prevent the spread of HIV. Each agent  $b \in \mathcal{B}$  has belief  $\hat{\rho}_b \in [0, 1]$  about the relative reduction in HIV transmission risk associated with ART. For example,  $\hat{\rho} = 0$  corresponds to the belief that ART has no effect on transmission, and  $\hat{\rho} = 1$  to the belief that it is impossible to contract HIV from a person taking ART.

We denote by  $F_{\hat{\rho}}$  the distribution of beliefs<sup>8</sup> in the population  $\mathcal{B}$ . We assume that  $F_{\hat{\rho}}$  is common knowledge among the population  $\mathcal{A}$ . This distribution of beliefs forms a key link between the model and our experimental design: our intervention provides information on the true value of  $\rho$ , which leads to a shift<sup>9</sup> in the distribution  $F_{\hat{\rho}}$ .

### 5.1.2 Strategies and Equilibria

We solve for the pure-strategy Perfect Bayesian Equilibria of this game.

<sup>8</sup>We do not assume any relationship between the distribution of beliefs and the true value  $\rho = 0.96$ . Indeed, Figure 4.5 illustrates the extent to which beliefs are incorrect.

<sup>9</sup>The distribution of beliefs, as well as the effect of the intervention are illustrated in Figure 4.5.



In the first period, agents in  $\mathcal{A}$  choose an HIV-testing strategy  $\{t^N, t^F\}$  to maximize their present discounted expected utility

$$\mathbb{E}(u_1^a + \delta u_2^a),$$

taking their private types, the strategies of  $\{b \in \mathcal{B}\}$ , as well as beliefs  $F_{\hat{\rho}}$  and  $\{\hat{\theta}_b(\sigma) : b \in \mathcal{B}\}$  as given.

In the second period, agents  $b \in \mathcal{B}$  receive the signal  $\sigma_a$  and form corresponding beliefs about  $a$ 's type  $\hat{\theta}_b(\sigma_a)$ , which are consistent on the equilibrium path. That is, agents use Bayes' rule to calculate the probability that a person is infected, taking into account whether or not they were observed seeking an HIV test. They then choose whether or not to consent in order to maximize their expected utility, based on their beliefs  $\hat{\rho}_b$  and  $\hat{\theta}_b$ .

**Proposition 1.** *There are two classes of pure-strategy Perfect Bayesian Equilibria in this game. The first is a "stigma" equilibrium, in which a fraction  $S$  of agents in  $\mathcal{B}$  reject a match who has been observed seeking an HIV test, and the remaining fraction  $1 - S$  of agents consent to any match. The second is a "reverse stigma" equilibrium, in which a fraction  $P$  of agents in  $\mathcal{B}$  consent if and only if their match has been observed seeking an HIV test.*

We restrict attention to the "stigma" equilibrium, as the "reverse stigma" equilibrium implies universal testing, which is not consistent with the low testing levels observed in the data. Discussion of this second equilibrium, as well as the proof that no other equilibria exist is deferred to Appendix 5.A.

### The stigma equilibrium

We begin by characterizing the most important equilibrium for our purposes, in which there is stigma against HIV testing. In this equilibrium, every  $b \in \mathcal{B}$  consents to a match who has not been observed testing, but a proportion  $S$  of  $\{b \in \mathcal{B}\}$  reject those who have been observed seeking an HIV test.

Given this strategy by agents in population  $\mathcal{B}$ , the decision to test for HIV is based on the expected impact on present discounted utility, which is equal to

$$\theta_a v(1 + \delta) - c - \delta S y_a$$

if the test is sought at a nearby clinic, and

$$\theta_a v(1 + \delta) - c - d - \phi \delta S y_a$$

if the test is sought at a far away clinic. In both cases, there is an indirect cost of testing due to the stigma agent  $a$  might face in the next period, and this cost is higher if  $a$  chooses to test nearby.

By assumption (5.1), low-risk types will never seek an HIV test in this equilibrium. If  $\theta_a = \theta_H$ ,  $a$  will select an action as follows.

$$(t_a^N, t_a^F) = \begin{cases} (0, 0) & \text{if } \frac{\theta_H v(1+\delta) - c - d}{\phi \delta S} < y_a \\ (0, 1) & \text{if } \frac{d}{(1-\phi)\delta S} < y_a \leq \frac{\theta_H v(1+\delta) - c - d}{\phi \delta S} \\ (1, 0) & \text{if } y_a \leq \frac{d}{(1-\phi)\delta S} < \frac{\theta_H v(1+\delta) - c - d}{\phi \delta S} \end{cases}$$

In the absence of stigma, all high-risk types would like to seek an HIV test nearby. However, if  $S > 0$ , high-risk types will choose to not test, test far away, or test nearby depending on their benefit from a future relationship,  $y_a$ . Those who value a future sexual relationship very highly will not seek an HIV test. Agents with intermediate values of  $y_a$  will choose far away testing, and those who value the relationship least will test nearby, as they have less to lose by being observed. In any case, the fact that only high-risk types seek HIV testing results in adverse selection.

We now turn our attention to the consent decision. If an agent  $b$  does not observe her match seeking an HIV test ( $\sigma_a = 0$ ), she will consent to a sexual relationship. This stems from assumption (5.6), which states that any agent  $b \in \mathcal{B}$  would obtain net benefit from a relationship with the average member of the population  $\mathcal{A}$ . Because low-risk types do not test for HIV, they generate the signal  $\sigma = 0$ ; meanwhile, some high-risk types generate  $\sigma = 0$  and others generate  $\sigma = 1$ . Therefore, the person  $b$  has been matched with cannot be more likely to have HIV than the average member of the population. Formally, maximizing her expected payoff (5.5),  $b$  will consent if

$$y_b > \mathbb{E} \left[ h_a \left( s\tau \left( 1 - \hat{\rho}_b(t_a^N + t_a^F) \right) + s_0 \right) \mid \sigma_a = 0 \right]$$

where we have replaced  $\rho$  by the belief  $\hat{\rho}_b$ . The right-hand side of this inequality is always<sup>10</sup> less than or equal to  $\bar{h}(s\tau + s_0)$ , so by assumption (5.6),  $b$  will consent.

If, on the other hand,  $b$  observes that  $a$  has tested for HIV ( $\sigma_a = 1$ ), she infers that he is a high-risk type. She will therefore consent if<sup>11</sup>

$$y_b \geq \theta_H (s\tau(1 - \hat{\rho}_b) + s_0). \quad (5.8)$$

Note that she will only consent if her benefit from the relationship ( $y_b$ ) is sufficiently high, or if she believes that ART is effective at preventing HIV transmission ( $\hat{\rho}_b$  is high).

We are now able to provide a formula for the total level of stigma in the population,  $S$ , which we previously defined as the fraction of agents in  $\mathcal{B}$  who would withhold consent from a match they have observed seeking an HIV test.

$$S = \int_0^\infty \left( \int_0^{1+(s_0/s\tau)-(y/\theta_H s\tau)} f(\hat{\rho}) d\hat{\rho} \right) g(y) dy \quad (5.9)$$

The functions  $f$  and  $g$  represent probability densities for  $\hat{\rho}$  and  $y$  respectively.

### 5.1.3 Comparative Statics

The previous chapter evaluates an experiment that was designed to shift beliefs about the ART prevention parameter  $\rho$ , by disseminating the information that ART reduces HIV transmission by 96%. In our model, we interpret this as a first-order stochastically dominant shift in the distribution  $F_{\hat{\rho}}$ . Indeed, we observe empirically that beliefs are biased towards 0 (most are unaware of the preventative effect of ART), and the information intervention appears to have shifted the distribution uniformly towards 1 (see Figure 4.5).

We now characterize the theoretical implications of such a shift in the distribution of beliefs.

