HÁSKÓLI ÍSLANDS

Félags- og mannvísindadeild

MA-ritgerð

Þróunarfræði

‘If I had a spear, I would kill the HIV beast’:
Views from a Malawian village on the HIV epidemic

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Abstract

AIDS in Africa has received much international attention. Development aid agencies, NGO's and national governments have concentrated much effort and financial resources in fight against AIDS. Special attention has been paid to young women's vulnerability towards HIV infections, which is thought to stem from harmful gender norms and cultural practices. The aim of this study is to explore development discourses of women, culture and gender relationships and to compare them with the lived realities of women in a small village in Mangochi District in Malawi. This study is based on fieldwork consisting of interviews and participant observation in Malawi, where the author lived for nearly two years. The results of the study, indicates that the prevailing emphasis in HIV policy documents are not always realistic. It is a characteristic of these policies to portray women as defenceless victims with little or no agency. It is shown in this thesis that the social relations of women in a Malawian village are far more complicated than this portrayal indicates. Preventive measures against HIV in sub-Sahara Africa would be far more effective should attention be paid to the women's lived realities and on-the-ground interpretations of women's agency.

Key words: Development Studies, HIV, AIDS, Malawi, feminism, cultural practices, culture, VCT, development aid

Ágrip

Mikið hefur verið fjallað um alnæmi í Afríku. Þróunarsamvinnustofnanir, frjáls félagasamtök og ríkisstjórnir hafa lagt mikla vinnu og fjármagn í þá baráttu. Hærra hlutfall HIV smitaðra stúlkna og ungra kvenna en karlkyns jafnaldra þeirra hefur vakið athygli og hafa þróunarsamvinnustofnanir reynt að sníða verkefni sín að þörfum ungra kvenna. Skaðlegir menningarbundnir siðir og ójafnrétti kynjanna eru taldar vera helstu ástæður þess að ungar konur smitast frekar en menn. Markmið þessarar ritgerðar er að skoða orðræðu þróunarsamvinnustofnana um ungar konur og alnæmi og bera þær saman við veruleika kvenna í litlu þorpi í Malaví. Ritgerðin er byggð á vettvangsathugun í Mangochi héraði í Malaví, þar sem höfundur dvaldi í tæp tvö ár og tók viðtöl og beitti þátttökuaðferð. Niðurstöður rannsóknarinnar gefa til kynna, að áherslur þróunarsamvinnustofnana í HIV verkefnum séu ekki alltaf raunsæjar. Það er einkennandi fyrir stefnumótanir HIV verkefna að draga upp staðlaðar ímyndir af konum sem varnarlausum fórnarlömbum sem litla sem enga gerendahæfni hafi. Sýnt er fram á í þessari ritgerð að félagsleg tengsl kvenna í Malavísku þorpi eru mun flóknari og fjölbreyttari en þessi ímynd gefur til kynna. Höfundur dregur þá ályktun að HIV forvarnarverkefni í Afríku sunnan Sahara væru árangursríkari ef meira tillit væri tekið til raunverulegra aðstæðna kvenna.

Lykilorð: Þróunarfræði, mannfræði, HIV, Malaví, femínismi, menning, siðir, VCT, alnæmi, þróunaraðstoð

Forewords

This thesis, which is 60 ETC units, marks the completion of my MA programme in Development Studies at the University of Iceland. I was fortunate to have both Jónína Einarsdóttir, Professor of Anthropology, Faculty of Social and Human Sciences, University of Iceland and Geir Gunnlaugsson, Medical Director of Health, Directorate of Health, and Professor of Public Health, School of Health and Education, Reykjavík University, as my supervisors during my fieldwork and while writing up this thesis. Their enthusiasm for the subject and encouragements as well as critical comments and conversations, inspired me to do this study.

I am indebted to ICEIDA in many ways. First of all, for granting me a study and travel grant which made this journey possible in the first place. When arriving to Malawi, I was welcomed and assisted in numerous ways. I would like to thank Margrét Einarsdóttir in particular for her unique hospitality. After the completion of my fieldwork, I got a position as an intern and later as an Administrative coordinator at ICEIDA in Malawi. This working surrounding was very stimulating and vibrant and I owe all the ICEIDA employees a big thank you for the endless conversations, debates, struggles and laughter we shared together. I would especially like to thank my Icelandic co-workers; Stella Samúelsdóttir, Skafti Jónsson, Ásdís Bjarnadóttir, Stefán Jón Hafstein, Glúmur Baldvinsson and Stefán Kristmannsson for their great friendship and moral support. Linley Magwira, Jolly Kazembe, Catherine Mandala and Elsie Dzanja are the heart of the ICEIDA office in Lilongwe and I'm very thankful to them for their great spirits and endless 'girls talk' we had. In Monkey Bay, Joseph Izaya, and Kadalela Phiri, were always willing and ready to assist me with any task and I think there is nothing they cannot do. I feel very fortunate to have shared house, time and friendship with Sólrún María Ólafsdóttir when in Lilongwe.

This thesis is based on my ethnographic experience in Karombo[1] village. Sadly, I cannot list all the people in Karombo that I owe thanks to. I was well received in the village and I am forever grateful to all those who allowed me to participate in their lives during my stay. I would especially like to mention; Waliya Ntchare, Edina Changamire, Catherine Kadarera, Elis Desdan, Mr. Luwani, Jenny, Assan, Geoffrey, Rashid, Seunate, Eliza, Loveness, Isabella, Butex, Kim and Aubrey for the good times we shared together.

Nissar and Farida became my second family in Malawi and did not only provide me with a place to stay but I got to enjoy Farida‘s marvellous cooking skills and their enjoyable conversations and friendship. Two strong women greatly influenced my fieldwork. One is June Walker who was my nearest neighbour and a priceless friend. She provided me with intellectual and moral support throughout my stay, her thoughts and experience were invaluable. The other is, Lifa Machira, who was my translator and assistant during my fieldwork. Not only did she translate my questions, but posed many herself, which very often were the ones which delivered the most fruitful and informative discussions. I hope I have managed to deliver a fraction of Lifa‘s knowledge of the subject and her lively character to this thesis.

My parents, Sigríður Guttormsdóttir and Pétur Skarphéðinsson, deserve my greatest gratitude for encouraging my in whatever I have taken on in life. They have supported me in realizing my desire to travel widely from young age, even though I know it has caused them worries more than once and more than twice. They have motivated me during my studies, my father by stressing the importance of putting things into an academic context and my mother with her deep compassion for the peoples of the world.

Last but not least, I’m deeply grateful to my partner Sveinn Eggertsson. Not only did he travel across the world several times while I was staying in Malawi but during the years this project has taken, been of greatest emotional support. His love, patience and care has enabled me finish this project.

[1] Karombo is pseudo name of the village.

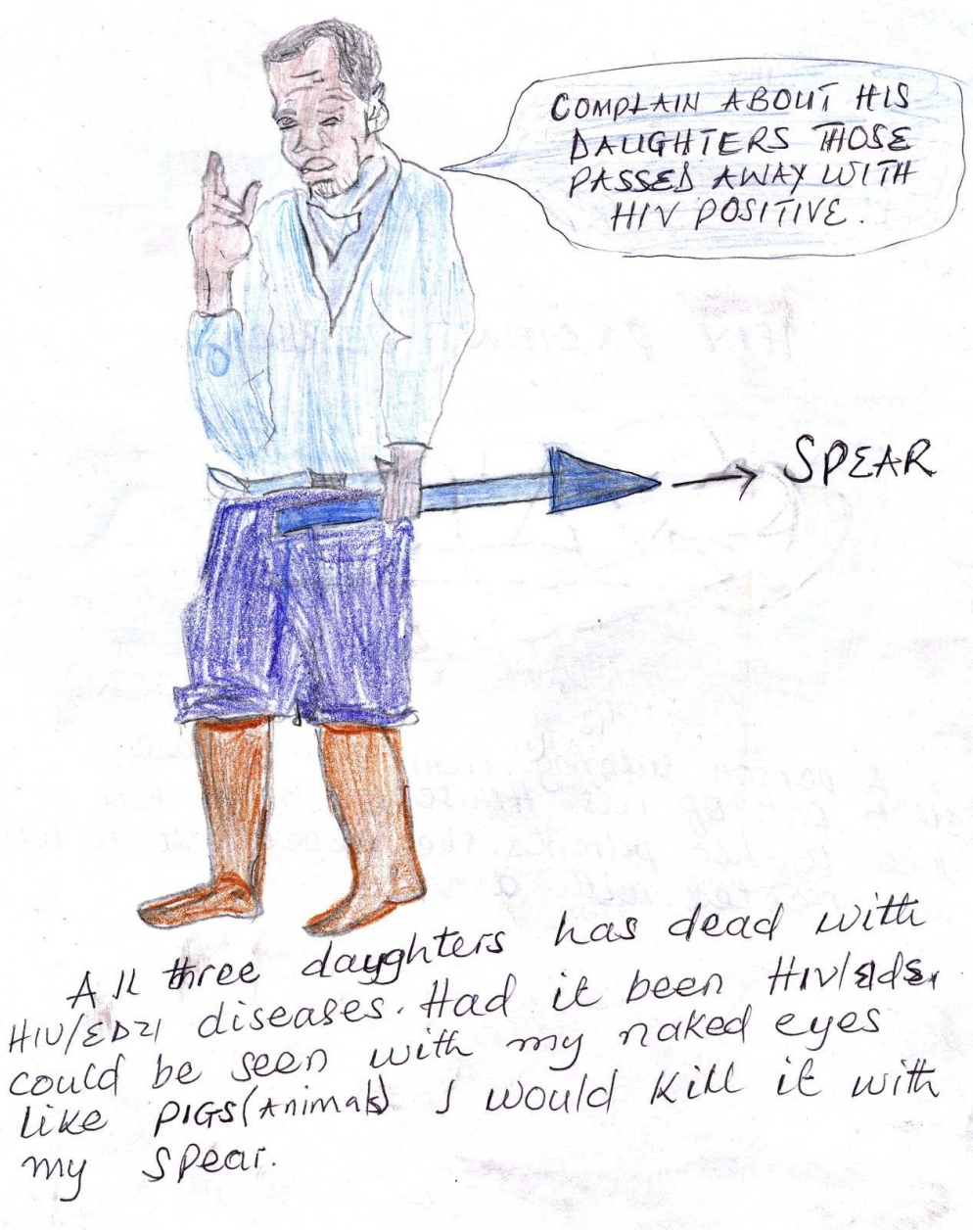

Figure 1: Drawing by James, Geoffrey and Morrey. Karombo, Monkey Bay, 28th of April 2007.

I dedicate this study to Lifa Machira. Her optimism, thoughtfulness and energy are truly inspiring.

Index

List of figures:

Abbreviations

ABC	Abstinence, be faithful, use condom
AIDS	Acquired Immune-deficiency Syndrome
ARV	Antiretroviral Drugs
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
Global Program	WHO Global Program on AIDS
GoM	Government of Malawi
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practices
ICEIDA	Icelandic International Development Agency
MACRO	Malawi Aids Counselling and Resource Organization
MBCH	Monkey Bay Community Hospital
MDICP	Malawi Diffusion and Ideational Change Project
MDG	Millennium Development Goals
MDHS	Malawi Demographic Health Survey
MOHP	Ministry of Health and Population
MSF	Medicins Sans Frontiers (Doctors without Borders)
NAC	National AIDS Commission
NACP	National AIDS Commission Programme
NAF	National HIV and AIDS Action Framework
OPC	The Office of the President and Cabinet
PEPFAR	President's Emergency Plan for AIDS Relief
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS?
UNGASS	UN General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Introduction

The AIDS epidemic is one of the most serious health problems in Africa. UNAIDS (2008: 30) estimates that over 22 million women, men and children are now living with the HIV virus in Africa sub Sahara. This amounts to 67 per cent of all people living with the disease in the world. In 2007, 75 per cent of all HIV related deaths occurred in Africa (UNAIDS, 2008a). According to the UNAIDS (2008), women are 61 per cent of all humans living with HIV, the ratio being as high as 75 per cent in some countries. Kofi Annan, the former Secretary General of the United Nations, brought attention to this in 2002 when stating that AIDS has a woman's face in Africa (Annan, 2002). Despite women and young girls being given special attention as vulnerable groups in HIV programmes, statistics continue to show this difference (Jungar and Oinas, 2004; IFRC, 2008; UNAIDS, 2008a).

Being diagnosed with HIV and living with AIDS is a disease which requires medical treatment. But HIV is also an epidemic, which needs to be examined from different epistemological points of view since it affects all layers of society. In the countries most affected by HIV in Africa sub Sahara, the disease is embedded within economic, cultural, political and social contexts (Craddock, 2004: 5). It is difficult to imagine the emotional suffering of those infected with the virus and of those who watch their beloved in pain while their immune system slowly fails. The disease does not only have devastating effects on affected individuals and their families, but also on extended families, villages and districts. It can even cause setbacks to whole countries.

This thesis is grounded within social theories of feminism, resistance, power, medical anthropology and sexuality, which serve as tools to channel the fieldwork notes to conclusions. Drawing from my educational background in anthropology and development studies, this thesis is based on ethnographic experience from Malawi mainly from February to June 2007. After the four months study period, I was offered to work for the Icelandic International Development Agency (ICEIDA) and in total I

spent 21 months in Malawi. This was a unique opportunity for me. Staying on in the country gave me the chance to continue my research and to deepen my understanding of people's conditions in the rural areas and how HIV affects their daily lives. The work on this thesis has taken six months over the period of one and a half year and is strained by a number of words, which has caused me serious headache at times.

I became interested in the issues related to AIDS after returning to Iceland after living one year in Ghana 2001 and 2002. While staying in Ghana, I was not particularly aware of the disease. HIV did not get much media attention and there were no public prevention to be seen. Certainly, I had heard about HIV and AIDS, but to me, a young woman from Iceland, AIDS was a rather exotic disease akin to other diseases I was witnessing for the first time, such as malaria, yellow fever and hepatitis, all of which can be fatal. I was carefree and so busy enjoying the realization of a long-wanted dream to be in Africa, that I was oblivious to the threat of HIV. It was not until I was back in Iceland and working in a small grocery shop in a village in the countryside that I started contemplating the problems of HIV. The villagers were curious about my stay in Ghana and often initiated conversations about Africa. To my surprise, many showed particular interest in HIV and AIDS and I was frequently asked if I had witnessed or heard off men raping infants in the belief of curing themselves of the HIV virus. This line of conversation was not what I had anticipated and I grew rather tired of correcting people's misconceptions of Ghana and Africa in general. What I didn't know at the time was that these conversations would kindle a five year academic flame for me; HIV in Africa.

I became curious of western[2] discourses about HIV and AIDS in Africa. While reading what western scientists had written about AIDS, I noticed that there was a tendency of many scholars to blame African cultural practices and a 'distinctive'

[2] I'm aware that geographical divisions such as the 'West', 'South', 'North', 'First World', 'Third World' and 'Developing World' are higly political, controversial and much criticed concepts (see for example Mohanty, 1988 and Said, 1979) for bearing historical connectations to colonialism and the power of the privilaged few to 'name' large geographical areas excluding the vast diversity within the areas. However, I choose to use these concept while discussing dominant discourses although aware of their disadvantages.

African sexuality for the high HIV incident rate in some African countries and found it interesting that most of the articles and books I read lacked information about how people in African countries viewed the HIV situation themselves (Caldwell *et al*, 1989, 1991; Leclerc-Madlala, 2000, 2004; Lawoyin, 1999). I explored this matter in some depth in my B.A thesis (Pétursdóttir, 2005), in anthropology inspired by Edward Said‘s (1978) explaination of how Western discourse tends to generalize exotic regions and their inhabitants in his book *Orientalism*. Said is of the opinion that by colonising and describing unfamiliar regions, creating theories about the inhabitants and by governing them, the Europeans created a prevailing image of these alien regions to the extent that today it is difficult to discuss, think about or describe them from outside these frames of reference. I wondered whether one could detect similar ‘colonial continuities in western scientific discourse of sexuality and AIDS in Africa’ (Arnfred, 2004: 10).

This inspired me to go to Malawi to conduct research for my master’s project: to study how the notion of AIDS affected the lives of people in a small village in a country where up to one fifth of the population is infected with the virus. The overall goal of this study is to review how the emphases of HIV prevention campaigns are understood in a local context and, to account for where these have been successful as well as point out how they might be improved. My research focus was mainly on the following topics:

Firstly, ‘Harmful traditional practices’ which is a term that has been highlighted by international and national agencies as a culprit of the high HIV prevalence in Malawi (NAC, 1999; Dzimnenani 2007; Kondowe, 1999). My research plan was to explore topics such as girls’ initiations rites, sexual promiscuity, gift-exchange in relationships, female genital mutilation and the practice of ‘dry’ sex, in the context of HIV and how these practices are viewed by local women.

Secondly, gender inequality. Research what has been written about the issue by academics, development agencies and other organizations and how people in Karombo perceive gender equality or gender in-equality. Women’s inability to

negotiate condom use, poverty, traditional gender roles, domestic violence and 'male oppressing culture' has commonly been named as factors contributing to the spread of HIV. Most HIV prevention programs focus on women and I will explore how women in Karombo view their situation compared to this emphasis.

Lastly, Voluntary Counselling and Testing (VCT). These services are viewed by many as pivotal in the fight against the HIV epidemic in Africa (UNAIDS, 2001, 2004, 2006, 2008). VCT combines HIV testing with HIV counselling and sometimes AIDS medication. This led to me to explore a VCT centre in the area of my study, focusing on how it is viewed by the health workers working there, patients and others living close to the VCT centre. It also brings up interesting questions concerning the use of western medication as opposed to the use of traditional ones and the how these different epistemologies either complement each other or collide.

This thesis is divided in to eight chapters. In the next I will give an overview of how the HIV epidemic has evolved and trace how AIDS became one of the main focuses of development agencies. I will also discuss the theoretical framework within which this thesis is grounded, with special emphasis on different discourses of gender inequality in poor countries. The third chapter is an introduction to the geography, history and politics of Malawi, I will be placing the HIV epidemic in a Malawian historical context. The methodology of the project will be explained in the fourth chapter. In chapter five, six and seven, I will address how gender relations and cultural practices are viewed in Karombo in the context of HIV. In chapter nine I discuss the VCT centre at Monkey Bay Community Hospital and in the last chapter I present a summary and conclusion of this thesis.

2. Literature Review

2.1 Theoretical framework

During my undergraduate courses in anthropology, I was taught to think of social theories as a set of glasses. Just like trying on different spectacles can change one's vision, a researcher can employ different social theories in his/her ethnographic work and it will influence the outcome. When using qualitative method, the researcher has to be particularly aware of this since his/her background, epistemological point of view or theory is the main analytical tool. Different theories and conceptual tools have been prominent within the social sciences at different times. While reading about social theories in historical context (Barnard 2002 [2000]), one can tell that synchronised events affect how theories evolve; theories do not emerge from thin air but are shaped by the political and social landscape where they are born. Even though theories can fundamentally differ from each other, the scholars who use them have the same purpose in mind; to understand how people interact with each other and within a given society or culture. In this thesis I do not limit myself to one frame of theories but rather in a Foucauldian sense of a theoretical tool box[3], apply different theoretical positions according to their importance in particular contexts.

In this chapter I review the literature background influencing this study. First I give a short historical overview of the development of the HIV epidemic in a global context. Secondly I recount how HIV became a focus of aid agencies by putting health and development aid in historical context. Thirdly, gender, or more accurately, poor social status of women in Africa sub Sahara, has been considered as one of the main reasons for high HIV transmission. An overview will be given of how gender equality is viewed by development agencies, Third World feminists and those who view gender as one of many factors shaping personal identity. My aim is to illustrate how gender relations can be approached from multiple angles and then to situate myself within

[3] As Micheal Foucault (1980: 145) explains: 'The notion of theory as a toolkit means […] (ii) That this investigation can only be carried out step by step on the basis of reflection (which will necessarily be historical in some of its aspects) on given situations.'

the discourse. I find gender relations and culture to be of the most relevance when trying to understand how HIV and AIDS affect people in a Malawian village.

2.2 HIV epidemic: Overview

AIDS and Africa have become interrelated in public discourse but this portrays a simplified image of the epidemic since within Africa, the HIV infection rates can vary from less than 2 per cent within a given country, up to 20 per cent of all adult population[4] in others (UNAIDS and WHO, 2009). The Southern and Eastern parts of Africa have higher HIV prevalence than countries in Western and Northern Africa. It is a devastating fact that in Malawi, Zambia, Mozambique, Zimbabwe, Botswana, Lesotho, Namibia, South Africa and Swaziland at least one in every ten adult is living with HIV (IFRC, 2008: 40).

In the combat against the HIV and AIDS epidemic over the last three decades, good news has been rare. In 2000 the magnitude of the AIDS epidemic had been growing immensely and despite prevention measures the incident rate did not halt in Africa sub Sahara (Oppong and Aguei-Mensah, 2004: 70). UNAIDS (2008) however reported on the XVII International AIDS Conference held in Mexico City in August 2008, that there has been a decline in HIV related deaths globally, from an estimated 2.2 million in 2005 to 2.0 million in 2007. This can partly be explained by extended availability of HIV drug therapies, which prolong lives of HIV infected people but not solely because lower incident rates of new HIV infections were also reported. Optimistic voices hope the peak of the epidemic has now passed, while UNAIDS (2008) warns against complacency since throughout history, epidemics have been difficult to control and hard to predict their futures' course.

2.3 First years of the HIV epidemic

The origin of the HIV virus is debated even though this topic has been much discussed. The general assumption in medical discourse seems to be that the HIV

[4] According to UNAIDS (2008b), 23% of people aged 15 – 49 years old in Lesotho are HIV positive but less than 2% are HIV infected in several countries in sub-Saharan Africa (Eritrea, Comoros, Madagascar, Mali, Mauritius, Somalia, Benin, Burkina Faso, Ethiopia, Gambia, Guinea, Liberia, Niger, Senegal, Sierra Leone).

virus originated in Africa where relational virus is known to be in apes. But there strong voices within Africa claiming that HIV is an 'invention of Western propagandists seeking to discredit Africans' (Schoepf, 2004a: 22) and a general understanding in Africa sub Sahara is that AIDS 'comes from somewhere else' (Campbell, 2004: 146; Stebbing *et al*, 2004: 1872). Some of the speculations sound more like complex plots in science fiction books than scientific explanations. One explains how the HIV virus was transmitted from apes to humans in obscure exotic African rituals where monkey blood and human semen were mixed together to use as aphrodisiac (Stebbing *et al*, 2004: 1872). Others guess the virus arrived to humans by eating raw chimp meat in Central Africa and the conspiracy theory of HIV as being man made with the intent to wipe out black people and homosexuals is prevalent in both the United States and in Africa (Marx *et al*, 2004: 221; Ross *et al*, 2006; Stadler, 2003).

It is somewhat surprising that in the beginning of the epidemic, AIDS and Africa were not interrelated. Scientists are quite certain that the first HIV cases were known in the mid and late 1970's even though they did not receive much attention. It was in the beginning of the 1980's that rare cases of pneumonia were diagnosed in five gay men in Los Angeles. What puzzled the doctors was that it seemed as if the patients' immune systems had failed. Over the next few months more incidents were diagnosed, mostly in gay men and the disease was called 'gay compromise syndrome' by some (Oswald *et al*, 1982; Brennan *et al* 1981). The majority of the first diagnosed cases were among gay men and later in Haitian immigrants to the Unites States. A few years into the 1980's, people with HIV were diagnosed in Europe. At the same time, countries in Eastern Africa and to some extent in West Africa were experiencing a new disease which locally was called 'wasting disease' or 'slimming disease' (Hunt, 1989). It took the doctors a while to realize that this new disease was indeed HIV infection or as David Serwadda a former medical resident in Uganda puts it: 'we just could not connect a disease in white, homosexual males in San Francisco to the thing that we were staring at…' (Avert.org, 2009a).

From the beginning, AIDS has generated strong responses and still today HIV infected people often experience isolation, shame and stigmatization (IFRC, 2008: 48). David Sibley (1995) discusses how the AIDS epidemic has served as a reminder of the importance to follow core family values by fuelling the HIV discourse with moralising messages of how promiscuity and homosexuality can lead to death. In the first years after HIV cases were discovered, the general discourse was characterized by much confusion, ignorance and prejudice globally (Avert, 2009b). In Sibley's opinion (1995), AIDS created a vacuum in western public media to openly express homophobia and racism. HIV infected people in the United States and Europe experienced isolation and stigmatization, and there was even a known family campaign in Britain that advocated quarantine of AIDS patients in the late 1980's (Sibley, 1995: 42). Even though the transmission modes were known by 1985 it drew the eyes of the world when Princess Diana shook the hands of AIDS patients without gloves in 1987 (Avert, 2009b). Unlike the U.S or Europe, the disease is primarily transmitted by heterosexual intercourse in the African continent. In Africa as elsewhere HIV became associated with prostitution and promiscuity and HIV patients experienced stigmatization. In the late 1980's Southern and Eastern Africa had become the focus of this new global epidemic and Africa is still today the worst hit continent of the disease even though the HIV infections are on the rise in other geographical areas in the world[5] (UNAIDS, 2008: 15). Since the millennium, halting the spread of HIV and AIDS has become one of the main focuses of development agencies.

2.4 Development aid and health in historical context

Development aid is a much debated and quite a complex phenomenon. It would be too long to recite what has been written about development aid but the origin of development aid is often traced to Harry Truman's speech when taking office as the President of the United States in 1949 and to the years after the Second World War (Escobar, 1995). In his speech, Truman offered assistance to poor countries of the world to 'modernize' with the assistance of U.S technological and scientific expertise

[5] UNAIDS estimates that 67 per cent of all HIV infected people are in Africa sub Sahara but notes that the HIV epidemic is growing fast in some countries in Asia.

(Rist, 1997: 249; Edelman and Haugard, 2005: 7). During the middle half of last century, development was believed to be linear in that societies were thought to develop from a primitive state to a modern one, with modernity being, to no surprise, defined as analogous to contemporary western affluent societies (Boas, 2003: 53). The task for wealthier nations therefore lay in progressive projects in poorer countries, to drag those who lagged behind to modernize. But since the early days of development, emphasis in development aid programmes has shifted in tune with historical and ideological events; from stressing industrial production and infrastructure in the 1950' and 60's, creating globally open financial markets and providing loans to development countries in the 1970's to structural adjustment and 'good governance' in the 1980's (Peet og Hartwick, 1999: 55–83; Edelman and Haugard, 2005: 7).

Despite Truman's statement as to there being no imperialistic motives for providing development aid to poorer countries, saying: 'The old imperialism-exploitation for foreign profit-has no place in our plans. What we envisage is a program of development based on the concepts of democratic fair-dealing' (Truman, 2008 [1949]) not everyone is convinced to say the least. Academics belonging to schools of post-development and post-colonialism have put forth strong criticism on development aid, claiming aid to be a mere pretence for forcing western ideological hegemony upon other countries (Escobar, 1995) or in Frederick Cooper's words: 'Development ideology was originally supposed to sustain empire, not facilitate the transfer of power' (1997: 84). Randall Packard (1997: 93), shares Cooper's views, in the context of the history of global health. He is of the opinion that the first steps of development aid in health care bear much resemblance to health care provided by colonialists in Africa. During the colonial era, much emphasis was paid to extinguish fatal diseases like malaria and yellow fever, foremost in the hope of making it bearable for Europeans to survive in the tropics and to enable them to continue their exploration. According to Packard, European interest in improving the health of Africans in the early years of last century, was primarily motivated by economic interests since the colonizers realized that 'economies depended on healthy workers

and not just healthy managers' (1997: 94). Packard argues that western health workers working in Africa during the colonial times, as well as in the first years of development aid, over-relied on technical solutions and western medicine when dealing with tropical diseases, by dismissing encompassing understanding of health and ignoring social and cultural issues. Faith in scientific and technological solutions is still prominent within health care in development projects, but the importance of a holistic view of diseases has slowly been forging its way to the framework of health projects.

2.5 HIV, AIDS and development aid

AIDS is a global disease, although the worst hit countries are poor countries in Africa, Asia and in Europe. In affluent countries emphasis on HIV and AIDS prevention has diminished over time since the transmission rate remains rather stable but funding earmarked HIV and AIDS to poorer countries has steadily increased year by year and is now roughly fivefold what it was in the 1990's (Shiffman, 2007; England, 2008: 1072). In the beginning of the epidemic the focus was not on developing countries but rather, as has been explained previously, on the United States and England. The fight against HIV and AIDS was mainly in the hands of the World Health Organization (WHO) and other aid agencies devoted to health issues during the first years of the epidemic (Schoepf, 1998: 239). In 1987, six years into the then epidemic, an agency called WHO Global Program on AIDS (Global Program) was established under the hat of WHO, whose purpose was to raise global awareness of the disease. Some social scientists objected to the prevailing emphasis of Global Program on exploring the HIV epidemic only from medical and public health perspective with qualitative methods (Schoepf, 1998, 2004a; Bolton, 1998). The anthropologist Ralph Bolton (1998) was quite harsh on his colleagues working in the HIV arena in the 1990's when stating:

> Ethnographers are called in after the quantitative data are collected and the number crunchers cannot make sense of them. We have become public opinion pollsters, we have delegated the collection of data to subordinates, we have become the servants of others with more power over funds (1998: 375).

After ten years of operation, the Global Program was increasingly criticised for not being able to muster enough political will among wealthy nations to donate funds to combat the AIDS pandemic in poor countries (Merson, 2006). In hope of being more successful to lead the project, a special UN programme was launched in 1996; Joint United Nations Programme on HIV/AIDS (UNAIDS). This turned out be successful and Merson (2006: 2414-17) the former director of Global Program cites four reasons for this sudden global interest in HIV and AIDS around 2000. First, he mentions that the World Bank took interest in the topic and increased its funding from 500 million in 1998 to 2.7 billion in 2006. Secondly, voices demanding provision of medical treatment to HIV infected people in Africa grew louder after the XIII International AIDS Conference held in Durban 2000. Thirdly, the former UN Secretary General Kofi Annan convened global leaders in 2001 to a UN Special Session on HIV/AIDS whereby representatives from 180 governments signed an agreement to secure funding for countries heavily affected with HIV (UNGASS, 2001). Last but not least, politicians' interest was revivified when HIV cases increased in China, Russia and India, which 'prompted concern that AIDS could destabilize global political and economic systems beyond sub-Saharan Africa, threatening global security' (Merson, 2006: 2415).

The first years of the millennium were characterized by donors' focus on providing treatment for AIDS patients although social scientists realized the necessity of combining sociological perspectives with the medical background, but funding was hard to come by (Dionne *et al*, under review). Horton and Das (2008) conclude that the debate within development agencies whether money should be concentrated on HIV preventions or supply treatment for as many as possible had a devastating effect, or, as they put it:

> From the very beginning of the global response to the AIDS pandemic, prevention has been marginalized. Treatment has dominated. This systematic imbalance in clinical and public health programmes is largely responsible for

> the fact that around 2.5 million people become newly infected with HIV every year (Horton and Das, 2008: 421).

Horton's and Das opinion is undoubtedly correct, however it must not be forgotten that scientists who research AIDS come from numerous academic fields like public health, demography, biology, sociology, psychology and anthropology just to name a few. Researchers with different epistemological backgrounds touch upon different issues concerning HIV and AIDS and this diversity is testified in the literature of HIV. Although funding was mostly diverted to Antiretroviral treatments (ARV), valuable research for HIV prevention was conducted in HIV laden countries by social scientists from 2000 to 2003, though most of them were not funded by development agencies (Castle, 2003; Kaler, 2003; Campbell, 2003; Lwanda, 2002; Schoeph, 2004a; Susser og Stein, 2004).

A group of scholars have shed light on other aspects of the epidemic in order to understand the encompassing effects the epidemic has. Some medical anthropologists have drawn attention to what has been termed 'structural violence' (Schoepf, 2004b; Farmer, 2003, 1996; Farmer *et al*, 2006), where the rapid transmission of HIV in poverty stricken countries is explained in terms of macro level policies, politics and poverty. Others (IFRC 2008) focus on the issue of stigma and negative factors, which it has on people living with AIDS. Still others have courageously and successfully fought against big pharmaceutical companies who sought to privatize ARV drugs, whereby ARV drugs are now affordable by great many. There is also a large body of literature, which touches upon the difficult situation for millions of orphans and child headed households as a result of HIV (Guest, 2004; Wittenberg and Collinson, 2007). Structural violence, stigma of those infected, lack of medical care for AIDS patients and the problem of growing number of orphans are just a few issues that overlap in the discussion of the AIDS epidemic in Africa.

Even though development aid organizations and governments around the world paid more attention to AIDS in 2000, one can speak of a new era in HIV and development funding in 2003 when the former president of the United States; George Bush,

launched a five-year programme called President's Emergency Plan for AIDS Relief (PEPFAR). This programme is the largest effort any nation has committed to any disease (PEPFAR, 2009a: 5). First phase of the programme endured from 2003 – 2008 but was renewed for another five years in 2009 and is now under the leadership of President Barak Obama. PEPFAR aims to provide prevention, treatment and care in their focus countries[6], although most of the funding is channelled for treatment and care. Vietnam, Cambodia and India are chosen as recipients although HIV prevalence is less than one per cent in these countries[7]. Dionne *et al* (under review) point out that five per cent of death worldwide is caused by HIV and AIDS but the US government spent 49 per cent of its' international health aid budget on HIV in 2007. PREPFAR allocates one third of the prevention budget to programmes that do not promote condom use and the rest is concentrated on so called 'ABC strategy' (Nelson, 2006: 194).

ABC is an abbreviation for abstain from sex before marriage, be faithful to spouse(s) and use condoms if having extra-marital affairs. The ABC strategy has enjoyed some popularity among African leaders who receive donations from PEPFAR. Uganda's success story of managing to lower HIV incidents dramatically has been credited to ABC (which was funded by PEPFAR) (Nuti, 2008; Murphy *et al*, 2006). The ABC strategy has though been much criticized mainly for not considering how cultural factors shape the outbreaks of the virus, putting too much emphasis on individual responsibility and for not being sensitive to women's risk of getting infected. Brooke Schoepf (2004a: 26) addresses one of the problem as she claims that encouraging individual responsibility in the midst of an epidemic is a naïve approach since by doing so the structural factors of the HIV epidemic are ignored. Oliver Phillips (2004: 165) further elaborates on this argument and adds that the idea of individual autonomy is more of a western construct whereas in many HIV laden areas, the

[6] The 20 focus countries that receive 80 per cent of the allocated budget are: Botswana, Cambodia, Côte d'Ivoire, Ethiopia, Guyana, Haiti, India, Kenya, Malawi, Mozambique, Namibia, Nigeria, Russia, Rwanda, South Africa, Tanzania, Uganda, Vietnam, Zambia and Zimbabwe. Five per cent is distributed between other 105 countries and 5% go to the Global Fund to Fight AIDS, Tuberculosis and Malaria (PEPFAR, 2009b).