<sup>10</sup>Proof:  $\mathbb{E}(h_a(s\tau(1 - \hat{\rho}_b(t_a^N + t_a^F)) + s_0) | \sigma_a = 0) \leq \mathbb{E}(h_a(s\tau + s_0) | \sigma_a = 0) = \mathbb{E}(\theta_a | \sigma_a = 0)(s\tau + s_0) \leq \mathbb{E}(\theta_a)(s\tau + s_0) = \bar{h}(s\tau + s_0)$

<sup>11</sup>Here, we make use of the fact that she is certain her match is a high-risk type, and has been tested for HIV:  $t_a^N + t_a^F = 1$ . In this case,  $\mathbb{E}[h_a(s\tau(1 - \hat{\rho}_b(t_a^N + t_a^F)) + s_0) | \sigma_a = 1] = \theta_H(s\tau(1 - \hat{\rho}_b) + s_0)$ .

**Proposition 2.** *If  $s = 0$ , a change in the distribution of beliefs  $F_{\hat{\rho}}$  has no effect on the level of stigma  $S$ .*

This comes from (5.8): if  $s = 0$ , a change in  $\hat{\rho}_b$  has no effect on whether  $b$  consents or not. Intuitively, if stigma is based on something other than the risk of HIV transmission, then changing beliefs about the risk of transmission will not affect stigma.

In what follows, we consider the case  $s > 0$ , that is, there is some cost associated with contracting HIV.

**Proposition 3.** *If  $s > 0$ , a first-order stochastically dominant shift in the distribution of beliefs  $F_{\hat{\rho}}$  results in a weak decrease in the level of stigma  $S$ .*

If the distribution of beliefs shifts upward, each agent is more likely to believe that ART is effective in reducing HIV transmission. For some of these agents, this will imply a change in strategy from not consenting to consenting. In aggregate, stigma will decrease. Formally, the level of stigma can be written as

$$S = \int_0^{\infty} F_{\hat{\rho}} \left( 1 + \frac{s_0}{s\tau} - \frac{y}{\theta_H s \tau} \right) g(y) dy. \quad (5.10)$$

Consider a first-order stochastically dominant shift in the distribution  $F_{\hat{\rho}}$ . For each value of  $y$ , the integrand will decrease. Therefore,  $S$  will also decrease. It is worth pointing out that if other forms of stigma  $s_0$  are large relative to the cost of contracting HIV,  $s$ , a shift in beliefs about  $\rho$  will have no effect, as the integrand in (5.10) will equal 1 for any distribution.

Proposition 3 demonstrates that, by shifting beliefs, the direct effect of the information experiment is to reduce the level of stigma in the community, if that stigma is based on a fear of contracting HIV. We next discuss the implications of this reduction in stigma on HIV testing.

**Proposition 4.** *A decrease in stigma leads to an increase in the total number of HIV tests, and an increase in the number of tests at nearby clinics.*

These two statements follow from the fact that a cumulative distribution function  $G(y)$  always increases in  $y$ , and  $\lim_{y \rightarrow \infty} G(y) = 1$ .

**Proposition 5.** *A moderate decrease in stigma has an ambiguous effect on the number of HIV tests at far away clinics, but as  $S \rightarrow 0$ , the number of far away tests approaches zero.*

The fraction of  $\{a \in \mathcal{A}\}$  who choose far away testing equals

$$G\left(\frac{\theta_H v(1 + \delta) - c - d}{\phi \delta S}\right) - G\left(\frac{d}{(1 - \phi) \delta S}\right)$$

which, depending on the distribution  $G$ , may be locally increasing or decreasing in  $S$ .

Figure 5.1 depicts the relationship between stigma, testing levels, and testing location in the case where the distribution  $G$  is normally distributed and initial testing levels are low. In this case, a moderate increase in beliefs results in an increase in far away testing, but as stated in Proposition 5, this is not a general result. The effect depends on the distribution  $G$  and on initial testing levels.

Finally, it is important to note that the predicted change in HIV testing behavior comes from a decrease in stigma, which is driven entirely by the beliefs of potential sexual partners. This leads to a specific empirical implication: that the decision to test for HIV should depend on the beliefs of the community, and not on one's own beliefs about the preventative nature of ART drugs.

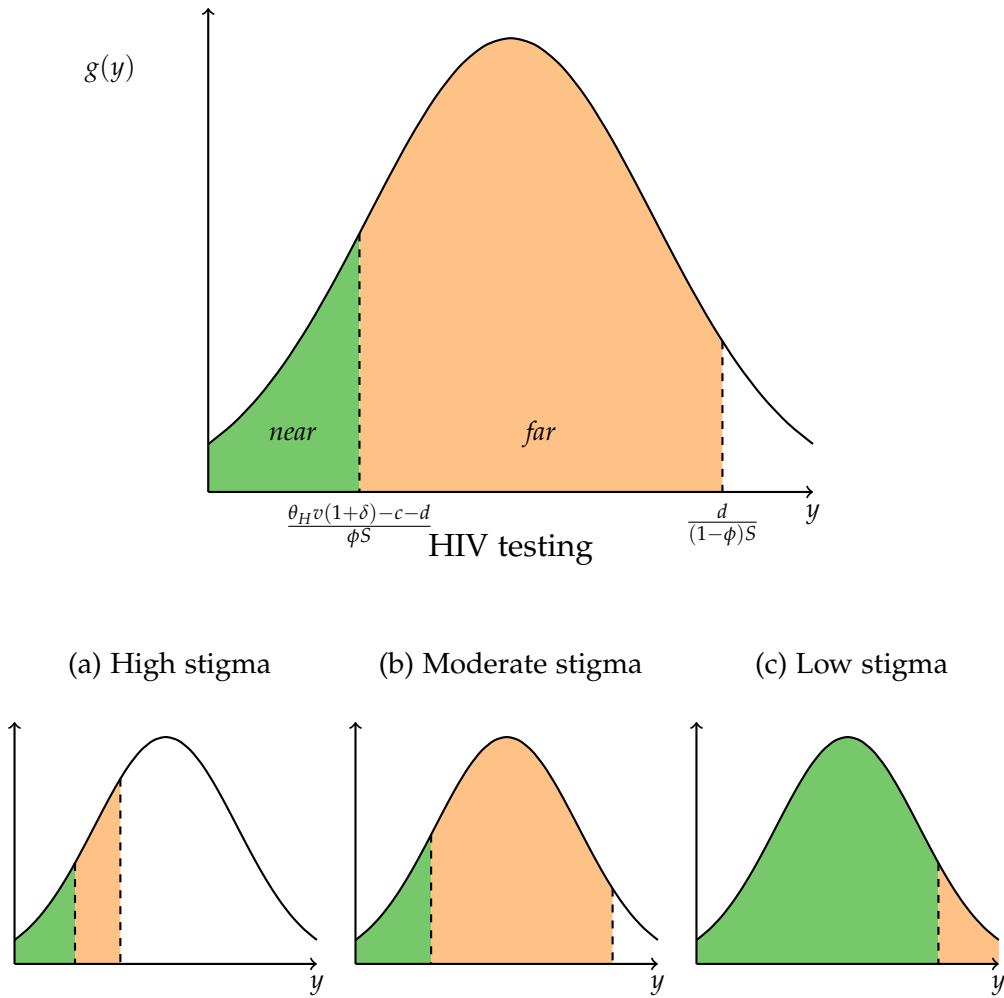
## 5.2 Empirical Evidence

In order to test the theoretical predictions of our model, we turn again to the experiment discussed in Chapter 4. The experiment consisted of an information intervention which shifted the distribution of beliefs about the public benefit of ART,  $F_{\hat{\rho}}$ . We investigate the effect of this shift on stigma and health seeking behavior, including HIV testing, the choice of testing clinic, and the relationship between perceived community beliefs and the decision to test for HIV.

### 5.2.1 Data

We make use of two datasets. First, in order to investigate the effect of the information intervention on stigma, we turn to the survey conducted five months after the intervention, which was described in detail in Section 4.3.1. Second, we use administrative data to measure health seeking behavior.