[7] Vietnam 0.5%, India 0.3%, Cambodia 0.8%. For comparison, Iceland has 0.2% HIV prevalence (UNAIDS, e.d: countries).

person acts in a communal interest, as suggested by Strathern's (1988) notion of a social person which is composed of his or her relationships with and responsibilities to other people.

Additional problematic issue is that the ABC strategy does not have a uniform understanding in various locations; research has shown that the understanding of abstinence, condom use and faithfulness to one's partner relies heavily on the cultural setting in which it is found. How this strategy is understood further depends on factors such as how does the media cover HIV (or excludes reportage of AIDS), government responses, whether members of the health professions talk about the disease openly and encourage people to use condoms, the appropriateness of the slogan to people's religion, just to mention a few important factors. The ABC strategy is obviously less relevant in societies that are experiencing war, civil unrest, high unemployment rates or migration (Dworkin, 2007: 13-19).

The U.S Agency for International Development (USAIDS), that implement their programmes in partnership with PEPFAR, claims criticism on the ABC strategy to be unjust since 'Promoting behaviour change entails addressing the social norms and environmental characteristics that might prevent individuals from protecting themselves' (USAID, 2009). USAID, concentrated for a long time on encouraging abstinence and faithfulness and was publically opposed to the distribution of condoms to unmarried people. Some claim that USAID forced other agencies, local and international, to adhere to its policy (Ahlberg 1994). USAID later reconsidered its position and is in fact now the single most important donor of condoms in Africa. But, continuing on a moral note, condoms were only distributed to clinics that did not promote abortion in any way[8] until the beginning of 2009, when President Barak Obama repealed this rule (Cohen, 2006; Bogecho *et al*, 2006; Sullivan, 2009). Ironically, the rule may have led to more abortions being executed. Criticism concerning PEPFAR's ABC strategy being dominated by American moralist

[8] This rule was effective after former President of the United States, George Bush, signed the so called 'Mexico City / global gag rule' (Bogecho *et al*, 2006).

ideology is countered on PEPFAR's homepage, stating that due to the ABC strategy, HIV prevalence has lowered in Uganda and Cambodia (PEPFAR, e.d). However, neither USAID nor PEPFAR have addressed the concern 22 EU member states released in a statement on the World AIDS day in 2006, whereby African governments were urged not to heed the abstinence-focused agenda of PEPFAR and to encourage comprehensive sexual education instead of the ABC (EU, 2006)[9].

After eight years of adequate funding for combating the disease, a new tone is now being heard among HIV and AIDS agencies. Positive results of the fight against the HIV epidemic released after the XVII International AIDS Conference 2008 are challenged by the global financial crises (UNAIDS *et al*, 2009). HIV analysts worry that financial cut in HIV programmes can have devastating effect such as:

> [I]ncreased mortality and morbidity, unplanned interruptions and curtailed access to treatment, increased risk of HIV transmission, higher future financial costs, an increased burden on health systems and a reversal of economic and social development gains (Hecker 2009: 2nd paragraph).

PEPFAR and the Global Fund, the largest single donors in HIV and AIDS, had to alter their promises for 2009 and 2010. During his election campaign, President Barak Obama promised to donate U.S 48 billion dollars to PEPFAR over the period 2009 to 2013 but has now granted PEPFAR 51 billion U.S dollar over six year period. The Global Fund is experiencing similar problems and the Director of the Global Fund, claims this to be the first time the institute does not have adequate funding. In a survey conducted by UNAIDS, WB and WHO among 71 countries, the majority of the respondents suspected strong adversely impact on HIV prevention programmes (WHO, 2009: 10-13). UNAIDS *et al* (2009) worry that it can be highly problematic to choose which prevention programmes should be financed, since it has

[9] Effective prevention means that people need to be properly informed. Simplistic messages about abstinence and faithfulness - sometimes ideologically driven - as the only ways to prevent HIV may mean that many vulnerable people are denied the information, knowledge, skills and services they need to protect themselves. Disinformation that casts doubt on the effectiveness of condoms is, frankly, inexcusable. People need the means to have safe and responsible options within the realities and circumstances of their daily lives. This should be based on mutual respect and dignity, and not on any particular morality or ideology.

been hard to evaluate which programmes have given the best results. However, prevention programmes with earmarked financing (like ABC) are usually continue even though 'they have lower priority or are less effective than those which are cut' (2009: 11). However, what most HIV prevention strategies have in common is that gender, read as women in much of the discourse, is a central theme in most HIV programmes.

2.6 Culture and HIV

Cultural barriers are often cited as a culprit in the rampant spread of HIV in Africa. Official texts from secular institutions, religious leaders, aid agencies within and outside Malawi and popular discourse commonly blame cultural practices for gender discrimination, human rights offenses and sexual violence against women as well as for the high transmission of HIV (WLSA, 2005; Gausset, 2001; NAC, 1999; The Nation, 2007). Ulrika Ribohn (2002: 166-177) has assessed how the concept of culture has changed in Malawi through the dramatic shifts in the political arena and with more governmental emphasis on what is perceived by many as increased western values such as democracy, human rights and gender equality. Interestingly, in Ribohns' view, the rural Malawian population does not share that view of cultural practices as something negative and dangerous but rather regards culture to be the essence of community life and in some way providing resistance to western values that some feel are being forced upon them. Her discussion is worthy of note since it is one of few studies that explore local understanding of culture and how women perceive their social status within their culture.

2.7 Gender and development aid

A large body of literature can be found on female subordination, male domination and sexuality in Africa, in relation to HIV transmission in Africa, and this discussion is often linked to the notion of culture. Much has been written about distinct 'African sexuality' as an explanation for high HIV rate in Africa. In 1989, Pat Quiggin and John and Pat Caldwell published a highly controversial article The Social Context of AIDS in sub-Saharan Africa where they aimed to explain high HIV rate in some African countries as the consequences of a distinct value system, which supposedly is

inherently sexually permissive, in the whole of Africa. Caldwells' *et al* argument initiated heated debates (Nyansi *et al*, 2008). The Caldwell's were accused of generalising, to be ethnocentric and for being ignorant of historical and social changes (Ahlberg 1994: 222; Heald 1999: 145). I understand, and actually agree with most of the harsh criticism the Caldwell's have received, but in my opinion, Jo Helle-Valle (2004: 195) puts forth an interesting arguments, stating:

> […] although sexuality is a meaningful practice, meanings are not unitary, invariable and geographically delineated wholes but linked to practically motivated social context [...] and people move in and out of them routinely […and] that sexuality, both as practice and as a discursive theme, is (in Africa as elsewhere) many different things depending on the context it is part of and must hence always be analyzed as part of such communicative context.

I find Helle-Valle's argument interesting for many reasons. Assuming sexuality is something static and inherited as the Caldwell's do, is deemed absurd by most when put it in a context familiar to them. How sexuality is used, lived and experienced is at the same time highly personally motivated and culturally shaped as Halle-Valle points out. Secondly, I find it interesting that Helle-Valle does not link sexuality and women in particular but talks of 'people' in this context. This simple fact is self-evident although the Caldwell's assume only women in Africa are sexual agents.

Interestingly, much of the texts written about gender relations predominantly focus only on women, rather than the dynamic relation between women and men or alternatively the making of femininity and masculinity, like Margrethe Silberschmidt (2004) and others[10] point out. Some anthropologists have given valuable insight into the making of manhood and the construction of masculinity in African societies, but a lot remains to be done (Dover 2001, Heald 1999). In order to put my field notes of gender relations and HIV in a Malawian village into a wider context, I read

[10] See UNAIDS (2008) and IFRC (2008). Even though the IFRC only mentions that attention must be paid to men who have sex with other men, which is an important issue and often neglected within Africa, attention to heterosexual men in relation to HIV should not be ignored.

extensively about gender in Africa. When reading relevant literature, I distinguished three dominant bodies of discourses, which are sensitive to women's social status in relation to HIV in Africa, although the audibility of these voices varies[11]. First of all I will outline the discourse produced by various development organizations, secondly explain the stance many third world feminist take on the matter and lastly talk about a group of scholars who have written extensively of the complexities of 'doing gender'. I will give a short overview of these different points of view and then position myself within these thoughts.

2.8 Donor discourse of gender

Various development organizations, agencies and governmental and non-governmental organizations have produced considerable amount of text concerning the social and economical status of women in resource poor settings. The interest in 'Third World women'[12] can be traced to the decade between 1975 and 1985, which the United Nations dedicated to women (Peet and Hartwick, 1999). The purpose was to draw attention to gender inequalities worldwide and the decade's theme was 'equality, development and peace' (United Nations, 2006). International attention was brought to the fact that 'women make up more than half the world's population, yet perform two thirds of its work, receive one tenth of its income and own less than one hundredth of its property' (UN Chronicle, 2009 [1985]). Development agencies started to design projects accessible to women in developing countries, aiming to relieve women's poverty (Edelman and Haugerud, 2005: 28). The work of the economist Esther Boserup (1970) was revolutionary in the field of development and women. Her analysis of work division between men and women in the Third World, showed historical importance of women's contribution to the national economy and how the economic status of women had been undermined by colonialism, changing landscapes of settlements and recent emphasis on technical innovations (Edelman and Haugerud, 2005: 29). It is safe to say that Boserup's work influenced the way in

[11] I must stress that these bodies of discourses are based on my understanding of the subject and are my classification. Those academics I cite do not necessarily identify themselves as working within a particular framework.

[12] I use the terminology of *Third World countries* and *Third World women*, in line with the writing of the academics in discussion.

which development projects started to incorporate women into the projects and this approach was called Women in Development or WID.

WID claimed that women should be brought to modernization by providing income generating projects for women (Peet and Hardwick, 1999). Projects centred on bringing scientific and technological advancement to rural women in poor countries (United Nations, 1996). However, this new line of development projects soon became criticised for not questioning the patriarchal, neoliberal and some claimed colonial, frame of thought it emerged from (Peet and Hardwick, 1999; Chowdhry, 1995). Critics claimed that this approach did not improve women's status de facto since it focused solely on women's productive work and neglected to analyse their role in the household and more seriously, did not attempt to analyse gender power relations or class differences (Peet and Hartwick, 1999). Geeta Chowdhry (1995) argues that the representatives of WID have been an amplified example of how reminiscent colonial thought was in western societies and further states that WID projects disempowered women rather than 'developed' them by homogenises 'Third World women' (Chowdhry, 1995: 26). According to Peet and Hartwick (1999: 186), the shift from Women in Development to Woman and Development (WAD) by the late 1970's, did not include a fundamental difference in epistemology since the latter 'tended to group women together without much notice given to race, class, or ethnicity' just as WID had been criticised for. However, the proponents of WAD rejected the idea that women had to be brought to modernization, since women had always been actively taking part in the market process (Peet and Hartwick, 1999). By the late 1990's preoccupied voices started to be heard within the development area. Projects focusing on 'women-only' were thought not to be effective in correcting women's social and economic status, but rather needed to be explored in terms of gender relations within a given society (Peet and Hartwick, 1999: 187). Today, the Gender and Development (GAD) approach is a globally accepted strategy for promoting gender equality and is mainstreamed into most development institutions and projects (OSAGI, n.d). WHO pledged to integrate gender analyses into their work in order to ensure gender equality (WHO, 2010). UN aims to 'mainstream gender' considerations in all offices,

although judging from their webpages, gender seems to signify women in many cases (OSAGI, e.d.; UNFPA, e.d). Others, who are more critical of this approach, believe this is more inscribed in principle rather than practice (Chant and Gutmann, 2005: 241).

2.9 Third world feminisms

While being a group of scholars who have various points of views, Third World feminists have in common their opposition to western discourse of women in Third World countries as a homogenous group (Ampofo *et al*, 2004). They point out the seemingly obvious, that Third World women have been defined by western scholars rather than being given voices themselves. In the beginning of the 1980's, women from Third World countries harshly criticised western feminist theories. Chandra Talpade Mohanty (1988) has been very influential in deconstructing western feminism but she among others claims that the construction of feminism in the West was very ethnocentric. In Mohanty's article 'Under the Western Eyes: Feminist Scholarship and Colonial Discourses' (1988) she doubts western feminist epistemology and objects to the notion of women's oppression and patriarchy having the same manifestation worldwide. Mohanty draws mainly from her experience in the Middle East but her criticism can be applied to other geographical areas as well, such as Africa sub-Sahara. In agreement with Edward Said's (1978) argument of the power of 'othering', Third World feminists reject the image they claim to be depicted by western feminists, in development discourses and in the media, of Third World women being victims, helpless, poor, ignorant, uneducated, exploited and as subjects of power (Oywúmi 2004, 1997; Mohanty 1988; Win, 2004). Chowdhry (1995), in line with Mohanty, takes this argument further and describes three ruling images in western discourses of Third World women. First she mentions, zenana, the stereotype of a veiled woman dominated by her 'master' and who is totally oblivious to the world outside her harem. The second image, Chowdhry depicts is of the 'eroticized, unclothed "native" woman, representing the need to be "civilized" (1995: 28) and thirdly the representation of women as victims. What these three images have in common in Chowdry's opinion is that non-western women are depicted as inferior to

western women and as being dominated by their male dominated cultures. Heavily influenced by the writing of Edward Said (1978), these Third World feminists call for deconstruction of monotonous images of women living in two thirds of the world's inhabited region. Donors' recent emphasis on gender mainstreaming in development projects in the hope of promoting gender equality, has been met with some resistance by African scholars for not taking cultural context into account, or as Kolawole (2004: 258) phrases it:

> When donor agencies began to sponsor gender research, African researchers adopted western theoretical frameworks for developing nations. […] Numerous gender training workshops, seminars and conferences were launched by African social scientists according to the agenda of the donors without adequately taking cultural contingencies into account.

2.10 Dividiuality

Various academics have suggested it would be more effective to drop the widely accepted binary view on gender and suggest instead we should point our eyes to the multiplicity of every person. This group of scholars cannot be identified within one theoretical frame but rather come from different directions but what they have in common is that their conclusions interrelate on the same point. Marilyn Strathern (1988: 268-305) came up with the notion of dividuality. She describes this concept thoroughly in the book *The Gender of the Gift*, and convincingly explains how in many societies individuality, as it exists as a modern western notion, does not apply. She prefers to emphasize the importance of the relations between the social person and other actors who play multiple roles in her / his life. The concept of dividuality aims to deconstruct the western idea of an individual as a holistic unit and rather point out the diversity of the person in multiple social contexts. Signe Arnfred (2004: 22) further discusses the concept of dividuality in the introduction to *Re-Thinking Sexualities in Africa* and correctly points out that every person moves freely in and out of multiple social settings routinely and how constraining the binary view of women versus men is when considering social relations. Even though Third World

feminist have criticised dominant western discourses for portraying monolithic images of women from developing countries, western anthropologists have for a long time stressed the importance of dissolving gender dichotomies across cultures. Work by Margaret Mead from her studies in Melanesia (1949) as well as the book *Sexual Meanings: The Cultural Construction of Gender and Sexuality* co-edited by Sherry B. Ortner and Harriet Whitehead (1981), present valuable input to the gender discourse in the 1970s and 1980s illustrated with ethnographic examples that show that gender, and sexuality for that matter, is not biologically determined but rather socially and culturally constructed. The feminist Oyéronké Oyewúmí (1997) discusses an example of how identities of the person are always context bound and depending on specific relations. Oyemúmí did her studies in Northern Nigeria and she concludes that among the Oyo-Yoruba ethnic group, seniority is the most influential point of each person's respect. In agreement with Arnfred's point, Oyewúmi states: 'no one is permanently in a senior or junior position; it all depends on who is present in any given situation' (1997: 42). According to this line of thinking, it can be concluded that social status of an individual is not fixed in time, place or by biological sex, but rather that every person has multiple statuses or identities depending on the relation they have with others around then at any given time.

2.11 How to speak of 'gender'?

I found it useful to have in mind these three ideological positions towards gender relations, outlined above, while exploring gender relations and HIV in Malawi. Emma Crewe and Elizabeth Harrison (2005) are of the opinion that many 'developers'[13] often work from an irrational point of view in relation to gender. They maintain that developers, mainly anthropologists, are shy to 'interfere with traditions of culture' (2005: 233) and therefore don't promote development projects that challenge locally accepted ideas of gender relations. This is not the first time anthropologists are accused of being blinded by cultural relativism. But as the anthropologist Liselott Dellenborg (2004: 82) sharply points out, cultural relativism is not the same as moral relativism. Dellenborg who conducted a research on the highly

[13] As they call people working within the development arena.

controversial topic of circumcision in Senegal, maintains that for any intervention to be effective there must be a socially grounded understanding of the socio-cultural context the intervention is aiming to change.