Figure 5.1: Testing and location depend on stigma



This figure illustrates the proportion of agents  $a \in \mathcal{A}$  who seek nearby and far away testing, respectively. The curve  $g(y)$  is the probability density function for the benefit of a relationship,  $y_a$ . To the left of the first threshold, agents seek a nearby HIV test. Between the first and second thresholds, agents seek a far away test. To the right of the second threshold no HIV test is sought. These thresholds shift up as stigma  $S$  decreases; a lower level of stigma implies a higher total number of tests and a higher number of nearby tests. The effect of a shift in stigma on the number of far away tests is in general ambiguous; in this example far away testing first increases and then decreases. As  $S \rightarrow 0$ , the number of far away tests decreases to 0.

### **Administrative data**

We use administrative data from the handwritten<sup>12</sup> patient registers of 18 health facilities in Zomba District, including all free clinics whose catchment areas include study villages, and all free clinics and hospitals in Zomba Town.

We photographed and digitized HIV testing registers and outpatient department registers, concealing identifying information due to ethical concerns about privacy. Data on ART use was digitized and provided by Dignitas International, a health care NGO, as a part of their monitoring and evaluation activity.

We collected HIV testing data for the period covering 2.5 months before the start of the intervention and 3 months after the intervention ended. HIV testing registers at each health facility include fields for the date, gender, age, and address or home village (see Figure 5.2). This last field allows us to link the HIV test to the patient's village, and in particular, to determine whether that village belongs to the study's treatment group or control group. HIV testing registers also indicate whether the patient was pregnant, whether or not the test was a joint test, the time since the client's last HIV test, and the result of the test. The distance traveled to the facility is calculated from GPS coordinates of the clinics and the study villages, as recorded in census data<sup>13</sup>.

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<sup>12</sup>There are two exceptions: Zomba Central Hospital and Matawale Health Facility both have electronic registers. Health facility data was obtained with the permission of the Malawi College of Medicine, as well as the Malawi District Health Office and Zomba Central Hospital

<sup>13</sup>Census data was obtained from the Malawi National Statistics Office

Figure 5.2: HIV testing register

Serial No.	Date	HTC Provider ID	Client Name	Phone / Physical Address	Sex / Pregnancy			Age	Age Group				HTC Access Type			Last HIV Test					Time Since Last Test		Partner Present at this session			
					Male	Female Non-Preg.	Female Pregnant		0-11 months	1-14 years	15-24 years	25+ years	Routine HTC within Health Service	Comes with HTC Family Ref. Slip	Other (VCT, etc.)	Never Tested	Last Negative	Last Positive	Last Expos. Infant	Last Inconclusive	No. of Days	Weeks	Months	Years	No	Yes
1.					M	FNP	FP		A	B	C	D	PTC	FRS	Oth	LNev	L-	L+	LEx	Lin					N	Y
2.					M	FNP	FP		A	B	C	D	PTC	FRS	Oth	LNev	L-	L+	LEx	Lin					N	Y
3.					M	FNP	FP		A	B	C	D	PTC	FRS	Oth	LNev	L-	L+	LEx	Lin					N	Y

Re-start counting on 1<sup>st</sup> July

Fill name and contact details only if client gives consent to be contacted



## 5.2.2 Survey Measures of Stigma

In the model, stigma is explained by the fact that some people will reject a potential sexual partner who has been tested for HIV, because such a partner is more likely to be HIV positive and taking ART drugs. According to the theory, a shift in beliefs about the public benefit of ART ought to reduce this type of stigma. If the information intervention described in 4 caused such a reduction in stigma, we ought to see a change in attitudes towards those taking ART drugs.

The survey measures in Columns 1 and 2 of Table 5.1 directly address this type of behavior, by asking whether the respondent would reject such a partner, and also whether others would do so. The first measure asks respondents whether they would prefer a sexual partner who is taking ART drugs over one who has never been tested. The second measure asks whether a person taking ART drugs would be able to find a new sexual partner. The fact that the information caused a significant change in both of these measures suggests that the specific mechanism outlined in our model of stigma may apply.

## 5.2.3 HIV Testing

The main outcome of interest, both theoretically and from a policy perspective, is HIV testing. The experiment shifted community beliefs about the public benefit of ART drugs (as observed in Chapter 4). As this reduced stigma, we expect to see a higher number of HIV test seekers from treatment villages. The HIV testing rate is also important for policy, especially in the context of this intervention. The information we provided only addresses the public benefit of ART drugs, so it is likely that any increase in HIV testing will be followed by increased demand for ART. Uptake of ART is important because the medication saves lives and slows the spread of the epidemic.

In the administrative data, we only observe those community members who seek an HIV test, so we are required to use a village-level specification. The primary outcome of interest is the percent of the target population that seeks an HIV test. We construct this outcome measure by first aggregating data on individual HIV tests at the village level, constructing separate variables for tests that took place pre-intervention and post-intervention<sup>14</sup>. The target population for the information cam-

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<sup>14</sup>The pre-intervention period covers 2.5 months before the start of the intervention,

Table 5.1: Survey Measures of Stigma Between Sexual Partners

	(1) =1 if respondent prefers untested partner to partner taking ART	(2) =1 if respondent thinks a person taking ART won't find a new partner
T	-0.155*** (0.036)	-0.121*** (0.042)
Reference cat	0.46	0.68
Mean of dep var in control	0.46	0.68
Individual controls	Yes	Yes
Village-level controls	Yes	Yes
Obs (Individuals)	1224	1276

Survey to meeting attendees in both treatment and control villages. (1) Respondent would prefer a partner who has never been tested for HIV to one who is taking ART drugs. (2) Respondent believes that a person taking ART will definitely not find a new sexual partner. T = respondent's village is in treatment group. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. Village-level controls: Table 4.1. Robust standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

paing consisted of individuals aged 15 to 49, and we restrict the outcome variable to include only HIV tests sought by members of this age group. Pregnant women are excluded, as they undergo mandatory HIV testing as a part of their antenatal health care. Information from the HIV testing register determines whether a given patient belongs to the target group, and census data provides the approximate size of the reference population in each village.

In order to identify the causal effect of the information intervention with high statistical power, we perform an ANCOVA regression at the village level, controlling for pre-intervention levels of the outcome variable. This estimator is unbiased in a randomized study, and has lower variance than either a simple regression of post-intervention testing levels on treatment, or a difference-in-difference estimator (McKenzie, 2012).

As stated above, the dependent variable is the percent of the target population who sought an HIV test post-intervention. Covariates include the pre-intervention testing rate, and other village-level covariates determined from the Malawi National Census, GPS coordinates, and the survey. The full set of village-level and pre-intervention covariates is listed in Table 4.1. We also control for the community educator assigned to the village, and stratification variables: the nearest health center and village population.

This intervention may be subject to spillovers. Indeed, 60% of the villages in the study are within 1 kilometer of another study village. We therefore include a specification which controls for both nearby study villages and nearby treatment villages, considering villages within 1 kilometer (based on GPS coordinates). Because treatment was randomly assigned, including these regressors together should not introduce endogeneity, and will remove the downward bias caused by spillovers from treatment villages to control villages. It will, however increase the risk of multicollinearity. We allow the number of nearby treatment villages to have a heterogeneous effect based on the treatment status of the village itself; for example, it may be that control villages are more strongly impacted by information spillovers than treatment villages, because in treatment villages the information was provided directly.

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and the post-intervention period covers 3 months after the intervention ended. We ignore all HIV tests that took place during the intervention period, which lasted 22 days.

Our regression specification is as follows:

$$\text{Percent HIV tested}_j = \alpha + \beta T_j + \gamma_T T_j * N_{Tj} + \gamma_C C_j * N_{Tj} + \gamma N_j + \delta^T \chi_j + \epsilon_j. \quad (5.11)$$

$T_j$  and  $C_j$  are indicators for the treatment group and control group respectively,  $\chi_p$  is a vector of village-level covariates including the pre-intervention testing level (see Table 4.1 for a complete list of village-level covariates), and community educator fixed effects.  $N_{Tj}$  is the number of treatment villages within one kilometre, and  $N_j$  is the total number of study villages within one kilometer. In regressions which do not control for spillovers, we apply the restriction  $\gamma_T = \gamma_C = \gamma = 0$ . Standard errors are robust.

Because  $T_j$  is randomly assigned,  $\mathbb{E}(\epsilon_j | T_j) = 0$ , and the OLS estimate  $\hat{\beta}$  is unbiased.

The information intervention caused a significant increase in the total number of HIV tests, as shown in Columns 1 and 2 of Table 5.2. Controlling for spillovers, the estimated effect size is 60%, measured over a three-month period. This is higher than the estimate without spillovers (37%), but also subject to a larger standard error.

Table 5.2: The Effect of Information about the Public Benefit of ART on HIV Testing

	% of population tested for HIV		
	(1) OLS	(2) OLS	(3) IV
Average beliefs $\hat{\rho}$ in village			1.224** (0.540)
T	0.590* (0.323)	0.956** (0.446)	
(C)*(#T villages < 1km)		0.364 (0.461)	
(T)*(#T villages < 1km)		-0.375 (0.607)	
#study villages < 1km		-0.148 (0.279)	
Weak ID F-stat (KP)			171
Proportional increase in dep var	37%	60%	77%
Mean of dep var in control	1.6	1.6	1.6
Village-level controls	Yes	Yes	Yes
Obs (Villages)	119	119	119

Administrative data from 18 health facilities and survey. Dependent variable: % of village target population tested for HIV post-intervention. (1)-(2): OLS. T = village is in treatment group. C = village is in control group. (3): 2SLS with T = treatment group as instrument for beliefs.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Community beliefs about  $\rho$  are approximated by the village-level average of beliefs, as obtained from the survey using the infographic in Figure 4.4. Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. All regressions are at the village level, with village-level controls and include a constant. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

Table 5.3: The Effect of Information and Beliefs about the Public Benefit of ART on HIV Testing by Gender

	% of men tested for HIV			% of women tested for HIV		
	(1) OLS	(2) OLS	(3) IV	(4) OLS	(5) OLS	(6) IV
Average beliefs $\hat{\rho}$ in village			1.388** (0.609)			1.051 (0.643)
T	0.669* (0.363)	0.975* (0.505)		0.507 (0.383)	0.936* (0.516)	
(C)*(#T villages < 1km)		0.169 (0.697)			0.569 (0.488)	
(T)*(#T villages < 1km)		-0.679 (0.656)			-0.054 (0.659)	
#study villages < 1km		0.170 (0.398)			-0.482 (0.334)	
Weak ID F-stat (KP)			171			171
Proportional increase in dep var	50%	72%	103%	27%	50%	56%
Mean of dep var in control	1.35	1.35	1.35	1.86	1.86	1.86
Village-level controls	Yes	Yes	Yes	Yes	Yes	Yes
Obs (Villages)	119	119	119	119	119	119

Administrative data from 18 health facilities and survey. Dependent variable: % of village target population tested for HIV post-intervention. (1)-(2), (4)-(5): OLS. T = village is in treatment group. C = village is in control group. (3),(6): 2SLS with T = treatment group as instrument for beliefs.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Community beliefs about  $\rho$  are approximated by the village-level average of beliefs, as obtained from the survey using the infographic in Figure 4.4. Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. All regressions are at the village level, with village-level controls and include a constant. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

Let us turn to the epidemiological literature to put this magnitude of HIV testing into some context. [Granich et al. \(2009\)](#) provide a mathematical model for the relationship between HIV testing and the spread of HIV, taking into account the fact that ART drugs greatly reduce transmission. The intervention increased annual testing rates among sexually active individuals from approximately 6.4% to 10.4%, which according their model should avert at least two new HIV infections per primary infection. While this is based on a model which abstracts from many behavioral considerations, it is worth noting that at low levels of HIV testing, a small increase has the potential to have large epidemiological implications.

The information treatment increased total HIV testing rates significantly for both men and women (as shown in [Table 5.3](#)). The magnitudes of the increases are similar, which may at first seem surprising given the fact that women are, in general, more likely to test than men, and attendance at community health meetings was higher among women. However, the model shows that one's HIV testing decision depends on the beliefs of one's potential sexual partners, so the gender split at health meetings should not necessarily match that of HIV testing clients.

An upward shift in beliefs about the public benefit of ART should lead to a decrease in stigma, and a subsequent increase in HIV testing levels. Beliefs about the public benefit of ART drugs were strongly affected by the information campaign, while other beliefs remained largely unaffected. This makes the information treatment a good candidate for an instrumental variables approach to estimating the effect of an increase in community-level beliefs about  $\rho$ , the ART prevention parameter. The village-level average of the measure  $\hat{\rho}$ , obtained from the infographic in [Figure 4.4](#), is an endogenous regressor. Using the information treatment as an instruments allows us to investigate the effect of community beliefs on HIV testing.

We estimate a two-stage least squares specification, with first stage

$$Beliefs_j = \alpha_0 + \beta_0 T_j + \delta_0^T \chi_j + \nu_j \quad (5.12)$$

and second stage

$$Percent\ HIV\ tested_j = \alpha + \beta Beliefs_j + \delta^T \chi_j + \epsilon_j. \quad (5.13)$$

where  $Beliefs_j$  denotes average beliefs<sup>15</sup> about the ART prevention param-

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<sup>15</sup>This is calculated from the survey measure using the infographic in [Figure 4.4](#).

eter  $\rho$  in village  $j$ , and  $\hat{Beliefs}_j$  denotes its fitted value from the first-stage regression.  $\chi_p$  is a vector of village-level covariates<sup>16</sup> and community educator fixed effects. Standard errors are robust. The identification assumption is  $\mathbb{E}(\epsilon_j|T_j) = 0$ . Villages were randomly assigned to treatment or control, and we assume that the intervention only affected village-level HIV testing rates through a shift in beliefs about the public benefit of ART, represented by the parameter  $\rho$ . Recall that the only difference between the community health meetings in treatment and control villages was the inclusion of information on the public benefit of ART, and Table 4.4 shows that other beliefs about HIV remained unaffected.

Higher average beliefs about the public benefit of ART lead to a higher rate of HIV testing. In particular, if an entire community were shifted from the belief that ART drugs have no effect on HIV transmission, to the belief that they block transmission completely, the results in Column 3 of Table 5.2 predict an 77% increase in HIV testing.

## 5.2.4 HIV Testing Location

Before the intervention, in the average village, 30% of those seeking an HIV test traveled at least four kilometers further than necessary from their home villages. This may be indicative of stigma, because traveling far from home is costly, but reduces the likelihood of being seen by friends and neighbors.

In general, individuals seeking an HIV test may travel to far away clinics for reasons other than to avoid being seen, such as differences in clinic quality or wait time. However, HIV testing is free, and the procedures are identical at all clinics. Wait times do not vary much, especially compared with the time spent traveling to the clinic; those who test far away travel, on average, an extra nine kilometers. Finally, if far away testing is fully explained by reasons other than stigma, we should not observe any link between beliefs about the public benefits of ART and the choice of testing location.

We say that an HIV test takes place *far away* if it takes place at least four kilometers further than the client's nearest health facility<sup>17</sup>, and investigate the effect of a shift in beliefs about the public benefit of ART on testing location. We again run a two-stage least squares regression with

<sup>16</sup>See Table 4.1 for a complete list of village-level covariates.

<sup>17</sup>See the Appendix for results using other definitions.



specifications (5.12) and (5.13). The dependent variable is the number of total, nearby, or far away HIV tests; Columns 1 to 3 of Table 5.4 show the results of these three regressions. A shift in beliefs may cause an increase in nearby testing: the coefficient is large, but imprecisely estimated (Column 2). The increase in far away testing is significant but small (Column 3).

In order to understand the intervention's ambiguous effect on testing location, we turn to the predictions of the model. The model predicts a specific relationship between the choice of HIV testing location and the distribution of beliefs about ART in the community, based on the link between those beliefs and stigma. In particular, a moderate shift in beliefs about the ART prevention parameter  $\rho$ , which corresponds to a moderate reduction in stigma, could increase both the number of people who test near their home village and the number who test far away. Meanwhile, a large shift in beliefs, which corresponds to a large reduction in stigma, should only increase the number of nearby tests, as people become less afraid of being seen to seek an HIV test.