The demand from Third World feminists, to not being spoken of but to speak for themselves as well as not to be viewed as subjects of problems that need to be solved, has to be respected. But does that mean it is ethically wrong for anyone outside that group to explore gender relations? I do not think so. Gender relations and women's social status is a sensitive subject in all cultures, and I agree with Crewe and Harrison (2005) that social scientists should not be afraid to address the issue, but should be careful of the way in which it is done. Cornwall *et al* (2007) do not regret the research conducted by radical western feminists for developing agencies, but worry that development agencies tend to simplify their results in order to 'sell'. They argue: 'For many, what were once critical insights, the results of detailed research, have now become 'gender myths': essentialisms and generalizations, simplifying frameworks and simplistic slogans' (Cornwall *et al*, 2007: 1). Local understanding of what it entails to be a woman or a man is not something that is easily understood. As discussed above, the image of the poor, vulnerable and exploited women in the Third World is very prominent and the same goes for men, who are often thought of as if their 'power and privileges are uniform, fixed and universal' (Chant and Gutmann, 2005: 241). Obviously, the web of power and economic opportunities are more complicated than biological sex, and that applies to both women and men. As Dover (1999) concludes, after a thorough study of the relationship between masculine identities and HIV in Zambia, men can not be viewed as a singular group nor do men identify themselves with one singular image of masculinity. In most societies, biological gender is a factor that determines individuals' identity, for both women and men, but so does for example one's skin colour, religion, age, economic opportunities, ethnicity, marital status, number of children one has, sexual orientation and so on and so forth.

3. Introduction to Malawi

Figure 2: Map of Malawi
(Taken from:
www.umsl.edu/services/govdocs/wofact98/586.gif)

3.1 Geography, history and politics

The Republic of Malawi is a landlocked country in Southern East Africa. Malawi is a comparatively small country in African context, 118,484 km². It shares borders with Tanzania to the north and northeast, Zambia to the west and Mozambique surrounds the country to the east, south and southwest. It has one of the deepest waters in Africa; Lake Malawi which covers about 15 per cent of the country. Temperatures vary between the highland and lowland; the climate being hot and humid in low areas close to the lake, and cooler in higher areas. Rainy season is normally from November to April (NSO, 2005: 1).

It is believed that the first settlers arrived to Malawi 50 or 60 thousand years ago from the Southern part of the continent. As in most parts of Africa,

different ethnic groups have migrated through the area, habiting for longer or shorter periods of time. Today, dominant ethnic groups in Malawi are Chewa, Nyanja, Timbuka, Lomwe, Tonga, Yao, Ngoni, Sena, Ngonde and one per cent of the population is descended from Britain, Portugal or India or can trace their inheritance to all of these countries and referred to in Malawi as coloured (Levinson, 1998: 147). No ethnic conflicts have been in the recent past and Malawians have enjoyed peace for the last decades. Many languages are spoken in Malawi but the official languages are Chichewa and English. The country is divided into three regions; North, Central and Southern Region, and the country is subdivided into 27 administrative districts. With recent emphasis on centralization, each district has gained more localised power and district authorities reside in each district's 'capital' city. Within these districts are traditional authorities (T/As) which are composed of several villages. Villages are the smallest administrative units and are overseen by a village headman / woman (Chinkonde, 2006: 15).

3.2 British occupation and independence

Malawi came under British occupation in 1907. Malawi, then Nyasaland, belonged to the British Central African Protectorate and became part of a federation with Rhodesia (now Zambia and Zimbabwe) in 1953, despite much opposition in Nyasaland (Briggs, 2006: 14). Voices demanding independence grew loader during the 1950's and under the leadership of Dr. Hastings Kamuzu Banda the country gained independence in 1964. Dr. Banda was a practicing medical doctor in the United States, Scotland and Ghana before he became the first Prime Minister of Malawi. Soon after independence, Banda started showing autocratic tendencies and unwillingness to collaborate with other politicians in Malawi. He declared himself 'President for life' in 1970 and reigned as a dictator until 1994. Under his regime Malawi experienced peace and stability, economic growth was around 5 per cent per annum and the infrastructure and agricultural system improved (Briggs, 2006: 16; ICEIDA, 2008). These improvements however came with costs; Dr. Banda was intolerant of any criticism and it is estimated that 250,000 people opposing Dr. Banda, were detained and tortured in prison without trial and over 20 thousand people became political fugitives (Mapanje, 2002: 182; Sturges, 1998: 196).

No space was too personal for Dr. Banda's suppression; dress codes were inducted, woman were not allowed to wear trousers or short skirts and men could not grow their hair nor beard under his regime. It was illegal to discuss certain topics; sexual matters were suppressed and family planning consisted of child spacing (Lwanda, 2004; Briggs, 2004: 16). Thousands of films, books and magazines were banned. Steve Chimombo (2007: 213-215), a Malawian writer explains in *AIDS Artists & Authors* how authors could only write innocent romantic love stories during Banda's regime, stories that contained no political agenda, since any mention of crop failures, hunger, torture or corruption would not be published. In Chimombo's experience, AIDS was excluded from public discourse until five years into the pandemic in Malawi since the disease would not 'project good image for a country ruled by a medical doctor' (2007: 214).

Due to internal and external pressure, Dr. Banda was forced to support multi party election in 1994 in which he lost to a newly formed party; United Democratic Front (UDF) and Bakili Muluzi resumed presidency (Briggs, 2006: 18). The new president and UDF promoted privatization, poverty reduction and endorsement of human rights and democratic ways. UDF continued their support of Muluzi in the second election in 1999 and he held the presidential chair. UDF won the third election in 2004 but the presidential candidate Bingu wa Mutharika split the party and established his own party; the Democratic Progressive Party (DPP) (ICEIDA, 2008: 6). Wa Mutharika's main agenda was to tackle corruption and eradicate poverty (Encyclopædia Britannica, 2008). Mutharika's crossing the floor of the parliament caused much rivalry between the two parties but in the spring 2009, DDP won in fair elections with wa Mutharika in the forefront (Malawi SDNP, 2009).

3.3 Demography

Malawi is one of the poorest countries in the world and according to UNDP's *Human Development Report* (HDR 2009), Malawi ranks 160 of the 182 countries included[14]. HDR ranks countries according to habitant's ability to 'lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community' (UNDP, 2008: 1). It is estimated that 52 per cent of Malawians live under the national poverty line, which is USD 0.50 per person a day and there of 22 per cent in extreme poverty which means that they are not able to meet their basic need for food[15] (UNDP, 2008c; OPC, 2007: 12).

Malawi's population has grown rapidly over the last few decades with a growth rate of 2.5 per cent a year. Population census from 2002 estimated 11 million people living in Malawi but they are now estimated to be over 13 million (OPC, 2007). Over 80 per cent of the population resides in rural areas and land has become scarce with increased population (ICEIDA, 2008: 6). Agriculture is the main source of livelihood and close to 90 per cent of all labour population is engaged in farming activities which provides 35 to 40 per cent of the Gross Domestic Product (GDP) and over 80 per cent of the foreign exchange earnings (International Food Policy Research Institute, 2010). Agriculture is mostly rain dependant in Malawi, which makes harvest highly vulnerable to erratic rainfall. Draught during the rainy season in 2003 and 2005 caused massive famine in the country (UNDP, 2008).

Although significant improvements have taken place in Malawi's health care over the last few years, it is still struggling with serious difficulties. Financial recourses are limited and lack of health care staff is a serious problem in Malawi but the ratio of doctors to population in Malawi is 1/100,000 (Kober and Damme, 2004). Malnutrition, malaria, bilharzia, diarrhoea and AIDS, just to name a few, are widespread medical problems in Malawi which can lead to serious implications if not

[14] HDR ranks countries at the top according to high human development and the countries at the bottom as having low human development.
[15] Estimated to be USD 0.30 per person a day.

treated and life expectancy in Malawi was only 48 years in 2007. Improvements have been very slow although new statistics from UNICEF (2009: 117) provide a glimpse of hope with a lowering of infant mortality from 124 deaths per 1000 newborns in 1997 to 71 per 1000 newborns in 2007. Positive development has also been noted in life expectancy rate of children under five years 209 deaths of every thousand in 1997 to 111 in 2007. On the downside, Malawi still has one of the highest maternal mortality rates in the world and it is not declining (Rosato *et al*, 2006; Costello *et al*, 2006). AIDS has had devastating effects on Malawians. UNAIDS (2009: 131) estimates 12 per cent of the adult population is infected with HIV and that 550 thousand children were orphans[16] due to AIDS related causes in 2007 and further that 91 children of every thousand will be HIV infected from their mother in the foreseeable future.

3.4 HIV in Malawi

The first HIV cases in Malawi were diagnosed in 1985 (NAC and Ministry of Health and Population, 1999a). It has been suggested that due to late responses in the beginning of the epidemic from the Malawian Government (GoM) under the administration of Dr. Banda, the pandemic hit the country worse than it needed have (Zulu and Chepngeno, 2003; Lwanda, 2004). The first official responses came in 1989, or four years into the epidemic, when GoM established an agency called National AIDS Control Programme (NACP) in order to lead HIV prevention. However, the institution remained quite ineffective due to the political environment in Malawi whereby the government tried to suppress public discussion of sexual matters (Lwanda, 2004). The GoM concentrated its' effort on ensuring access to blood screening in the two biggest hospitals in Blantyre and Lilongwe while NACP was to involve a variety of stakeholders like religion leaders, NGO's and other aid agencies to promote HIV awareness (Ministry of Health and Population and NACP, 1999: 3). However when evaluating NACP's progress in 1989, it became clear that the institution had failed miserably. During this time interval HIV surged Malawi and the infection rate increased from 2 per cent in 1985 to 19 per cent in 1989 (Yoder and

[16] From the age 0-17.

Matinga, 2004). In an attempt to improve the situation, the government decided to close down NACP and establish a new body called National AIDS Control[17] (NAC) in 2000. NAC's responsibility is to provide leadership to all HIV projects in Malawi and serve as a mediator between the public, private and civil organizations in agreement with the HIV Office of the President and Cabinet (Yoder and Matinga, 2004). To give an embracing support to HIV prevention and access to treatment, NAC develops several key strategic documents[18] to guide distribution of the donors' funding pool every four years with midterm reviews every two years (OPC and NAC, 2009).

At the Millennium Summit in September 2000, leaders of the world agreed to concert efforts to reduce global poverty. Deriving from the meeting were eight time-bound goals, known as the Millennium Development Goals (MDGs) each associated with relevant targets. Indicator MDG 6 is to combat HIV/AIDS, malaria and other diseases and the key target of MDG 6 is to halt and begin to reverse the spread of HIV by 2015. To monitor the progress, the HIV prevalence among young women (15-24 years) is used as an indicator of new infection rate in the population (UNDP, 2005; UNDP, 2003). GoM signed the Millennium Development Goals in 2000 and also took part in UNGASS in 2001 where leaders decided to take concrete actions against AIDS (UNGASS). A midterm evaluation of the MDG's was conducted by the Ministry of Economy and Development (2008) and of the UNGASS goals by the Office of the President and Cabinet (2007). In terms of halting and reversing the spread of HIV and AIDS, the reports show some achievements. According to the MDG's evaluation report the HIV infection rate among 15 – 24 year old pregnant women dropped from 24 per cent in 1998 to 15 per cent in 2005, while the UNGASS (2007: 11) report estimates 16.2 per cent were infected in 1998 and 14 per cent in 2005. While the reports do not agree on numbers, both report decrease in HIV

[17] NAC is still a leading institution in matters of HIV and AIDS in Malawi.

[18] This includes the National HIV/AIDS Strategic Framework, Agenda for Action, National Reproductive Health Strategy and Sexual and Reproductive Health Policy which are updated every fourth year.

infection rates. The situation is now believed to have stabilized at 12 per cent which means that one million Malawians are HIV infected and thereof are 10 per cent children (OPC and NAC, 2009: 8).

3.5 HIV funding in Malawi

Malawi has enjoyed considerable financial support from international development agencies to tackle the HIV and AIDS problem. In 2003 the GoM signed a Memorandum of Understanding with five donor agencies; the Canadian International Development Agency (CIDA), Norwegian Agency for Development (NORAD), Department for International Development (Dfid), Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the World Bank, to assign their support to a sector wide approach (SWAP) in charge of NAC. The pool funding allows NAC to align HIV projects to national priorities while the donors are responsible to keep track on financial accountability and provide technical support to NAC (OPC and NAC, 2009; personal communication with CIDA's employee, 2008). The funding pool has increased between the years, mostly because of generous donations from the Global Fund. NAC spent USD 195 million between 2005 and 2009 but has been promised USD 238 million from 2010 - 2012 whereby Global Fund provides USD 190 million of that sum. It is worth noting that NAC's expenditure increased from almost USD 26 million in 2005/6, to more than USD 86 million in 2007/8. Other development partners do not donate their funds to the NAC pool but provide earmarked funding for HIV projects managed by their own agencies. The U.S government (PEPFAR) is by far the largest donor working bilaterally but other big donors are various UN agencies, WHO and European Development Fund (OPC and NAC, 2009).

Since 2005 NAC has prioritized which areas HIV projects should focus on, although while evaluating the actual spending indicates somewhat different emphasis. The following are priority areas and percentage of the actual spending of the financial year 2008/2009:

1. Prevention and behaviour change	10%
2. Treatment, care and support	58%
3. Impact mitigation	12%
4. Mainstreaming and decentralisation	7%
5. Research, monitoring and evaluation	2%
6. Resource mobilisation and utilisation & Policy and Partnerships	11%

(OPC and NAC, 2009: 8, 52)

The high percentage of HIV funding spent on treatment can be explained with Global Fund's emphasis on providing universal access to ARV treatment (Global Fund, 2009). It has been noted that Malawi has made impressive strides in scaling up ARV treatment but by the end of 2008, over 200 thousand patients (8% children) had registered for ARV treatment, while only 40 thousand had access in 2005 (Weigel *et al*, 2009). HIV prevention has not been as successful but GoM estimates that over 100 thousand new infections occur every year (OPC and NAC, 2009: 22). HIV prevention campaigns aiming to raise AIDS awareness among Malawians have succeeded since recent studies show that HIV and AIDS knowledge is almost universal (Dionne *et al*, under review). Unfortunately behaviour change has not followed raised awareness but most HIV infections occur with unprotected heterosexual sex. In order to reduce HIV infection rates, the prevailing emphasis in HIV prevention campaigns has been on chastity before marriage and to encourage marriage fidelity (Zulu and Chepngeno, 2003). If and how the global financial recession will affect HIV and AIDS programs in Malawi remains unclear. In a report from MSF (2009) it is strongly recommended that cut backs in HIV funding should not affect availability of ARV treatments. How this will affect programs aiming at prevention and behaviour change will unravel over the next few years.

4. Methodology

4.1 Me and the Place

Preparing for my research in Iceland, I explored internet pages for hours, looking for information about Malawi. From the information I gathered, I understood that Malawi is mainly known for its' poverty, the lake, bad food, no music tradition of its own and thousands of different types of cichlid in Lake Malawi. The image of Malawi drawn from the internet is neither a very positive one nor inviting. I decided beforehand that I would do my research around Monkey Bay in Mangochi District in the Southern part in Malawi. I was fortunate to receive a study grant from ICEIDA[19] to realize this mission and ethical approval for the study was sought through the National Health Sciences and Research Committee within the Ministry of Health and Population in Lilongwe.

Unlike most other areas in Africa, a substantial amount of literature is available about Mangochi District in Icelandic. This is due to ICEIDA's operation in Malawi, with particular emphasis on Mangochi, since the mid 1990's (ICEIDA, 2008: 34). Therefore I was aware of issues concerning health care, water and sanitation, illiteracy and lack of primary schools in the area, which are focus projects of the agency. I found it interesting to explore people's conception of HIV and AIDS in a place where ICEIDA had been so heavily involved in people's lives and had among other things opened a VCT centre at the Monkey Bay Community Hospital two years previously. The area is interesting for other reasons, for example unlike most areas in Malawi, people's livelihood arrives from diverse sources; such as agricultural farming, fishing and tourism. Monkey Bay is a small but lively town since it serves as a central junction in the public transport system between the many villages in the area and is inhabited by a mix of ethnic groups.

[19] Nordiska Afrika Instituted also awarded me with travel grant but I had to decline the grant since ICEIDA offered a grant for the same purpose. However, I'm grateful to NAI for the nomination.

The guidebook, which I had thoroughly read, informed me that the climate in Monkey Bay was hot and sticky, transportation slow and unreliable and tourists were advised to bring enough money to avoid getting stuck there (Briggs, 2006). I didn't have to worry about slow transportation on my arrival since I was lucky enough that one of my supervisors, Geir Gunnlaugsson, was by coincidence on a working trip in Malawi at the same time and I got a lift with him. ICEIDA kindly offered me to stay in one of their houses in Karombo village, approximately 5 km from Monkey Bay while I looked for my own accommodation. Arriving to Karombo village was not what I had expected. The stunning beauty of the place was a pleasant surprise.

Figure 3: View of Karombo beach

Karombo village is built along Karombo bay. The village lies in crescent along the shore, with cottages owned by well-off Malawians and foreigners nearest to the lake and local houses further from the beach. Inhabitants are believed to be around 1.200 (Zauwah *et al*, Forthcoming) but the village is densely populated with housing varying from mud brick houses with thatched roofs to cement houses with corrugated iron roofs. Few houses in the village have electricity. The houses are generally small, one or two bedrooms, with thatched fences around the compounds where women sit during the afternoons and weave mats and baskets, dry maize, prepare and cook food, chat and watch the children play. During the first hours

of darkness, one can hear chatter from the compounds; smell the mix of charcoal and *nsima*[20] simmering and hear children's laughter before everything falls silent around ten o'clock. Running water is a luxury that few enjoy but people in Karombo are grateful for easy access to the lake, which plays an important role in everyday life. In the mornings and afternoons people bathe there, men go fishing on canoes, children wash the kitchen utensils and women wash clothes and catch small *usipa*[21] to add to their dinner. A striking feature of Karombo to my western eyes, is the great number of children running around the village, often dragging their younger siblings with them or carrying them on their back.