We define *high beliefs* as beliefs<sup>18</sup>  $\hat{\rho} \geq 0.95$ , for the simple reason that this threshold approximately matches the true value of  $\rho$ . From a policy perspective, it is useful to know the effects of shifting beliefs to the true value of  $\rho$ , and whether this is sufficient to cause a reduction in stigma. As the majority of individuals in control villages hold beliefs  $\hat{\rho} = 0$ , we define *moderate beliefs* to be  $0 < \hat{\rho} < 0.95$ .

On average, the information intervention shifted beliefs from low beliefs  $\hat{\rho} = 0$  to either moderate or high beliefs, as shown in Figure 4.5. The distribution of beliefs in a given village can be described by three numbers: the proportion of the population who hold low beliefs, moderate beliefs, and high beliefs.

We analyze the following OLS specification.

$$y_j = \alpha + \beta_1(\text{moderate beliefs})_j + \beta_2(\text{high beliefs})_j + \delta^T \chi_j + \epsilon_j \quad (5.14)$$

$y_j$  is set equal to either the percent of the target population in village  $j$  that seeks an HIV test nearby, or the percent of the target population in village  $j$  that seeks an HIV test far away from their home village. The regressors  $(\text{moderate beliefs})_j$  and  $(\text{high beliefs})_j$  represent the proportion of

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<sup>18</sup>These beliefs are elicited in the survey using the infographic in Figure 4.4. Note that this beliefs measure is discrete, and the selection  $\hat{\rho} = 0.95$  is closest to the true value of  $\rho = 0.96$ .

the village that has moderate or high beliefs, as estimated from survey responses. These regressors are not exogenous, and we must interpret the estimated coefficients  $\hat{\beta}_1$  and  $\hat{\beta}_2$  as correlations between the level of community beliefs and the number of HIV tests either nearby or far away.  $\chi_p$  is a vector of village-level covariates<sup>19</sup> and community educator fixed effects. Standard errors are robust.

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<sup>19</sup>See Table 4.1 for a complete list of village-level covariates.

Table 5.4: The Effect of the Information Treatment on HIV Testing Location

	% tested for HIV (IV)			% tested for HIV (OLS)		
	(1) Total	(2) Nearby	(3) Far	(4) Total	(5) Nearby	(6) Far
Average beliefs $\hat{\rho}$ in village	1.224** (0.540)	0.838 (0.519)	0.386* (0.204)			
Proportion of village believes $0 < \rho < 0.95$				0.518 (0.647)	-0.106 (0.626)	0.624** (0.295)
Proportion of village believes $\rho \geq 0.95$				0.815 (0.698)	1.055* (0.621)	-0.240 (0.296)
F-stat	171	171	171			
Proportional increase in dep var	77%	75%	80%			
Mean of dep var in control	1.6	1.11	.48	1.6	1.11	.48
Village-level controls	Yes	Yes	Yes	Yes	Yes	Yes
Obs (Villages)	119	119	119	119	119	119

Administrative data from 18 health facilities and survey to meeting attendees in both treatment and control villages. Dependent variable: % of village target population tested for HIV post-intervention far/nearby. Far clinics defined as >4km further than nearest free clinic. (1)-(3): 2SLS with T = treatment group as instrument for beliefs. (4)-(6): OLS.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Community beliefs about  $\rho$  are approximated by the village-level average of beliefs, as obtained from the survey using the infographic in Figure 4.4. Omitted reference category: % believe  $\rho = 0$ . Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. All regressions are at the village level, with village-level controls and include a constant. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

Consistent with the predictions of the model, high beliefs about the public benefit of ART are associated with an increase in the number of nearby tests, and an (insignificant) decrease in the number of far away tests, as seen in Columns 5 and 6 of Table 5.4. This suggests that any increase in far away testing is driven by a moderate shift in beliefs (Column 6). In addition, a large shift in beliefs about the public benefit of ART reduces stigma enough that more people feel comfortable seeking an HIV test, and are also willing to risk being observed by attending a clinic near their home village.

### 5.2.5 HIV Testing and Community Beliefs

The theory predicts that HIV testing decisions should depend on the level of stigma in the community, which in turn depends on community-level beliefs about the public benefit of ART. This differs sharply from predictions based on a model of social preferences, in which one's own beliefs matter most, or a model of household bargaining, in which one's spouse's beliefs are important.

In order to test this prediction, we measured *perceived* beliefs of the community. That is, as a part of the individual survey we asked respondents what they thought most people in their respective communities believed about the public benefit of ART. Once a respondent had fully understood the infographic in Figure 4.4, she was asked which option that her spouse would choose, and which option most members of the community would choose.

We regress self-reported HIV testing on this measure of perceived beliefs. We use the specification

$$HIV\ test_{ij} = \alpha + \beta_0(\text{respondent has high beliefs})_i + \beta_1(\text{spouse has high beliefs})_i + \beta_2(\text{community has high beliefs})_i + \delta^T \chi_{ij} + \epsilon_{ij} \quad (5.15)$$

where the dependent variable is an indicator for respondent  $i$  in village  $j$  reporting an HIV test post-intervention. The three regressors of interest are the respondent's own beliefs, her perception of her spouse's beliefs, and her perception of the community's beliefs. These three variables are indicators for high beliefs about the public benefit of ART,  $\hat{\rho} > 0.95$ . The set of covariates  $\chi_{ij}$  includes individual- and village-level controls<sup>20</sup>.

<sup>20</sup>Individual-level controls are age, gender, whether the person is pregnant, married,

Standard errors are clustered at the village level.

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has regular partner, employed, primary school educated, secondary school educated, has livestock, and has a brick house.. Village-level controls are covariates listed in Table [4.1](#) and community educator fixed effects.

Table 5.5: Own Beliefs vs. Perception of Community Beliefs and Self-Reported HIV Testing

	HIV Test: post-intervention			pre-intervention
	(1)	(2)	(3)	(4)
Respondent believes $\rho \geq 0.95$		-0.033 (0.047)	0.000 (0.072)	0.007 (0.061)
Respondent thinks spouse believes $\rho \geq 0.95$			-0.084 (0.084)	-0.016 (0.069)
Respondent thinks community believes $\rho \geq 0.95$	0.083* (0.043)	0.106** (0.049)	0.139** (0.055)	-0.058 (0.054)
Mean of dep var in control	0.35	0.35	0.36	0.23
Village fixed effects	Yes	Yes	Yes	Yes
Individual controls	Yes	Yes	Yes	Yes
Obs (Individuals)	1333	1330	1079	1079

Survey to meeting attendees in both treatment and control villages. Dependent variable: indicator for whether the respondent reported having an HIV test.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Beliefs about  $\rho$  are obtained from the survey using the infographic in Figure 4.4. (5)-(8): sample restricted to married respondents. The pre-intervention period is 5 months. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

As predicted, Table 5.5 shows that survey respondents are much more likely to report an HIV test post-intervention if they perceive the community to have high beliefs about the public benefit of ART drugs. The respondent's own beliefs and perceived spouse's beliefs do not play a significant role.

## 5.2.6 Sexual Behavior

A reduction in stigma, as defined in the model, may lead to risk compensation in the context of sexual behavior. We model stigma as the fraction of the population who would reject a potential sexual partner based on his decision to seek an HIV test, and we predict that this fraction should decrease in response to the information intervention. Because HIV testing increases, the overall effect on the level of sexual activity is ambiguous.

We regress self-reported measures of sexual behavior on village treatment status, following specification (4.1). The dependent variables are the number of sex acts and number of condoms used, both recalled by respondents over the past seven days. We estimate the number of unprotected sex acts (Column 3 of Table 5.6) by subtracting the number of condoms from the total number of sex acts<sup>21</sup>.

The number of unprotected sex acts is insignificantly higher in the treatment group (see Table 5.6). The overall effect comes from an insignificant increase sexual activity and a small decrease in condom use, as seen in Columns 1 and 2. These results are in line with previous work showing limited risk compensation in response to information on HIV transmission risk (Kerwin, 2014), and in response to the large benefits of ART drugs (Friedman, 2015).