When staying in Karombo, it is easy to get the feeling that the village is a melting pot. The people who live there are a mix of ethnic groups. The majority of the inhabitants are Chewa followed by Yao and Lomwe. These ethnic groups speak distinctive languages, although they are all of Bantu origin. The communication language in Karombo is Chichewa but English is hardly spoken between villagers even though many have learned some English in school. Migration to the area is common, although mostly by men, who come from other areas to look for part time work at construction sites, to work in one of the many cottages along the beach, to look for work among donor agencies or to sell handcraft to tourists. Malawians who migrate to Karombo for work are regarded and viewed as *foreigners*[22] by the villagers. Unlike many of the surrounding villages, many of the people in Karombo have parents who were born somewhere else. People often mention that their original family place 'has deep culture, unlike Karombo, which has a lot of '*foreigners'*, meaning that people in their original home adhere more strictly to traditional values and cultural practices than inhabitants of Karombo. During my fieldwork I sometimes doubted if Karombo was an ideal place for my research. I felt like it was not a 'real' enough Malawian village and that my field notes were not representing the average rural Malawian people's view. However, the more time I spent in Malawi, I

[20] The main stable food in Malawi, a porridge made of grained maize, eaten with relish, which is a kind of stew made of vegetables and sometimes meat or fish.
[21] Small fish that is fried or boiled in one piece and eaten whole. The fish is the size of a finger
[22] For clarification, words in italic letters are words in Chichewa or English words that have a particular local meaning in Malawi.

understood the diversity within the country and that there is no village more 'real' than another. Some villages are very isolated while others have good access to transportation and services whereby people move freely between villages.

4.2 Methodology

In total I spent twenty-one month in Malawi even though I had only planned to stay there for five months. From February to June 2007 I conducted my research in Karombo village but from June to October 2008 I was working for ICEIDA; first as an Intern and later as Administrative Coordinator. I was very grateful for getting the opportunity to work for ICEIDA, as it gave me the chance to get to know more people, to strengthen the relationships with the friends and acquaintances I already had and to explore the research subject in more depth and from different angles. Being Icelandic in Karombo village, where ICEIDA has been operating since early 1990's, made it hard for me to explain that I was not part of the agency. Although I did not live in an ICEIDA residency, went by foot or *matola*[23] between places and spent all days 'just hanging around and chatting' unlike ICEIDA employees, there was an indiscrete connection between me and ICEIDA in people's minds. When accepting the ICEIDA's internship position, I worried it might add distance between me and those who I had established friendship with in Karombo, since I would be having working relationship with some of them. Fortunately, I did not feel that the relationship with friends changed with me working for ICEIDA, however I noticed that people who I got to know while working for ICEIDA treated me differently. This was for example apparent in the way in which people addressed me. Those who knew me already always called me Inga while those I got to know as an intern addressed me with 'madam' or 'madam Inga'[24]. Even though I was based in Lilongwe while working for ICEIDA, I got to spend much time in Karombo for both work and leisure and the ethnographic experience was intermitted throughout my stay in Malawi. While I had numerous conversations about HIV with people in Lilongwe I do not

[23] Public transportation

[24] There is a strong tendency in Malawi to address one's employee with the terms boss or madam, and I humorously witnessed Icelanders' attempts to ask their domestic workers to please refer to them by their first name, which they without an exception got the reply: 'Yes madam / Yes boss'.

quote those conversations directly in this thesis although it influences the way I perceived things in Karombo.

Before heading to Malawi I had read extensively about HIV related issues in Africa in general and more specifically about the situation in Malawi during my MA courses in Development Studies and in Anthropology. In Development Studies one can choose from different methodological approaches since it is an interdisciplinary study but because of the nature of the topic I found qualitative methodology to be best suited. Quantitative HIV research is valuable in that it provides comparable data but is less suited to capture manifested aspects of social life and local understandings of diverse phenomenon. The tools I relied the most on were individual in-depth interviews, focus group conversations, participant observation and informal conversations. Written documents, especially academic journals and books about the subject as well as Malawian newspaper clips enhanced my focus. The use of different methods to collect data on the same issue is called triangulation by Esterberg (2002: 36) and that is what I aimed for.

4.3 Ethical considerations

When studying people's reaction to the devastating disease AIDS, it is hard to avoid questions about sex, sexuality and sexual relations. These topics were for a long time, and still are to some extent, a sensitive issue for western social scientists, especially anthropologists, because of their fields' history during the 19th and early 20th century when 'African sexuality' was 'described as wild, animal-like, exotic, irrational and immoral' (Gausset, 2001: 510) and were very much tinted with ethnocentrism and racism. Prominent figures in anthropology such as Margaret Mead (2001 [1928]) and Malinowski (1984 [1922]) addressed sexuality in their works but the subject was not salient within the discipline for the latter half of the 20th century. Brook Schoephs (1998: 236) believes the uncomfortable history of the subject to be the main reason why anthropologists dragged their feet to get involved in AIDS research during the first 15 years of the epidemic since many researchers were debating if it was ethically justifiable to study sex in Africa, worrying to fall into the same trap as the so called

armchair anthropologists a century earlier. Working on AIDS research in Zaire (now the Democratic Republic of Congo) in the early 90's, Schoepfs (1998: 236) claims these worries were not unwarranted since she met strong oppositions from many 'Africanists' who did not welcome western scientist to 'study the sexual life of the natives' as they phrased it. But in agreement with Schoepf's conclusions, I find it ethically irresponsible to exclude sexual matters from HIV research since this knowledge is valuable to improve HIV prevention strategies. But while discussing sexuality, one must be particularly aware of what anthropologists have called the 'power of naming' (Eriksen, 2002 [1993]: 87-90) whereby researchers should be careful not to address issues in such a way that they do not have any 'empirical existence outside the mind of the ethnographer' (88). By naming certain practices or acts, without consideration of the cultural context it exists in, can invite misunderstanding; promote prejudice and result in an ethnocentric study. Although Eriksen (2002 [1993]: 88) is pondering whether anthropologist can 'invent' tribes by naming a group of unrelated people a tribe, I find the concept useful in other instances, such as when relating to Gausset's (2001) discussion of how practices such as wife inheritance, polygamy, genital alteration, pre-marital sexual activities, and many more practices, in Africa have gained an independent life in western discussion without references to how it is perceived by those who practise it.

A more practical ethical consideration revolves around how to conceal informant's identification, keep confidentiality and honesty. In the beginning of each interview, I explained in English that I was a student from Iceland, interested to learn about Malawian culture, which Lifa, my research assistant, translated to Chichewa. The informants were also told that I would use the information given to write a thesis for my university and that they could stop the interview when they wanted. I did not say that my main interest lay in how understanding of HIV and AIDS was constructed, since I realized my first days in the capital city that when mentioning HIV it often provided standardised responses and HIV prevention campaigns were literally recited. However, when showing interest in Malawian culture, most informants were eager to demonstrate their knowledge of various cultural traditions which often

developed naturally into discussions about AIDS. I promised all informants confidentiality and offered to give them pseudo names both in the process of writing the thesis as well as in the final product. Even though many insisted I should use their own names, I have decided not to do so since I do not have the opportunity to consult with them on the final stage of the writing. Both Lifa and I, promised our informants total confidentiality of our discussions. All the informants participated voluntarily. Since the informants were spending their valuable time with me, I decided to provide them with a soda drink after the interview and sometimes a bag of rice, a bar of soap or a pack of biscuits.

4.4 Conducting the research

Well aware of the harsh criticism from Third World feminists and other academics of western social scientists doing research on sexual matters, I must admit that I felt quite shy entering the field. I was also aware that the idea of 'blending in with the local people' as a white woman in my thirties was unrealistic. I crushed the romantic idea of being able to become native in a foreign place many years previously but obviously I hoped I would be able to make good friends in Karombo. Once there, it doomed upon me: How do I go around asking strangers, such personal questions as about their experience of HIV, their sexual relations and cultural practices? I seriously considered changing the subject of research during the first few days and I probably would have if I had not met my, now dear friend, Lifa.

I spent my first day in Karombo resting and reading in the house. Therefore it took me by surprise to wake up early next morning to find a group of young men sitting in the garden waiting for me to wake up. They had brought handcrafted things they wanted to sell me but when realizing I would not buy anything that day they happily took their time to converse with me and they regularly came to visit me from that day on. To my disappointment I found it harder to reach to women in the village. I walked around the village for the first days, greeting everybody with the few words of Chichewa I knew to people's amusement (because of the very odd pronunciation I

later found out). But all attempts to converse with women failed. But on my 7th day in Karombo, a woman my age[25] appeared in the garden of my house. She introduced herself as Lifa and suggested she should be my translator and assistant. We got along very well from the start even though I had doubts about her being my translator since she worked as a housekeeper for one of the Icelandic ICEIDA employee's as well as living in the village. I thought this might cause the interviewees discomfort when discussing intimate issues. Fortunately, Lifa is strong minded, and she became my invaluable assistant without me ever agreeing formally to her role.

Lifa is born in Nchisi in the Central Region of Malawi but came to Karombo village a few years back, divorced with her two sons[26] in search for work. In her company I got to know her friends and chat with them in the afternoons and thanks to Lifa's undisputed social skills she managed to keep these afternoon conversations lively and flowing despite how annoying it must have been for them sometimes to be around this slow *mzungu*[27].

With her assistance, we found six women from the village who were willing to be core participants in the research and we conducted one to three interviews with each of them from February to June 2007. The interviews were transcribed and coded as we went along, searching for themes to follow. These participants were found with purposive strategy since we looked for women with diverse backgrounds in terms of age, marital status, education, ethnicity, condition of health and family size (Esterberg, 2002: 93). These interviews were semi-structured, the topic was decided but we did not follow formal questionnaires. Informal interviews are considered to be a good way to give the interviewees freedom to express themselves in their own words and it gives the researcher an opportunity to understand how individuals construct and interpret their social surroundings (Esterberg, 2002). During the interviews with the core participants, I realized that it was as if trying to clap with one hand by only talking with women when defining gender relations and people's

[25] Close to thirties.
[26] And her third son was born in Karombo.
[27] Chichewa word used for 'white person'.

perception of HIV in Karombo village. Therefore, we interviewed five men from the village. All in all we conducted 16 semi-structured interviews with the core participants, which lasted from half an hour up to two hours and they normally took place at the interviewee's home in the afternoon. The interviews were conducted both in Chichewa and English but most commonly in a mix of both languages.

Even though conscious of trying not to get stuck in the footsteps of a First World intellectual interested in 'the' voice of 'the' Other, as Spivak (2003 [1995]) sharply puts it, by being aware of my social status and the complicated power relations between me, the informants and Lifa, I had to confront the naïveté of some of my questions. One such incident came while talking to a 21 year old single mother of two children. She was telling me what she had done to impress her former boyfriend. After she had told me how well she had treated him, I asked:

> I: What else can you do to please your boyfriend?
>
> R: If you have got hair here [points to the pubic area] the man will be happy, and to touch some breast they will be happy and if you are having sex you can, like, dance when you are under him. He can then say 'oooohhh, this is a good girl!'

Then she added with a surprise: 'What about you? You don't like dancing?' This honest remark hit me in the face, when realizing how uncomfortable I felt to talk about my own sexual behaviour. I evaded the question for some time with laughter and jokes before I was forced to reconsider my attitude of sharing personal information. A few days later I was discussing a practice called eleven or *kukuna*, which means elongation of the labia *minora*, with a married woman in her early thirties when she suddenly asked me if I hadn't done the same? When I told her that I hadn't, she asked smiling slyly 'Then, how can men like you?' After this experience, I have related to Liselott's Dellenborg (2004: 79) account of feeling embarrassed when doing fieldwork in Senegal on female circumcision, when facing women's complaints of her never ending interest in their own genitals.

The subject of sexuality, sex and sexual relations should not be avoided by western academics[28] but reflexivity is important as well as an open dialogue. I was astonished how freely some women spoke to me about sexual matters and how many of them enjoyed the conversations. I remember trying to end one interview by saying: 'OK now we have talked for a long time! I think we should meet again later if that is OK with you'? But the woman responded: 'No, it is OK, let's go on, you don't feel the time because the talk is so sweet[29]!' Lifa's part in making the situation comfortable for all of us was crucial.

4.5 Focus group discussions

As well as personal interviews, we conducted two focus group discussions with people from the village. A focus group interview is a session where a group of participants meet to discuss a given topic. This is thought to be a good way to get people to share ideas and gives the researcher an idea about people's opinions (Laws, 2003: 299). This method is often used to capture people's normative attitude and beliefs concerning HIV and AIDS (Castle, 2003: 148). The participants in the focus groups knew the discussion topic would be HIV, unlike the personal in-depth interviews where I did not ask directly about HIV or AIDS. One group consisted of five women from the age of 18 to 21 and the other group of five men from 22 – 29 years old. A questionnaire was followed but more questions added as we went along. The discussions took place in Chichewa but the answers were translated to me in English. In order not to interfere too much in the discussion I tape-recorded the session and it was translated to me after the meeting. The final answers the group came up with did not interest me as much as the debates within the group behind the answers. These two focus groups proved to be successful in the way Crang and Crook (2007: 90) describe, since the groups discussion did indeed 'provide forums for the expression and discussion of the plurality of sometimes contradictory or competing

[28] I find Courney's Smith (2008: 54-62) research interesting in this respect. With in-depth interviews in Senegal and United States, she discussed female genital mutilation (which is common in Senegal) and breast augmentation (which is common in the U.S but not in Senegal). Her research demonstrates clearly that what is considered to be sexually attractive is dependent on the cultural context it arrives from.

[29] Sweet in the meaning, nice or having fun.

views that individuals and groups hold'. The discussions of witchcraft, contraception and traditional medicine turned out to be exceptionally fruitful.

4.6 Interviews at the MBCH

The health care system is very different from what I am used to from Iceland, so I found it important to spend some time at the MBCH to get a feeling of the way in which the hospital operates. I spent roughly three weeks continuously at the hospital in March 2007 and visited irregularly for the rest of my stay. Most of my time there, I was involved with the VCT service and got to know the health staff who patiently explained their tasks to me. I conducted two formal personal in-depth interviews with VCT counsellors at the MBCH and eight interviews with VCT counsellors at other clinics in the nearby area. These interviews took place in English and were not tape recorded. I took four interviews with patients waiting for VCT service in MBCH with the assistance of a translator. Countless valuable conversations about health care, VCT's problems and advantages and HIV and AIDS took place with health care staff, local and international and other development workers, during my research period. Two formal interviews were also conducted with *asing'anga* or traditional African doctors working in the area.

4.7 Academic texts and newspapers

This thesis is based on ethnographic data collected in Malawi but in order to put the data into a wider context it is necessary to have an understanding of what has been written about the subject. Due to how much attention has been paid to HIV and AIDS over the last decades, it has been relatively easy to access articles on the subject. An open access to large databases from the National and University library of Iceland has been invaluable, since it has enabled me to download recent articles written in the field of medicine, anthropology, development studies and African studies without financial cost.

In order to familiarize myself with the national debate in Malawi, I decided to read daily the two main newspapers; *The Nation* and *Malawi News*. The idea sounded simpler than it turned out to be. Since most people in Karombo village do not choose to spend their limited cash on newspapers (and illiteracy is quite high as well), I had to buy the newspapers in Monkey Bay. As I did not go to the township every day, I made a deal with a very friendly couple running a small vending stall at the market. They would collect a daily copy of both papers and keep for me. About once a week or once every two weeks, I came to collect the papers from the shop. Reading these papers gave me a very useful insight onto Malawian society concerning HIV and AIDS, cultural practices, witchcraft, gender relations and development organizations, and filed together in maps. In numerous occasions, these news clips gave me another aspect of what had been discussed during the interviews or enabled me to ask further questions of certain topics.

Two local boys were hanging around the house and me and my partner thought it might be interesting to give them a 'project' as an English lady had given them some months before, given them a camera to take photographs of the village life. We gave them some drawing material and they set of to have their friends draw pictures of their impression of HIV and AIDS. I did not analyse the drawings as such but I include some of them as illustrations in this thesis.

4.8 Participant Observation

Alan Barnard (2002 [2000]) explains in his book *History and Theory in Anthropology* how theories and ethnography merge into one and make a holistic entity, since the two are subjected to each other. Bronislaw Malinowski, often called the father of participant observation in anthropology[30], encouraged anthropologist to 'get off the veranda' and participant in the daily life of the subjects. Malinowski emphasised the importance of being in close contact with the informants, learn the local language and

[30] Although as been pointed out, Malinowski was not the pioneer of participant observation in the field since Morgan, Boas and Radcliffe-Brown and others had conducted fieldwork before him but Malinowski has been given the credit for 'elevating the fieldwork method into theory' (Tedlock, 1991: 84)

stay for longer periods of time. To which extent the 'lone anthropologist' should participate though has been much debated within the field of anthropology the last decades. But I strongly agree with Malinowski's (1984 [1922]: 25) view of the ethnographer's role as to 'grasp the native's point of view, his relation to life, to realize his vision of his world'.