While the increase in unprotected sex is statistically insignificant, the magnitude of the coefficient is not negligible. Before reaching the conclusion that this is a negative effect of the information campaign, it is worth noting that rational agents may be expected to increase their sexual interactions in response to the information. Risk compensation may come with large benefits including, for example, being able to start a family.

Finally, if we assume that the increase in risk taking was among those who either tested negative, or are taking ART, the level of risk compensation we observe is inconsequential in terms of HIV transmission<sup>22</sup>

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<sup>21</sup>In the case where more condoms were used than sex acts performed, we set the number of unprotected sex acts equal to zero.

<sup>22</sup>Risk compensation may be of concern for other reasons, for example, the spread

Table 5.6: Risk Compensation

	(1) Sex acts	(2) Condoms used	(3) Unprotected sex acts
T	0.418 (0.335)	-0.103 (0.124)	0.442 (0.281)
Mean of dep var in control	1.57	0.37	1.30
Village-level controls	Yes	Yes	Yes
Individual controls	Yes	Yes	Yes
Obs (Individuals)	1037	1037	1037

Survey to meeting attendees in both treatment and control villages. Dependent variables are individual responses to survey questions. (1) Number of sex acts, recalled over past 7 days. (2) Number of condoms used, recalled over past 7 days. (3) Number of unprotected sex acts over past 7 days calculated by subtracting (2) from (1). If this difference is negative, we set the number of unprotected sex acts equal to 0. T = respondent's village is in treatment group.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Beliefs about  $\rho$  are obtained from the survey using the infographic in Figure 4.4. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. Village-level controls: Table 4.1. Robust standard errors are clustered at the village level and given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$



compared with the preventative strength of ART drugs. There would need to be a minimum 25-fold increase in unprotected sexual activity to offset the 96% reduction in HIV transmission associated with ART<sup>23</sup>.

### 5.2.7 Other Potential Mechanisms

We claim that the effects of the information experiment are due to a reduction in stigma towards HIV testing. However, other models may generate similar predictions. For example, both social preferences and household bargaining would predict an increase in HIV testing in response to new information about the public benefits of ART drugs. We will attempt to rule these out as first order explanations for our results.

Social costs are not the only potential barrier to HIV testing and treatment. For example, the psychic costs of testing may be quite large. [Oster et al. \(2013\)](#) propose an optimal expectations model to explain low uptake of a medical test for Huntington's Disease. This type of model, in which individuals prefer to choose optimistic beliefs about the future rather than learn the truth, may also partly explain low HIV testing rates. However, such behavior is unlikely to be affected by information on the public benefit of ART, conditional on the private benefits being known. For this reason, we restrict attention to mechanisms which are plausibly linked to our intervention through a social component of behavior change.

#### Social preferences

Altruism is an obvious alternative mechanism by which information on the public benefit of ART might increase HIV testing. People may derive utility from protecting their sexual partners from HIV. If this were the primary mechanism, we would expect to see self-reported testing increase in one's own beliefs about the public benefits of ART, as opposed to the beliefs of others. As shown in [Table 5.5](#), this does not seem to be the case. Additionally, while altruism may cause either nearby or far away testing to increase, it does not explain the pattern observed in [Table 5.4](#); high

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of other sexually-transmitted infections which ART does not prevent. [Gong \(2014\)](#) and [Baird et al. \(2014\)](#) find an increased risk of sexually-transmitted infection after a person tests positive for HIV.

<sup>23</sup>Let  $\tau$  be the HIV-transmission rate. The probability of avoiding infection in an interaction with an HIV-positive person is  $1 - \tau$ , or, if the person is taking ART,  $1 - 0.04\tau$ . We are interested in solving for the proportional increase in sexual interactions  $x$  which equalizes risk:  $(1 - \tau) = (1 - 0.04\tau)^x$ . For any  $\tau \in (0, 1)$ , this is solved by  $x > 25$ .

beliefs about the public benefit of ART are linked specifically to nearby testing.

This is not to suggest that individuals are not altruistic, or that altruism does not play a role in HIV testing. It is plausible that a person who is altruistic towards his partner is also less likely to be HIV positive, as he might use condoms and have fewer concurrent partners. In addition, an altruistic person may choose to test even without knowledge of the public benefit of ART, in order to make informed choices about the risk of transmitting the virus.

### **Household bargaining**

Household bargaining has been shown to play a role in family planning decisions ([Ashraf et al., 2013](#)). There are many reasons to believe that HIV testing decisions are also subject to household bargaining, and this suggests an alternative explanation for the increase in HIV testing we observed. In particular, a person who is aware of the fact that ART reduces HIV transmission may put greater pressure on her spouse to get tested and treated for HIV. In this case, we would expect the testing decision to be strongly linked to one's spouse's beliefs about the benefits of ART. Table 5.5 shows that this is not the case.

Table 5.7: Pressure to Test for HIV

	(1) % of pop- ulation joint tested for HIV	(2) =1 if re- spondent tested for HIV due to pressure	(3) =1 if re- spondent would prefer joint testing to private testing	(4) WTP for joint testing over private testing
T	0.111 (0.108)	0.005 (0.008)	0.003 (0.016)	-18.207 (21.215)
Mean of dep var in control	.3	0.01	0.77	111.36
Village-level controls	Yes	Yes	Yes	Yes
Individual controls	No	Yes	Yes	Yes
Obs (Individuals)		831	831	831
Obs (Villages)	119			

(1) Administrative data from 18 health facilities in Zomba District. Dependent variable: % of village target population joint tested for HIV post-intervention. Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. Regression is OLS at the village level, with village-level controls and a constant. (2)-(4): Survey to meeting attendees in both treatment and control villages. Dependent variables are individual responses to survey questions. Sample restricted to married respondents. The post-intervention period is approximately 5 months. All regressions are OLS, at the individual level, and with individual-level controls, village-level controls and a constant. Individual-level controls: age, gender, pregnant, married, has regular partner, employed, primary school educated, secondary school educated, has livestock, has a brick house. (2) Respondent sought HIV test due to pressure. (3) Respondent would prefer a joint test over private test. Sample restricted to married respondents. (4) Respondent's willingness to pay for door-to-door joint testing campaign vs. private testing (Malawi Kwacha: 400MK = 1USD). (1)-(4): T = respondent's village is in treatment group. Village-level controls: Table 4.1, population, nearest health center and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

A model of household bargaining would also predict an increase in joint testing. A person has little to gain by putting pressure on her partner to seek an HIV test if he is not intrinsically motivated to get treated. The results of the test are private, and he can simply report a negative test result. However, if a couple is tested jointly, the results are seen by both, which means that each member of the couple can exert additional pressure on the other to seek ART if necessary. Column 1 of Table 5.7 shows that the effect of the information campaign on joint testing is insignificant, and does not explain the overall increase in HIV testing. Survey results indicate that treatment villages are similar to control villages in terms of HIV tests reported due to pressure, preference for joint testing over private testing, and relative willingness to pay for joint and private testing (see Columns 2, 3, and 4 of Table 5.7).

Household bargaining does not seem to explain the increase in HIV testing we have seen as a result of the information campaign. It may nevertheless play some role in HIV testing decisions. In both treatment and control villages, most respondents report a strong preference for joint testing, and approximately 20% of HIV tests in the clinic data are joint tests. Those with enough bargaining power to pressure their partners to test jointly may have already been motivated to do so before learning that ART would protect them from transmission. For example, joint testing allows couples to make informed decisions about condom use and family planning, and form accurate expectations about the future.

## 5.A Appendix: Equilibria

In this section, we characterize the pure-strategy Perfect Bayesian Equilibria of the model presented in Section 5.1. The *signalling equilibrium*, in which a fraction  $S$  of the population rejects potential sexual partners who have been tested, was analyzed in Section 5.1.2. Proposition 1 claims that there is only one other type of equilibrium: a *reverse signalling equilibrium*.