There is no one way of doing fieldwork but it is of utmost importance to establish good relations with the people, one is to spend time with. Some have described ethnography as 'deep hanging out' which I find very appropriate since most of the time I was just hanging around, chatting with different people, waiting for something unusual or eventful to happen, going between the village and Monkey Bay, with the Tuesday second hand market as the highlight of the week, or just lazing around with friends. However unscientific this may sound, I found this to be a good way to get to know people, and to get to participate up to a point in daily life in Karombo. This provided me with the opportunity to observe people's behaviour in their daily life and I find it not only a useful addition to the interviews but an indispensible part of the research. Observing health staff at work at the VCT clinic also gave me a valuable understanding of the VCT programme, its functionality as well as the interaction between health staff and attendants.

To follow the fashion, I have to end this by being a bit self-reflexive. I did not truly participate in the lives of the women of Karombo. I stayed in a very spacious hut made of cement with high ceiling thatched roof. I had electricity, running water and other luxuries, that none of my informants or friends had. I do not know the worries the mothers I spoke to experience when their children fall sick or when they experience food shortage for longer times on my own skin. The huge difference of financial status between me and the women in Karombo is perhaps the most obvious difference but is not the only one. I entered the field as a lone young woman, staying on my own with no children (great many expressed their relief when my partner came to stay with me although it still worried them that we were not formally married). This way of life is alien to most rural women in Malawi. But in a very interesting and

a pleasant way, I sometimes experienced magical moments when the things that set us apart did not matter but there was a beautiful connection of friendship.

4.9 Short sights of the research

Studies conducted with qualitative method do not intend to give representative results for a wider area but if care is taken to use a diverse sample, qualitative method can give a reasonably good idea of prevailing discourses in local areas (Laws, 2003: 365). This must be kept in mind since I do not intend to give a normative view of how HIV is perceived by Malawians but rather to give an idea of how people respond locally to this invasive disease and place this in a context of cultural practises and development discourses.

Much more focus needs be paid to how the role of masculinity influences the spread of HIV in Malawi and in Karombo village. If and how the threat of getting infected with HIV has influenced the complex social reshaping of masculinity is an interesting research focus. I would suggest that this research topic might be more suitable to a male researcher.

5. Contagious Culture?

5.1 Culture

In this chapter I discuss practices that may transmit HIV. The list of practices I present here may not make much sense to the inhabitants of Karombo, since they are those defined by NAC, but I find it useful to address them jointly. They reflect certain official views, sometimes misunderstandings, but they have an effect in that they provide a discursive framework for a discussion of cultural practices in general and, importantly, suggest a particular definition of culture. The practices discussed here take place in an ever changing social context and many of them have become transformed from one generation to another or been abandoned. Some may not have existed at all. In short, the practices I present in the following sections, are not static phenomenona nor is each named practice necessarily a single homogenous act. The list is an approximation, by a centralized NAC, to what is perceived as harmful cultural practices in Malawi.

The much discussed concept of culture is a central theme of this chapter. The definition of culture within anthropology has changed over time. It is no longer considered to be a holistic unit fixed in time, but regarded as a dynamic process. The concept does imply certain unity within a group but at the same time this group consists of individuals with contradictory meanings and intentions (Haraldsdóttir, 2002). In the anthropological sense, the concept of culture can be understood as a common historical framework that facilitates members' interaction and mutual understanding. This is in line with Bourdieu's (1977) definition of 'habitus', a concept I find useful in my discussion here. In the Malawian context culture can be viewed as habitus, as social reproduction of what is commonly agreed upon. But this agreement is only valid to certain extent. People disagree, and a notion of culture must therefore take into account different agendas, differing opinions and divergent attitudes. In texts about HIV in Malawi, culture is commonly viewed as something static, which requires to be altered, adjusted, changed or even eliminated in order to hinder HIV transmission. What is forgotten in this rhetoric is that although cultural values shape people's understanding of life, it is not a script people adhere to

uniformly. Each person moves within this common cultural framework according to his or her agency.

When discussing cultural practices in the context of Karombo village it is necessary to place the village in a historical context since it is in some ways unusual for Malawian villages. Many of those living in the village have not lived there for a long time but have migrated from other parts of Malawi in search for work. Some stay there for limited time and go back when they no longer find work, while others have moved to the village with their families and settled there. While Karombo village is not an archetype of a 'traditional' Malawian village it is not that unusual either. Wage-based migration labour work has been practiced ever since colonial times and with the relatively recent development of many choosing to engage in business trading instead of agriculture farming, migration within Malawi has increased (Mtiki, 2007). Although Chewa people make up the majority of the inhabitants of Karombo, there are many other ethnic groups living there as well, mainly Yao and Lomwe. Unlike other neighbouring villages, there is not a centre of the village where those who have lived for longest live but Chewa culture is predominately practised in the village and they are consider to be the owners of the village. Traditional Chewa ceremonies take place there, such as girls' initiation rites, whereas Yao and Lomwe families send their daughters to their 'home village' to attend their initiation ceremonies. I think that views from Karombo village can provide a valuable contribution to the discussion of harmful traditional practices and HIV in Malawi in that the village presents a particular discursive space where historically different voices have come together and made an effort to construct a common ground.

5.2 Harmful Cultural Practices (HTP)

The National AIDS Committee in Malawi and other national and international aid agencies working in the field of HIV have identified 'harmful traditional practices' (HTP) that should be 'discouraged' (NAC, 2003: 22). Malawi's National HIV/AIDS Strategic Framework from 2000 – 2004, placed it as its top priority to address 'cultural values, beliefs and practices that predispose men and women, boys and girls

to HIV infection' (NAC, 1999). NAC (2003: 22) notes eleven key practices, which are important to address in this context:

Inheritance of a wife or husband
Practice of *Fisi* (hiring of a man for sex and conception)
Death rituals
Use of traditional herbs to induce labour
Insertation of herbs or plants in the vagina for dry sex
Performance of traditional circumcision under unsterile conditions
Male or female prostitution
Postpartum abstinence, which predisposes a man to promiscuity
Traditional treatment of genital warts and haemorrhoids
Polygamy
Kuchotsa Fumbi (sex without the consent after first menarche for initiation)
(NAC, 2003: 22)

I will address each of these practices in this chapter and the following chapters. Most of the HTPs mentioned above stem from sexual taboos of the traditional Chewa religion which can lead to diseases called *mdulo or tsempho*[31]. The Chewa religion could best be described as a fertility cult since fertility, procreation and sexuality are dominant factors in this worldview as Musopole (2006: 13) explains so well:

> Sexuality is one of the most profound life forces. It has the secret of life to the point that even the growing of food, the fertility of the land and an abundant harvest depend on sexual rituals. It is so pleasurable that it must be indulged in frequently except when it is prevented by a very strong and life threatening taboos. It is an energizing force so that without it people feel dead. It has links

[31] Distinction between *mdulu* and *tsempho* can be found in academic literature (Lwanda, 2004) but my informants did not make this distinction.

> with other forces in the cosmos. It links each one of us to past and future generations. By it, our vital relationships with the earth are renewed and, when it is a taboo, then it secures the life of the community from destruction and even death.

Lwanda (2004) gives an interesting account of how the Chewa religion provided an all-inclusive frame of being in the pre-colonial Malawi or in his own words: it shaped 'complex socially formative and normative constructs, myths, beliefs, rituals, and taboos integrating religious, economic, political, and cultural elements' (Lwanda, 2004: 30). Van Bruegel, a Dutch born catholic priest, conducted an extensive field research of Chewa traditional religion system in the 1970's and he explains how these sexual taboos served as a supernatural sanction to strengthen family bonds and emphasise couples' obligation to care for their children. It is ironic in itself that practices that stem from these sexual taboos are now counted as a factor of HIV transmission since as noted by Lwanda (2004: 31) *mdulo* served as a prevention of sexually transmitted diseases in the pre-colonial Malawi with its emphasis on family integrity. Breaking these taboos by committing sexual misconducts would inflict illness *mdulo* or even death upon a third person, most commonly the people's children or other close relatives. Therefore, inappropriate sexual behaviour was considered to be a crime against the whole community (van Breugel, 2001).

During my stay in Karombo, I discussed *mdulo* with several people. I didn't get much feedback in the first interviews but later realized that these taboos are called *tsempho* in Karombo. When asking about *tsempho*, people were willing to talk. Some older people explained various taboos patiently to me, others were quick to close the subject by stating that *tsempho* was something that belonged to the people of Nyasaland (former Malawi) and did not exist anymore. Younger people often added the sentence 'but that only happens if you believe in it' when discussing the consequences of breaking these taboos. What interests me is that some of those who convincingly argue that these sexual taboos are not in place in the contemporary society at the same time defended other sexual taboos. In my experience, certain

sexual taboos affect young people's understanding of appropriate sexual behaviour but at the same time these taboos can easily be re-adjusted when confronting new circumstances. Other taboos are disregarded as mere stories, as Callista explains when telling me about *tsempho*:

> *Tsempho* is for example if you are not married and you go and have sex with your boyfriend outside and then go home to the house of your mother. And maybe she is not having sex. If you do that, your mother can become sick. But today nobody believes this.

5.3 Kuchotsa Fumbi / Fisi

Another practice NAC (2003: 22) lists as HTP is *kuchotsa fumbi*, but *kuchotsa fumbi* is explained as 'sex without the consent after first menarche for initiation'. This conduct is called *afisi* in Karombo, which translates as hyenas in English and is traditionally part of girls' initiation rites or *chinamwale* as it is called in Chichewa. *Chinamwale* is still held as an annual event in areas inhabited by Chewa even though the festival's scope has decreased. Van Brueger (2001) explains the initiation rite thoroughly in his book, *Chewa Traditional Religion*. Traditionally, this festival would endure five days and require the participation of most of the villagers. When a girl had her first menarche she was considered to be transforming from a girl to a woman. This transformation would make the girl highly vulnerable so that she would have to stay in isolation during her menses. Her vulnerability would make her highly susceptible to catch *mdulo* if any of her extended family members broke any of the sexual taboos. After her menses ended, she would be accepted back to the house, but would continue to be in a vulnerable state until formally accepted as a grown up woman after the *chinamwale* ceremony. During the five-day ceremony, much emphasis was put on teaching girls about fertility rites, the ancestors' rules, *mdulo* and the appropriate behaviour of a woman. According to van Bruegel (2001: 188), a special ceremony called *afisi / kuchotsa fumbi* marked the end of the *chinamwale*, whereby a girl's husband or a hired man had sex with her during the last night. With this act the man was imparting his strength to the girl. Van Bruegel remarked that this

tradition was declining in the 1970's, parents increasingly choosing to buy medicine from the *asing'anga*[32] to strengthen their daughter.

This practice has received much media attention worldwide. BBC World (Siddle) reported in 2004 that in Balaka District, southern Malawi 'Young girls, 10 or 11-years-old, were taken off to a separate hut in a corner of the village, and visited by several men who had sex with them during the ceremony. It followed the story that these intercourses were conducted without contraception and against the girls' will. Initiation ceremonies in Malawi even gained media attention in Iceland. In a newspaper interview with a former employee of ICEIDA, he stated that:

> There is hidden sexual violence committed by all kinds of men, under the disguise of witchcraft and culture, which cannot even be retold.' (*Fréttablaðið*, 4th of November 2007).

A few days later the same person was asked in a radio programme if girls in Malawi are being raped during this particular ceremony, to which he replied:

> R: Yes, it is known. People prefer not to talk about it. Nobody denies it when asked, but yes it is known that girls are practically raped three times to initiate them to the society.[33]' (Linda Blöndal, 5th of November 2007.)[34] [Emphasis mine.]

The girls and older women I talked to in Karombo did not relate such a dramatic experience from the initiation ceremony they had been trough. When asked to elaborate on their initiation, most marked the beginning of this event on the day they

[32] Traditional doctor.
[33] Viðmælandi: 'Já, er sem sagt þekkt, fólk vill ekki tala mikið um það. Enginn neitar því þegar maður spyr en það er sem sagt þekkt að þar er ungum stúlkum beinlínis nauðgað þrisvar sinnum til þess að vígja þær inn í samfélagið'.
[34] This story is re-counted in an interview with the same employee in *Fréttablaðið*, 27th of July 2007 (Icelandic Newspaper).

had their first menstruation. When 'seeing the blood' for the first time[35], they advised a neighbour or their grandmother. It varied how much these older women talked to the girls but the following August or September, all the girls who had gotten their menses during the year would be summed up for some 'education', also provided by an older woman. The answers I got were quite coherent and Joyce's answer sums it up:

> I: What can you tell me about girls' initiation?
> R: She is called *nankungwi*, who is like a big woman with respect in the village. When the girls go to the big woman of the village, we go together, the girls in the village who are around 12 - 14 years. The big woman tells us not to have sex, no playing with boys because of pregnancy and because of the virus [HIV]. She teaches us about the period and how to tie the cloth [while having menstruation] because it is not good for the men to see your blood.

Others, recounted stories of how they had been educated at the same time in courtesy and good manners:

> R: They are teaching us to respect people. Like if we see older people carrying something we go there and help. And if you see there is something wrong with someone, you should not laugh. And they tell us not to go through our mothers' bedroom without notice. That is all.
> I: So what do they teach you about being a woman? Like how to treat your husband and such?
> R: So when the big woman of the village is talking she says that if you see your husband coming, it is better to welcome your husband and take his bag and say 'welcome my husband'. I don't know what more they were saying because I was just a small girl. (Respondent a 22 year old girl.)

[35] Girls who I spoke to of Yao tribe, had been sent to their 'home village' the village their parents' were born, to go through the ceremony. I do not include them in this account since it did not take place in Karombo.

Although my informants hadn't experienced the *afisi* part of the initiation ceremony themselves, the term was not unknown to them. The younger girls I spoke to had learned about *afisi* at school while older women had been told about it by their parents. While asked what was the purpose of the *afisi*, I was told that it had been done to teach the girls not be afraid of sex. Today, the end of the *chinamwale* in Karombo is marked by parents going to the chief's house and paying him some money now that the 'girl in his village has grown up'. However, as Lwanda (2004) points out, traditional cultural practices vary considerably between Malawian localities, in his opinion due to the fact that traditional practices were hidden from the 'colonial gaze' and therefore were preserved to different degrees between villages. Even though I did not encounter the practice of *afisi* in Karombo or neighbouring villages, it could still be found in other areas. After extensive reading on the subject, I have found one source claiming *afisi* to be practised in Dedza District, in Central Malawi (Munthali *et al*, 2004: 13).

When asked if they had heard about *afisi*, a first reaction of many was to tell me of another practice called *fisi*[36], which NAC (1999) explains as 'hiring of a man for sex and conception'. Great importance is attached to fertility and having children in Malawi and being barren is considered to be a great shame or even a curse (Musupole (2006: 14). The barren person or the couple becomes a subject of much speculation of others and this can cause much stress within the marriage. It is known that women look for men in secrecy to attempt conception if the husbands are infertile, as the following excerpt shows:

> I: What about *fisi*? What do you know about that?
> R: It is about that maybe you as a woman have a friend. Just a friend and maybe you come to him and say 'ahh' – asking a friend to give you pregnancy if your husband can not do it. It is not good because of the virus [HIV] but you don't like to be without children so sometimes it is good to do this. It has to be a secret and get the friend from another place because otherwise everybody will

[36] *Afisi* is plural and *fisi* singular for hyena.

> know about it. In the village everybody talk so in the end the husband doesn't like that baby. Maybe the friend tells one person and the one person another one and in the end everybody knows it!

It seems to be hard to continue a childless marriage for a long time (Chimbiri, 2007). It is not only the couples' preoccupation but the extended family often puts on much pressure if a child has not been conceived within a reasonable time. A young woman I interviewed had given up hope of ever getting married again after her divorce. I didn't pay much attention to this during the interview but later asked my assistant why this young woman had been so pessimistic about finding a new husband. She simply replied 'because she is barren'. Apparently, her infertility had caused her husband to apply for a divorce and my assistant found it highly unlikely she would find a husband who didn't mind her infertility. This explanation resonates with Musopolo's (2006: 14) argument, saying that just as men would not waste time on ploughing barren land, they would not waste time on a barren woman but rather search for a more productive one. Even strong marriages can break if they are not able to produce children. I was very surprised when hearing of the divorce of a good friend of mine, who I thought was in a particularly good marriage. He told me that he had impregnated a neighbouring woman and was now moving in with her. I asked him how this had happened and he frankly told me that he still loved his wife who is barren, but that he just could not take the jokes and assaults from friends and family anymore and had decided to prove to them all that he was 'a real man'.

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I was uniformly told of the importance of respecting postpartum abstinence and even though people did not agree on the duration, three to six months seemed normal to all. Nobody I spoke to mentioned *tsempho* specifically when explaining postpartum abstinence but the prevailing explanations I got was that postpartum blood was poisonous if it came into contact with men. When having longer conversations about the topic, I was told how powerful fluids blood, semen and breast milk are. Blood is thought to be exchanged through sexual intercourse and should either of the parent 'exchange blood' with a third person and then have sexual intercourse with the spouse, this would not only contaminate the spouses' blood but also the breast milk which would become spoiled. Being faithful to one's partner during this period is therefore highly important to protect the child's health. A traditional birth attendant gave me this thorough explanation:

> I: Can you explain postpartum abstinence to me?
>
> R: It is about 8 months, if you start at eight months maybe you can stop having sex with your husband.
>
> I: Ohh, while you are pregnant?
>
> R: Yes.
>
> I: What about after giving birth?
>
> R: Because we stop sleeping with your husband at eight month it is like suffering, suffering before giving birth, so it is a suffering month. So then you can wait for 5 months after you have the baby, so it is 6 months with no sex. After that you can take your baby and have the kutenga mwana. Now you can take your baby. It is like when you take your husband and your baby in the month of six and then you can sleep with your husband. You take your baby here [holding it in your arm] and you the women sleeping here [lying down] and the husband coming here [on top of the woman], so with this man you can carry the baby and start making the sex. After sex you don't have to do it again until tomorrow and then you can sleep well with your husband. You understand?
>
> I: Yes, but why is it not good to have sex in the ninth month?