### 5.A.1 The Reverse Signalling Equilibrium

For some parameter values, the game described in Section 5.1 has a class of pure-strategy Perfect Bayesian Equilibria in which a fraction  $P$  of the population  $\mathcal{B}$  consent only if their match has been tested, and the remaining fraction  $1 - P$  consent to all matches.  $P$  must be large enough to induce universal testing, because the equilibrium relies on extreme off-equilibrium beliefs about those who do not test for HIV. Intuitively, high-risk individuals have more to gain from testing, so it is not natural to believe that a person who has not been tested is more risky than someone who has. Nonetheless, this equilibrium satisfies the definition of a Perfect Bayesian Equilibrium.

Fix  $P$ , and consider the strategy of each  $a \in \mathcal{A}$ . He will not test far away, as it is costly, and there is no benefit to hiding the decision since all matches consent to those who test. His benefit to testing nearby is access to ART drugs plus the guarantee that his potential sexual partner will consent next period,  $\theta v(1 + \delta) + \delta P y_a$ , and the cost is  $c$ . He will therefore test nearby if

$$\theta v(1 + \delta) + \delta P y_a > c.$$

High-risk types  $\theta = \theta_H$  will always test, because we assumed  $\theta_H v(1 + \delta) > c$ .

The proportion of low-risk types who test is equal to

$$\mathbb{P}(\theta_L v(1 + \delta) + \delta P y_a > c). \quad (5.16)$$

If this measure is less than one, that is, testing is not universal, then this is not an equilibrium. To see why, consider the beliefs of  $b \in \mathcal{B}$ . If her match has not been tested, she concludes that his type is  $\theta = \theta_L$ . But in this case, she will consent, because we assumed that everyone consents to a person of average risk (assumption (5.6)), and therefore  $P = 0$ . This

implies that for parameters such that

$$\mathbb{P}(\theta_L v(1 + \delta) + \delta y_a > c) < 1$$

there is no reverse signalling equilibrium, because even if  $P = 1$ , that is, everyone rejects those who have not been tested, universal testing will not be achieved. Some low-risk types are not sufficiently motivated by the prospect of a sexual relationship to bother seeking an HIV test.

Conversely, a reverse signalling equilibrium exists for any  $0 < P \leq 1$  such that

$$\mathbb{P}(\theta_L v(1 + \delta) + \delta P y_a > c) = 1.$$

All agents  $a \in \mathcal{A}$  best respond to the strategies of agents  $\mathcal{B}$  by testing nearby. In this case, beliefs about a match who has not been tested ( $\sigma_a = 0$ ) can take any value, as this action is off the equilibrium path. In order to demonstrate the existence of the equilibrium, we set these beliefs equal to  $\hat{\theta}_b(0) = 1$  for all  $b \in [0, P]$  and  $\hat{\theta}_b(0) = 0$  for all  $b \in (P, 1]$ . That is, a fraction  $P$  of the population believe that a person who has not been tested is HIV positive with probability one. The remaining fraction  $1 - P$  believe that a person who has not been tested is HIV negative. In this case, because it is never worth consenting to a match who is infected and untreated,  $\mathbb{P}(y_b < s\tau + s_0) = 1$  (assumption (5.7)), all  $b \in [0, P]$  will reject a partner who has not been tested. Meanwhile, because we have assumed it is always worth consenting to an average-risk match (assumption (5.6)),

$$\mathbb{P}(y_b > 0) \geq \mathbb{P}(y_b > \bar{h}(s\tau + s_0)) = 1,$$

all  $b \in (P, 1]$  will consent to any match. In equilibrium, HIV testing is universal.

### 5.A.2 Ruling out Other Equilibria

We have described two classes of equilibria. A *signalling equilibrium* is one in which a fraction  $S \in [0, 1]$  of the population rejects matches who have been tested for HIV, and otherwise all matches obtain consent<sup>24</sup>. A *reverse signalling equilibrium* is one in which a fraction  $P \in (0, 1]$  of the population

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<sup>24</sup>We are including the case  $S = 0$ , in which all  $b \in \mathcal{B}$  consent to any match, under the title *signalling equilibrium*. Within this equilibrium,  $S = 0$  describes the case in which the cost of stigma is zero.

rejects those who have not been tested, and otherwise all matches obtain consent. We now describe and rule out other potential types of equilibria.

**There is no equilibrium in which any agent rejects all matches**

In the case of either universal testing or universal abstention from testing, consistent beliefs on the equilibrium path will equal the average HIV prevalence in the population:  $\hat{\theta}_b = \bar{h}$ , and by assumption (5.6),  $b$  will consent, because

$$y_b > \bar{h}(s\tau + s_0) > \bar{h}(s\tau(1 - \hat{\rho}_b) + s_0).$$

Consider the case in which some agents test and others do not. Because of random matching, all  $a \in \mathcal{A}$  face the same expected cost of seeking a test. However, high-risk types have more to gain. This implies adverse selection among those who test, and those who do not test are therefore lower-risk than the average member of the population. So, consistent beliefs about those who do not test are  $\hat{\theta}_b(0) < \bar{h}$ , and by assumption (5.6),  $b$  will consent to those who do not seek an HIV test.

**There is no equilibrium in which different agents adopt opposite strategies towards matches who have been tested**

We can now restrict attention to equilibria in which each agent  $b \in \mathcal{B}$  adopts a strategy of consenting to some or all matches. The *signalling* and *reverse signalling* equilibria cover the cases in which some agents always consent, and those who do not always consent all adopt the same strategies.

The only other potential class of equilibrium is one in which different agents  $b \in \mathcal{B}$  adopt opposite strategies towards those who seek an HIV test. That is,  $S > 0$  and  $P > 0$ .

Suppose  $S > P > 0$ . In this case, all low-risk types will not test, and some high-risk types may not either. Among those who do not test, the average risk is less than that the average risk in the population, so consistent beliefs are  $\hat{\theta}_b(0) < \bar{h}$ . By assumption (5.6), all  $b \in \mathcal{B}$  will consent to those who do not test, so  $P = 0$ , which is a contradiction.

Suppose instead that  $P > S > 0$ . In this case, all high-risk types will test, as the net cost of stigma is negative ( $S - P < 0$ ). We consider two

subcases. First, suppose this does not induce universal testing. That is,

$$\mathbb{P}(\theta_L v(1 + \delta) + \delta(P - S)y_a > c) < 1.$$

Then any person who does not test is a low-risk type, so rational beliefs are  $\hat{\theta}_b(0) = \theta_L$ . By assumption (5.6), all  $b \in \mathcal{B}$  will consent to those who do not test, so  $P = 0$ , which again forms a contradiction. Instead, suppose that this does induce universal testing, so

$$\mathbb{P}(\theta_L v(1 + \delta) + \delta(P - S)y_a > c) = 1.$$

Now, rational beliefs about those who do seek an HIV test are  $\hat{\theta}_b(1) = \bar{h}$ , so by assumption (5.6) everyone will consent. This implies  $S = 0$ .



## 5.B Appendix: Alternative Definitions of Distance

Throughout this thesis, we have defined a *nearby* test as an HIV test that takes place at most four kilometers further than the nearest clinic to a client's home village. In this section we reproduce results on the choice of testing location using different buffer zones around the nearest clinic.

Results with no buffer zone are shown in Table A1. In these tables, we say an HIV test took place nearby only if it took place at the nearest health facility to the village, as measured by GPS coordinates. Using this definition, we see no significant link between beliefs about the public benefit of ART and the number of nearby tests. This definition of *nearby* is unsatisfactory as it does not take into account the fact that for some villages, the nearest clinic as measured in travel time may not be the same as the nearest clinic by GPS. Indeed, 61% of villages do not have a single HIV test taking place at the nearest clinic during the pre- and post-intervention periods combined. In addition, if a clinic is less than a kilometer further than the nearest clinic, we should probably not categorize that clinic visit as far away and claim that the choice is due to stigma. On this margin, other factors such as wait time or quality may play a larger role.

For the above reasons, a good definition of *nearby* should include a buffer zone. Table A2 shows results with a buffer zone of two kilometers, that is, a visit is considered *nearby* if it takes place at most two kilometers further than the nearest clinic. This choice gives results that are quantitatively similar to those presented in the main specifications with a buffer zone of four kilometers (Table 5.4).

Table A1: The Effect of the Information Treatment on HIV Testing Location (no buffer zone)

	% tested for HIV (IV)			% tested for HIV (OLS)		
	(1) Total	(2) Nearby	(3) Far	(4) Total	(5) Nearby	(6) Far
Average beliefs $\hat{\rho}$ in village	1.224** (0.540)	-0.343 (0.292)	1.567*** (0.508)			
Proportion of village believes $0 < \rho < 0.95$				0.518 (0.647)	-0.450 (0.419)	0.968 (0.603)
Proportion of village believes $\rho \geq 0.95$				0.815 (0.698)	0.086 (0.359)	0.729 (0.649)
F-stat	171	171	171			
Proportional increase in dep var	77%	-44%	192%			
Mean of dep var in control	1.6	.78	.81	1.6	.78	.81
Village-level controls	Yes	Yes	Yes	Yes	Yes	Yes
Obs (Villages)	119	119	119	119	119	119

Administrative data from 18 health facilities. Dependent variable: % of village target population tested for HIV post-intervention far/nearby. Far clinics defined as >0km further than nearest free clinic. (1)-(3): 2SLS with T = treatment group as instrument for beliefs. (4)-(6): OLS.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Community beliefs about  $\rho$  are approximated by the village-level average of beliefs, as obtained from the survey using the infographic in Figure 4.4. Omitted reference category: % believe  $\rho = 0$ . Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. All regressions are at the village level, with village-level controls and include a constant. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

Table A2: The Effect of the Information Treatment on HIV Testing Location (2km buffer zone)

	% tested for HIV (IV)			% tested for HIV (OLS)		
	(1) Total	(2) Nearby	(3) Far	(4) Total	(5) Nearby	(6) Far
Average beliefs $\hat{\rho}$ in village	1.224** (0.540)	0.773 (0.509)	0.451* (0.240)			
Proportion of village believes $0 < \rho < 0.95$				0.518 (0.647)	-0.073 (0.609)	0.591* (0.345)
Proportion of village believes $\rho \geq 0.95$				0.815 (0.698)	0.999 (0.604)	-0.185 (0.384)
F-stat	171	171	171			
Proportional increase in dep var	77%	78%	74%			
Mean of dep var in control	1.6	.99	.61	1.6	.99	.61
Village-level controls	Yes	Yes	Yes	Yes	Yes	Yes
Obs (Villages)	119	119	119	119	119	119

Administrative data from 18 health facilities. Dependent variable: % of village target population tested for HIV post-intervention far/nearby. Far clinics defined as >2km further than nearest free clinic. (1)-(3): 2SLS with T = treatment group as instrument for beliefs. (4)-(6): OLS.  $\rho$  = the relative reduction in HIV transmission associated with antiretroviral drugs. True value:  $\rho = 0.96$ . Community beliefs about  $\rho$  are approximated by the village-level average of beliefs, as obtained from the survey using the infographic in Figure 4.4. Omitted reference category: % believe  $\rho = 0$ . Target population: age 15-49, non-pregnant. The target population was calculated from the Malawian National Statistics Office census at the village level. The post-intervention period is 3 months. All regressions are at the village level, with village-level controls and include a constant. Village-level controls: Table 4.1 and community educator fixed effects. Robust standard errors are given in the parentheses with stars indicating \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$ .

## Chapter 6

### Conclusion

The cost of social stigma is significant for HIV positive individuals. It forces many to seek treatment further than the nearest clinic, and prevents others from seeking treatment at all. This carries a large personal cost, as treatment greatly improves both quality and duration of life for people living with HIV. It also carries a social cost, as ART drugs prevent HIV transmission.

We find other barriers to treatment to be even more important. Our results suggest that reducing travel costs or improving clinic quality would have a large impact on the uptake of ART drugs. However, as we demonstrate, a policy to reduce stigma may be less expensive to implement than a policy to reduce travel costs.

This study identifies a particular type of social stigma as a barrier to HIV testing: statistical discrimination between potential sexual partners. HIV testing disproportionately benefits those infected with the virus, and is therefore a signal of underlying risk. An individual's testing decision may be observed by members of the community, and some community members reject potential sexual partners who are known to have been tested.

This example of statistical discrimination is based on misinformation. Most are unaware of the fact that an HIV-positive person who is tested and treated for HIV is much less contagious, due to the public benefit of ART drugs. Providing information about the public benefit of ART reduces stigma, and increases HIV testing by 60%. Villages with high beliefs about the public benefit of ART drugs after the intervention see a large increase in the number of HIV tests sought at nearby clinics, but no increase in HIV testing at far away clinics. In addition, the testing

decision appears to be based on perceptions of the community's beliefs about ART, and not one's own beliefs. These results suggest that it is possible to diminish this form of social stigma, by shifting the incorrect beliefs upon which it is based.

If the increase in HIV testing we observed was indeed due to a reduction in stigma, the effect should persist. Uptake of ART drugs should also increase, since the intervention consisted only of providing information on their benefits. Future data will allow us to determine the long run effect of this intervention on HIV testing and demand for ART. In addition, the theory suggests that the intervention targeted those who care most about the number of sexual prospects. Individuals who prefer to have many potential sexual partners are also most at risk of contracting and spreading HIV. Long-run data on HIV incidence will allow us to investigate the effect of the intervention on the spread of the virus.

This work may be relevant to other contexts in which a technology is under-adopted due to stigma. In particular, if a technology disproportionately benefits a stigmatized group, it may be under-adopted, as individuals know it will signal their underlying type. For example, a person who suffers from mental illness may be reluctant to seek psychiatric care, for fear his friends or employer might find out. Stigma, in many contexts, may be explained by statistical discrimination; employers might believe that the mentally ill are less productive workers. This situation leads to a bad equilibrium: the employee's mental illness goes untreated, and he is less productive than he would be if he were receiving treatment. Of course, one solution is to help the employee obscure the signal, by ensuring privacy of psychiatric care. However, if statistical discrimination is based on incorrect beliefs, providing correct information to the public, or in this example, to employers, should eliminate the stigma equilibrium.

A community-level information campaign on the public benefit of ART drugs is an inexpensive way to reduce stigma and increase HIV testing. A policy which reduces stigma directly is more attractive than one which helps HIV test-seekers conceal their decision to test or their motivation for testing. For example, while monetary incentives increase HIV testing, in order to be effective in the face of stigma, they must be paid repeatedly to the entire community. This might make monetary incentives for ART use infeasible. A reduction in the level of stigma should affect all health seeking behavior, and have permanent effects.

While our experiment took place in Malawi, there is reason to believe its policy lessons apply elsewhere. Southern Malawi is representative of

sub-Saharan Africa in many ways. HIV prevalence is high (above 10%), ART drugs are widely available at rural clinics, and the population is concentrated in rural villages, in which health seeking behavior is often observable. Our model of stigma is based on rational behavior and does not depend on cultural norms, therefore it might well apply in communities outside of our study area.

A scaled policy intervention should have two important features: information on the public benefit of ART should be provided at the community-level, to ensure common knowledge, and the information should be provided in a credible way, for example, by trusted health authorities. It is not sufficient to rely on learning and information sharing to shift beliefs over time, because in the presence of stigma, both of these activities will be hampered. Under-adoption of ART drugs means that most people do not learn of their effects first hand, and stigma makes people reluctant to discuss these effects with social contacts. Additionally, those who are infected cannot transmit the information credibly, as they stand to benefit from a shift in community beliefs about ART drugs. In the absence of an information campaign, social stigma allows incorrect beliefs to persist.

Our results suggest that providing precise information on the effect of ART drugs on HIV transmission is an effective way to reduce stigma. Some public health campaigns aim to inflate perceptions of HIV risk by distorting or hiding facts about transmission from the public, in an effort to reduce risk taking. This study suggests that such policies may have unintended consequences; they exacerbate stigma and inhibit health seeking behavior. Informed communities have higher rates of HIV testing and treatment, which improves the lives of those who are infected, and serves the community as a whole by reducing the spread of the virus.

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