R: The eight month the baby can turn around in the stomach and maybe the man can make mistake and pfff [crashing sound] and hit the head of the baby.

I: But why should you not have sex after the birth? Why is it not good?

R: There is a poison in the stomach of the woman that is why you have to wait for it to clean out.

I: Do many women complain of their husbands looking for other women while they are waiting for the *kutenga mwana*?

R: There are different people, the man likes his wife but he has been waiting for five months and he goes and talk to the mother and saying 'ooohhh I'm tired, I just waiting waiting and now I'm tired.' Then the woman can take the penis and put it here [between the thighs] and then everything is ok, and the man is happy in the body [laughter].

I: So women are not complaining to you about their men looking for sex somewhere else?

R: To control the husband you have to do this and make like masturbation [more lauging].

I: So this is the advice you give to women?

R: Ehhhh, yes, yes. Because I'm a TBA [traditional birth attendant] the woman are coming here so I tell them to do this to keep the husband from running away.

Semen is thought to be essential for the foetus to grow and sex during pregnancy is strongly recommended as Joyce explains to me:

I: What about having sex while you are pregnant?

R: That is very good. It gives the baby good sperm to swim in. You can have sex until the eight month. If you have sex after that the baby will be born with sperm on its' head and the midwife will not be happy with you.

Should either of the parents break the families' unity by having sexual relations with a third party the breast milk would damage and become dangerous for the child's consumption.

I: So do you think most husbands can wait these 5 months without sex or do they look for another woman?

R: Some men can wait, others not. If a man sleeps with another woman who is not the mother of the baby and then goes home and has sex with his wife while she is still breastfeeding, the baby gets very sick. If the mother has sex with other men while she is giving the baby breast the baby will have diarrhoea because of the mixing blood. It is not good and very dangerous.

Not all women I interviewed took this seriously. A young woman, who had been in a relationship with a man who had repeatedly been unfaithful to her during and after her pregnancy, did not worry about this. She had respected the postpartum abstinence for several months but was aware of her husband's affairs when resuming sexual intercourse and still breastfeeding. I asked her if she had heard that a baby might get sick if there is 'mixing blood' with another woman while the mother is breastfeeding, she replied:

R: It is a lie! I can say that, if you believe this, it can happen but if you don't believe it nothing will happen, and the baby is not suffering. And I don't believe in it.

I: So you didn't worry about your child?

R: No, I never noticed anything wrong with her.

The cultural meaning of postpartum abstinence has changed over time and is constantly re-invented and re-adjusted to one's situations. The importance of respecting sexual taboos has diminished from before and only the parents' sexual actions are thought to be able to harm the child, but not the actions of any member of the extended family as described by van Bruegel (2001). Semen and blood are vital to child's health but should either of the parent have an affair, and by doing so, break traditional sexual taboos, it can cause harm to the child. During pregnancy, the foetus gets its' nutrition from the mother but the semen is equally important, signifying the importance of parenthood. Care must be taken to preserve the breast milk and the blood of the mother from contamination of a third person. This ideology of health and

illness complies with ideas of how to avoid HIV infection. Given the universal idea in Malawi that men cannot live without sex for long time, women deploy a self-evident way to keep their husbands. It is perhaps characteristic of HIV policy makers' lack of imagination that they worry too much about this practice.

5.5 Menstruation blood

As described above, postpartum blood is thought to be highly poisonous to men and so is the blood of menstruation. Van Bruegel (2001) recounts how menstruating women were thought to be in a dangerously 'hot' state and had to avoid close contact with their husbands during their menses. They should sleep on a separate mat away from their husband and could not put salt in the family's food since this could pass on the dangerous hotness to its members. I was told that today it was unnecessary to sleep on a different mat when menstruating but all sexual relations should be avoided. Zulu (2001) found this idea to be prevailing in the whole of Malawi. I asked Callista what she thought of having sex during menstruation:

> No sex then. If you do the husband will get sick. He will become thin, pain in the back, long hands and no water or salt in the body. It happens if your blood goes in your husband's body through his penis. It is not good for the women either because she will have pain in the stomach.

When asking men what their thoughts were on menstruation blood, they shared the women's opinion; contact with the blood should be avoided at all costs. Bofomo, who is 27 years old, told me the disease caused by menstruation blood, was curable if seeking medical help timely:

> If it is your wife, you can't use a condom because it is your wife. So if the girl has the period and you want to have sex and you get the thing in your stomach so you have to go to the hospital and tell the truth. Say that you had sex with your wife and she was having the period and now you are not feeling well. Then they give you medicine to drink to have the power again. Then it cleans your body and everything will be ok.

In terms of HIV infection risk, it is positive to omit sexual relations during the menstruation period, as some studies have shown increased vulnerability among women to infection during the menses (Kalichman and Simbayi, 2004). It is interesting that it is common to speak of the HIV virus as a beast living in the person's blood and those diagnosed with AIDS are often referred to as having 'bad blood'. The above quotations are interesting in the ways in which they relate to the HIV discourse in the village; as people with 'bad blood' often become thin, powerless and without essential 'water and salt' in their bodies when HIV infected; they can seek treatment if being honest and going to the hospital.

5.6 Culturally Constructed Sexuality

Female sexual pleasure has received much academic interest. While some view sexual pleasure in terms of biological and anatomical responses others maintain that sexuality is culturally constructed (Caplan, 1987). Pat Caplan (1987) convincingly asserts that by looking at sexuality in a historical context, one can detect that sexual pleasure, longings and acts are highly conditioned by its socio and cultural surrounding. The public discourse in the West of female sexual pleasure in other parts of the world appears to be quite intolerant of sexual practices unknown in the West. 'Dry sex' practiced in Malawi and neighbouring countries[37], has received considerable negative attention in relation to AIDS, but the practice is well documented in Zambia and Mozambique (Dover 2001; Gausset 2001; Bagnol and Mariano, 2008). Dry sex refers to the practice of drying and tightening the vagina before intercourse. This is accomplished through various methods such as by inserting herbal medicine into the vagina or by consuming it orally. Women can also wash with water, introduce certain leaves or stones into the vagina or apply Vick's ointment internally before coitus. This is done to enhance sexual pleasure through the creation of a 'hot and tight vagina' producing increased friction during intercourse (Bagnol and Mariano, 2008; Dover, 2001: 85). Paul Dover (2001: 85) gives an

[37] According to Kitts and Roberts (1996: 73) dry sex is preferred in Zimbabwe, Zambia, Malawi, Mozambique, Cameroon, Kenya, Ghana, Costa Rica, Dominican Republic, Haiti and Saudi Arabia.

interesting account of how the desire for dry sex among the Chiawa in south east Zambia, is in accordance to locally based ideas of antonymous meanings of hot/cold and dry/wet which are grounded in the perception of the body, health and procreation.

Dry sex has been labelled 'harmful traditional practice' in the HIV discourse since too much friction can cause vaginal wounds, and therefore make women more vulnerable to HIV infections. Further, dry sex can also cause condoms to break (Card et al 2007: 313). Birgitte Bagnol and Esmeralda Mariano (2008) explored local ideas of dry sex with in-depth interviews in the Tete district of Mozambique. Their ethnographic data is exceptionally rich and informative and suggests that dry sex is prevalent in the area. According to them, women use these vaginal substances without their partners' knowledge and it is considered mainly as 'women's matter' as they secretly 'prepare' their vagina to 'taste sweet'. Bagnol and Mariano, (2008) noted that uses of vaginal substances were changing over the years, and instead of herbal remedies, increased usage of chemicals was observed. The majority of the women had positive experience of these substances, while some women using chemicals complained of unpleasant side effects.

Eager to explore this subject in Malawi, I had an appointment with the manager of the Light House, which is one of the first VCT and ARV's clinics in Lilongwe, during my first week in the country. The manager informed me that dry sex was preferred by most Malawians and this custom facilitated HIV infection. He further claimed that it is difficult to discuss the matter openly at VCT centres since the herbs used are obtained from traditional doctors. In Karombo, dry sex is well known but unlike the women in Tete (Bagnol and Mariano, 2008) the women I spoke to did not admit using any substances themselves. I was often told that women who needed to go to the *sing'anga* to get herbs to dry their vagina had a 'problem because their blood and their partner's blood did not go well together'. In this case, it was argued necessary to go and get medicine, since the sperm would not be able to 'swim against the water' and conception would be impossible. This was however not viewed as a grave

problem since it was easy to cure. A traditional doctor in the village explained to me how to make this remedy:

> It is very easy. One day you want to try it? You soak maize, but first you pound it. Aha! So you want to be a doctor! African doctor! Icelandic African doctor! Good, very good….So you take off the grain itself and soak it in water and let it be sour. Then you drink it for three days and stop. You drink it three times a day for two days and then it will be OK. As simple as that!

None of the women I spoke to acknowledged soap, stones or other ointments being used for the purpose of drying their vagina. My feeling is that women in Karombo do not use vaginal drying substances to enhance sexual pleasure on regular basis but look to *asing'anga* in case of any discomfort in the vaginal area[38]. Since few qualitative or ethnographic studies have concentrated on the subject, there is no comprehensive knowledge of this practice.

When denying the use of drying substances the topic of other magical powders frequently was brought up. In Monkey Bay, a friend of mine spoke freely of different vaginal substances she sometimes got sent from Zambia. She particularly recommended one, which were white little stones to swallow that 'make your body really hot and tight' but despite all efforts we could not find it over the four months we searched for it. But I had the opportunity to see, and taste, two types of other magic powders, also taken orally. When showing other friends in Karombo this remedy, it created a lot of excitement and they were eager to get some for themselves. From what I was told, I was very lucky to come by the powder which 'makes love making more pleasurable'. I didn't experience the specific effects it was suppose to have on the body, I must be too insensitive to feel the difference. The love poison I got on the local market at Monkey Bay[39] did not gain me the same admiration from the women in Karombo since it is very easy to obtain. Love poison as the name

[38] My feeling is further supported by a study conducted by Dallabetta *et al* (1995) which shows that one third of the participants used intravaginal agents for vaginal discharge and itching.

[39] I will never forget the laughter it created among nearby saleswoman and others passing by when I bought the love poison. This incident was not easily forgotten and I was offered to by some more every time I went to the market after this with appropriate laughter and jokes.

implies is a sweet powder, taken orally in order to impress one's lover as a lady explains to me:

> There is also a drink you can take, it is like sugar and if the man comes and makes sex with you, he will say 'I will never let you down, you are sweetened!' Because of the medicine!

In order for the poison to be fully effective it is important to take it in discretion of the lover. I did not detect any doubt among the women about its impact and even when a friend of mine in Monkey Bay was in the disadvantageous situation of hearing her lover and former boyfriend were in town at the same time, she relied on the effects of the love poison on her present lover, in case of trouble, saying 'he will love me too much'. Even though I don't know the ingredients of love poison I do doubt that it facilitates the contracting of HIV.

5.7 Sexually desirable bodies

Another practice, which has been labelled a 'harmful traditional practice' in the international community, is female genital mutilation (FGM) in connection to HIV. World Health Organization defines female genital mutilation[40] (Type 4) as all 'procedures that intentionally alter or injure female genital organs for non-medical reasons' (WHO, n.d). Little is known of FGM in Malawi, although it has hit the headlines of international press from time to time, more as a 'rumor' and cultural practice embedded in secrecy (Jamieson, 2006; Siddle, 2004). In Mangochi District a form of FGM is practiced which is locally called *Kukuna* but clinically known as 'elongation of labia *minora'* (Bagnol and Mariano, 2008). This tradition is not related to traditional sexual taboos that I know of, but is found among various ethnic groups in Mozambique, South Africa, Tanzania, Uganda and Zimbabwe (Bagnol and

[40] The concept *female genital mutilation* has been strongly criticized for being too value laden, and it has been pointed out that *female genital modification* would be more neutral term (Koster and Price, 2008). Denniston *et al* (2008:86) are of the opinion that WHO needs to re-consider their four groups of FGM. Group 1 – 3 consist of procedures where part of the outer female genitalia or all of it is removed. Group 4 consists of : '*Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area* (WHO, n.d). Denniston *et al* (2008), argue that group 4 needs to be defined more accurately.

Mariano, 2008). Denniston et al (2008: 84-94) set out in 2004 to Mangochi District to explore 'aspects concerning health and sexuality in connection with labia *minora* stretching'. Although they view this cultural practice in general in a positive light, they conclude that it might be a culprit of HIV spread since it encourages sexual promiscuity among young girls. Brigitte Bagnol and Esmeralda Mariano (2008) who are members of a WHO multi-country research project on Gender, Sexuality and Vaginal Practices[41], are of the opinion that elongation of the labia is now under scrutiny because of desperate measures to find a reason for high HIV rate in the area.
This practice is very common in Karombo and is found among girls of all tribes. The women were not shy to talk about *kukuna* openly and it seems to me that they actually rather enjoyed talking about it and it evoked a lot of laughter. Usually, the girls had learned of this practice from peers or elder sister. They had either gone to the bush together with age mates or with friends in the dormitory of their boarding schools, carrying medicine from the *sing'anga* and some cooking oil. Unlike what was reported to Denniston *et al* (2008), the girls in Karombo do not pull their vagina lips themselves, but rather do it to each other. In re-counting these experiences, most of the women described this as a positive thing. I must have shown some signs of disbelief since they were eager to explain to me the benefits of enlarged labia *minora*. I was told, among other things, that elongated labia made it 'simple to give birth to the baby', 'if the penis is entering it is not easy to get out because the vagina is holding the penis', 'your husband can play with it and be happy' and 'it is better to have sex, then I'm a beautiful girl to the man'. When asked if it caused any discomfort the answer was simple; 'you can even tie a knot on it and keep it inside you!'

Hilber *et al* (2007), worry that little is known about the traditional medicine, women apply to the genitalia while pulling them and the possible harmful effects it can

[41] Their ethnographic data was collected in Tete Province in Mosambique which borders Malawi in the South.

have[42]. They are concerned that it might disrupt the natural balance of genital mucosa and therefore make women more vulnerable to HIV infection. In Rwanda, Koster and Price (2008) identified two traditional herbs that local women use for the same purpose and both of these herbs were found to be beneficial compounds. Research on this in Malawi would be worthy of note.

It is interesting that none of my informants mentioned that elonged labia *minora* enhanced their own sexual pleasure, but rather told me that it made their husbands happy to 'play with it'. Studies from neighbouring countries have concluded that this practice is done to enhance both partners' pleasure (Koster and Price 2008; Bagnol and Mariano, 2008). In Mozambique (Bagnol and Mariano, 2008) as in Malawi (Undie et al, 2007) the metaphor of a 'door' is often used for the elongated vaginal labia. It was explained to these anthropologists that a sexual partner could not come in through these doors without 'opening' them first, indicating the importance of foreplay before penetration.

It is obvious that this practice is done in relation to sexual activity. Denniston *et al's* (2008) concerns that *kukuna* might encourage girls to initiate sex sooner might be correct, even though I did not encounter any support of this. I am rather in agreement with Bagnol and Mariano (2008: 42) who argue that the tradition is rather an indication of how girls form a 'secret society' with their age group and is an expression of power over their own bodies and how they manipulate sexuality.

5.8 Widow Inheritance and Death Rites

Malawi News (Munlo, 21st to 27th of April 2007: 7) published an article, discussing *Chokolo* or widow inheritance. The article starts by tracing a young man's complaints of being forced by his extended family to marry the much older wife of his diseased brother. He does not like the idea of taking her as his second wife and finds it of little

[42] It is interesting that the lengthening of the labia *minora* causes such an alarm as it is becoming quite common in western countries that women have labiaplasty, removal of a part of the labia *minora*, performed as cosmetic surgery (Pétursdóttir, 19th of October 2009).

amends to inherit his brothers' property. Widow inheritance or levirate marriage, is mainly practiced among patrilineal groups whereby a widow is 'inherited' by either a brother or a nephew of the deceased. Such marriages often provide widows with social and financial security. Women belonging to matrilineal groups traditionally have access to agricultural lands for their provision and therefore often have economic means (Bruun, 2006). Levirate marriages are widely known among the Luo people in Kenya, Uganda, Tanzania and Sudan but few academic sources can be found of the practice in Malawi. Some suggest the practice to be known in the Northern region of the country, but sources differ on among which ethnic groups they occur (Munlo, 20th to 26th of January 2007; Okeyo and Allan, 1994; Gwako, 1998; Bruun, 2006).

A recent study by Reniers and Tfaily (2008: 12) shows that 'levirate or widow inheritance is probably not very important in Malawi' but unfortunately no questions of levirate marriages were included in the household section of the *Malawi Demographic and Health Survey 2004.* In the newspaper article cited above, lawyers and priests are asked to comment on the prevalence of this practice. All are rather sceptic of its existence, but do not exclude the possibility that *chokolo* is practiced in secrecy in some places in Malawi. The commentators also point out that it is unlikely that this would be done without the widow going first for a HIV test saying: 'No one wants to marry the widow if the cause of death is unknown. People are more cautious of diseases like HIV/Aids now' (Munlo, 20th to 26th of January 2007: 7).

My informants in Malawi were not unfamiliar with *chokolo* although all claimed it was not practised anymore in the nearby area but that 'other' people did it. It remains unclear who these others are:

> R: Well there are some tribes who do that but not all, no, no, no. There is the…. Katonga? Yes, they do that, they live way up in the country, near Tanzania. (Respondent an older man.)

I: I thought that [widow inheritance] was part of the Malawian culture...?

R: There is no tradition about widow, it is just the Tumbuka people who do that. (Respondent a young woman.)

A closely related custom of *chokola* is widow cleansing, known as *kupita kufa* whereby a widow is cleansed of her husbands' spirit by having sexual intercourse with a hired man. According to Karombo's elders, this custom was never practised in the area. Although commonly cited as a HTP in connection with HIV, especially in international newspapers, there is no evidence of this still being practiced anywhere in Malawi. Widow cleansing is commonly listed as a HTP in Malawi but the practice is never further explained (Rankin et al, 2009; LaFraniere, 2005; Reniers and Tfaily, 2008; Mfutso-Bengo, 2009; Kondowe, 1999). It would be very informative to carry out further research on widow inheritance and widow cleansing in Malawi in order to estimate to which extent these practices influence the spread of HIV.

5.9 Summary

In the beginning of this thesis, I wondered whether it was possible to detect 'colonial continuities in western scientific discourse of sexuality and AIDS in Africa' (Arnfred, 2004: 10). I find this an appropriate question to ask in the context of the much discussed harmful traditional practices. It is my understanding that some of the taboos mentioned above influence people's perception of appropriate sexual behaviour, but that these same taboos can easily be adjusted when people are confronted with novel circumstances. It is frequently seen in HIV policy papers, that cultural factors are blamed when discussing the spread of AIDS in sub-Saharan Africa. Crewe and Harrison (2005) discuss the tendency of Western scientists to view culture and customs in the more impoverished countries as different from their own. Traditional culture and customs are readily presumed to be permanent and unchangeable phenomena since time immemorial and prevent poor people from addressing their problems properly and acquire modern knowledge. It is thus implied that culture has a stronger grip on inhabitants in poorer countries than in affluent ones. But culture and cultural practices are not immutable phenomena passed on, from generation to

generation, through the centuries. Neither in African countries nor elsewhere. The people I spoke to in a Karombo often looked at me in surprise when I kept asking them to explain widow cleansing rites to me and how the *fisi* part of *chinamwale* ceremony was conducted. Without exception they looked at me in wonderment and asked, 'Don't you know about HIV?[43]'

[43] Part of the text in chapter 5.9 was published in *On Development* (Pétursdóttir, 2008).

6. Girls and gifts

6.1 Risk factors

In the *UNAIDS Global Report* (2008: 39-40) it is stated that the HIV epidemic appears to have stabilized in Malawi 'amid some evidence of favourable behaviour changes' although stark difference of HIV infection rate between girls and boys of 15 - 24 years of age are still noted; girls being worse hit by the epidemic. According to MDICP[44] 3.71 per cent of young women are thought to be HIV infected while 1.58 per cent of young men (Watkins, Forthcoming). Various social norms are accounted for girls' vulnerability to HIV infections but 'primarily harmful gender norms' whereby girls do not have control of their sexual bodies because of low economic and social status (UNAIDS, 2008: 67; Gupta, 2002). In this chapter I will address some of these gender norms considered to trigger girls' vulnerability such as girls' lack of sexual education, inability to negotiate condom use, intergenerational sex or so called sugar daddy phenomena whereby girls seek to have sexual relationships with older men for economical advances. A closely related discussion of intergenerational sex is of girls being forced to practice 'survival sex' or sex for basic survival needs. In order to explore these phenomena I find it appropriate to compare this common understanding of girls' vulnerability to what girls in Karombo village consider appropriate sexual behaviour, which are the pathways that lead to marital unions and lastly how they respond to increased danger of getting infected with the HIV virus.

6.2 Gendered Spaces

When walking around Karombo village, one realizes quickly that there exist clearly defined gender roles and it is noteworthy to see how space is gender divided. Men tend to group together on the beach in their free time, preparing their boat before fishing in the afternoons, repairing fishing nets or sitting under the shade of trees, listening to the radio, playing *bawo* and chatting. Women however are more visible in the surroundings of their homes, either working alone or chatting with neighbouring women. When on the beach in the afternoons, women go together in groups to wash clothes in the lake, with shrieking children playing by their sides. Appropriate gender

[44] Malawi Diffusion and Ideational Change Project.

roles are taught at home and are practiced from an early age. A friend of mine who has three sons often complained of how much her life would be easier if she had a daughter as well to help her with the house chores. Instead of sending her oldest son to the beach to wash the plates, she paid a neighbouring girl to help her.

Children, boys and girls play together in their free time. This changes during their adolescent years. As discussed previously, girls go through the *chinamwale* initiation ceremony after having their first menstruation, which marks their entrance into womanhood. After this ceremony, boys and girls are told not to play together and the children now act in separate gender spheres – at least publicly.

Figure 4: Common sight, proud girls preparing food for their friends in the afternoon.

In contrast to being taught not to be afraid of sex as I was explained was the purpose of *fisi*, the phrase 'they told me not to play with boys / girls' respectively, was frequently brought up when discussing adolescent years. Curious of that phrase, I was told that they had been given this instruction to avoid pregnancy and HIV infection. Grace, a 20 year old, a single mother of two children explained this to me with these words:

I: So did your mother explain sex to you when you had your first period?

R: No [laughing]. My mother is not talking about sex, just told me not to play with boys and take care of myself. I just heard it from my friends that sex is good, at school. They told me to try it.

I: So when you were smaller did you play with boys…?

R: No!

I: So you had no relations?

R: No!

My translator cuts in: Yes you did! [laughing]

R: Yes, I did [laughing too]

I: So then you were not afraid of getting pregnant?

R: No because I didn't know!

6.3 Sexual Education

Geeta Rao Gupta wrote an article in the *BMJ* (2002) called 'How men's power over women fuel the HIV epidemic'. In this article she states that:

> […] the power imbalance in heterosexual interactions leads to a culture of silence that surrounds women's sexuality. This restricts women's access to information about their bodies and about sex, which in turn contributes to their inability to protect themselves from HIV infection.

In the excerpt above, Grace claims that she was unaware of the risk of becoming pregnant when having sexual relationships during her adolescent's years. She insists that she had not received sexual education from her mother but had been encouraged to try sex by her friends at school. It is hard to tell if Grace, really did not know that sexual intercourse can lead to conception or if she was replying to the question half heartedly. Should we take Grace's answer literally, it conforms with Geeta's (2002) worries that girls ignorance of sexual matters kindles HIV transmission in Malawi. But there are conflicting discourses about the necessity of formal sexual education for Malawian youth. Chi-Chi Undie, Chrichton and Zulu (2007) explored young people's conceptualizations of sex in Malawi by conducting eleven focus group discussions around the country. They conclude that there is a need for comprehensive sexual education in schools. According to Undie *et al* (2007: 2), only 22 – 34 per cent of

girls aged 12 – 14 received any education about sex and family planning. In their opinion, it is essential that the youth receive comprehensive knowledge of sex at schools in order for other interventions, such as HIV awareness campaigns, to be effective. In personal communication, Mrs. Banda, who works for the Department of Women and Development in Mangochi District, expressed concerns about the way in which parents and other adults shy away from having honest talks about sexuality with young people. Mrs. Banda is of the opinion that the common phrase 'don't play with girls / boys' only makes young people more curious of exploring this forbidden area.

Others, strongly disagree with this view. Older informants commonly complained about the youth, accusing them of being 'too loose and moving to much around' (having too many sexual partners) and for disregarding sexual taboos they had grown up with themselves. One of the older informants told me that as a young man, he had been threatened that if he had sex before marriage, both his parents would immediately die. According to him, he hadn't dared to have sex because of this fear, and finished our conversations by stating 'nowadays, the young people just do whatever they feel like, that is why we have this big problem of AIDS'. Agnes Chimbiri (2007: 1112) reports similar worries of older people in Balaka District, whereby elders find the youth to have no moral disposition towards sexual relationships, which they commence as easily as 'buying and drinking a bottle of Coke'. Others are of the opinion that easy access to sexual education is destructive. In the Malawian newspaper, *The Nation* (Nyirenda, 2007: 13), a group of rural people expressed their concerns, stating that high pregnancy rate among school girls in the area was due to sexual education being taught at schools, claiming: 'This is one of the negative impacting things on the education of girls. They have been introduced to sexual education very early'.

Should the youth of Malawi receive a comprehensive sexual education at school, or be informed by parents and other relatives or should the youth be taught to be afraid of breaking traditional sexual taboos? These different views reflect the liminality of

attitudes towards youth and sexual education. Grace laughingly replied that she had not known she could become pregnant by having unprotected sex when she was a young woman. Compared to other people's discussions of youth and sexuality I understood that although elders do shy away from talking explicitly of sexual matters, young people have other means of getting informed. During the *kukuna* or the elongation of the labia *minora*, older sisters or girls tell the younger of sex and during the *chinamwale* ceremony, girls are discouraged from having sex 'because of pregnancy and the virus' (HIV). Studies have shown that there is a universal understanding of the ways in which the HIV virus transmits, I find Gupta's worries of girls being ignorant of their bodies and sexualities is exaggerated, at least in the context of Karombo (NSO, 2004; Lwanda, 2004a).

6.4 Sex and Education

I noticed that some girls had taken a firm decision not to have any sexual relations until after graduation. Since primary education became free in the mid 1990's, girls' enrolment has slowly increased and is now equal to that of boys. About 86 per cent of all children finish primary school but only 13 per cent continue to secondary schools (ICEIDA, n.d; NSO, 2005b). Fewer girls than boys complete secondary education and one of the reasons for this is pregnancy. It is a widespread belief in Malawi that having sexual relationships is incompatible with having ambitions for one's study especially for girls (Watkins, Forthcoming). Pregnancy can hinder further education for girls, at least temporarily, although the government decided in 2007 to allow school-age mothers to continue their studies. However, this remains hard for many due to economic and social circumstances and there is always the risk of the 'boy not taking responsibility of the child'. Being a single mother is not uncommon in Karombo but is socially and economically tough. Interestingly, in the same radio interview as quoted in previous chapter, the former ICEIDA employee expressed his concerns that:

> If a girl has miscarriage out of wedlock, then she has to have sexual intercourse with three men from the village, first of all to punish her, and pay attention,

> they say they are punishing her, for having, eh, sex without being married, second of all for having a baby and thirdly for having a termination of the pregnancy. So there is all kinds of culture in the villages which is very hard to change and of course just directly influences the spread of STD's (Linda Blöndal, 5th of November, 2007).

Pregnancies out of wedlock are frowned upon in Malawi but so severe punishments are unheard off (Munthali *et al*, 2004). A study made in two villages in Mangochi District revealed that about 12 – 15 per cent of all households were headed by women (Haraldsdóttir, 2002: 169).

But even though unwanted pregnancy recoils upon women more than men, especially since abortion is legally restricted[45], it is not something that most men can easily walk away from, particularly if they are residing in the same area as the pregnant woman (Munthali *et al*, 2004). John, who is 20 years old, was obviously not comfortable of the idea of becoming a father yet:

> R: But right now she [speaking of his girlfriend] can't have the pregnancy because of the medicine [Norplant injection]. If she is having the pregnancy her parents would say what was needed and that we would have to move in together.
>
> I: So you would have to marry her?
>
> R: NO! Not now.
>
> I: But if she would be pregnant?
>
> R: If it is happening, we can marry. I can't say no because it is me who give it to her.

[45] Like Munthali *et al* (2004: 17) demonstrate, illegal abortion in Malawi is a considerable and unexplored problem, but in 1994, the cause for 68 per cent of all admissions to the gynaecological ward at Queen Elizabeth Central Hospital in Blantyre were complications after abortion. I was explained how abortions take place in Karombo, whereby a traditional doctors retrieves the foetus with a designated root of a tree.

Figure 5: A drawing by Mphotso Bulea and Mabvuto L. Banda's; showing a

Figure 6: 'Don't copy bad behaviour from your friends: Think of the future. Avoid AIDS'. Poster found in Mangochi District.

Sitting in a group with women chatting one afternoon, some expressed anger over these 'selfish' girls who refused to engage in sexual relationship until their twenties. This caused lively discussion within the group and it was clear that abstinence is clearly out of the ordinary even though much promoted on HIV posters in town. I found this discussion particularly interesting for two reasons. Firstly, because I gained a new understanding of the phrase 'to be selfish'. I had gathered that a 'good woman' is 'not selfish' but I hadn't put that in a sexual context before. Secondly, it surprised me to hear these women express this view since three of the four women chatting, had previously told me how sorry they were that they dropped out of Secondary School because of pregnancy. This discussion can be viewed as an example of contradicting discourses; should women obey their traditional role as first and foremost mothers and wives or should they refrain from sexual relationships to pursue their education? As the term dividuality suggests, people have different perspectives and opinions depending on the communicative context they are part of (Helle-Valle, 2004: 196). In the context of HIV, increased enrolment of girls in primary schools is positive news since studies have found a correlation between

school attendance and delaying of sexual intercourse (UNAIDS, 2010). Other studies show that the majority of students prefer to be faithful to their partners to avoid getting HIV infected during the time they are together and to chose a boyfriend or a girlfriend whom they believe not to be infected (Lwanda, 2004a). This strategy is in accordance with the HIV prevention slogan 'be faithful' but keeping it in mind, that most young people have various sexual relationships before marriage it would be safer to use condoms if the HIV status is not known.

6.5 'Don't play with boys!'

Although some choose not to have boyfriends or girlfriends while at school in order to better concentrate on their education, there seems to be a general acceptance of young people making sexual experiments. In a focus group discussion, which consisted of women over their twenties, the participants responded that it is normal for girls from 12 to 15 years old to have sex for the first time, or just after they have their first menstruation[46]. I asked where they would have sex and was told that the bush, the boy's house or a rest house are the normal places. They couldn't stop laughing when I asked if a 12 year old could have sex in a rest house and replied 'No! In the rest house it is hard sex but in the bush it is just playing!' People in Karombo make a distinction between sexual 'playing' on one hand and 'hard' sex on the other. For obvious methodological limits, it is hard to observe the difference between those two acts but to my understanding youngsters get involved in sexual playing, which is considered quite innocent by most although it can involve penetrative sex. In a focus group consisting of men, there was agreement with the women's group on the actual age of girls' first experience of sex and added that:

> Because girls are bigger than boys at the same age, so girls can have sex when they are 12 years old but boys when they are around 18...when they can see the penis is big. When they are 12 or 13 they are just playing, they can try it!

[46] The median age for girls in Malawi to have their first menarche is 15 years old (Munthali and Zulu, 2007: 153).

When asked if it could damage the girl's reputation if she had sexual partners before marriage, the common answer was that it did not matter since it happened before they were engaged or like Mary stated: 'They [the husbands] don't have any day to ask such question. The husband cannot be angry about these things or be jealous because if he is a good man he knows that you were just trying.'

After some years of 'playing' with the opposite sex, more serious relationships start to develop, normally in the higher classes of primary school. In accordance to Clark *et al* (2007), I found that boys generally initiate these relationships. A girl who is being 'proposed' normally refuses the boy for some time, from a few days and even up to some months if she is interested in the boy. It is important to note, that should the girl not be interested, she has ways to make this clear from the beginning. But statements such as 'the first time he called me I didn't like him but then he tried and tried, and then I said OK' were common. During this time the boy tries to convince the girl by bringing her small gifts such as soft drinks, biscuits, bars of soap or sugar. Whether these relationships develop into marriage depends on circumstances. Many of those I spoke to and were in a relationship, were not sure if they wanted to marry their partner but argued that it is 'good to have one partner in these times', meaning because of risk of getting infected of HIV if having various sexual partners. Others said they were not contemplating marriage at this point in time but would like to do so later.

6.6 Gifts in a Relationship

If a girl agrees to the proposal of 'being a team', sexual intercourse follows quite quickly according to what I was told. The boy's ability to give his girlfriend gifts seems to be a prerequisite to form a relationship. Michelle Poulin (2007) brings a new perspective to this discourse by stating that her findings from Balaka in South Malawi, do not indicate that gifts in sexual relationships are given to meet the financial need of women, but rather serve as an expression of love and commitment and emphasises that girls do have a 'decision making power over their sexual lives' (2007: 2391). I agree with Poulin that gifts seem to be a fundamental issue in forming

relationships and girls do assess a boys' ability to care for them before considering marriage. These gifts in the early relationship are often taken as a marker that the boy is 'serious with his love'. As Poulin concludes, gifts are normally not given in direct change for sex in these kinds of relationships. Muhammed, a 19 year old boy who has been with his girlfriend for over two years explains to me 'if my girlfriend is coming to my house [to have sex] I have to buy something nice, like drinks or biscuit'. Instead of interpreting this as a gift in return for sexual gratification, I think it is more useful to see such acts as part of a young man's presentation of himself as being nice and capable.

In both academic texts and in the HIV discourse produced by development agencies, there is a tendency to ignore other factors involved in the process of gift giving in the formation of relationships. According to my informants, gifts are just one gesture of many that boys show in order to demonstrate their love. Other desirable qualities are to 'tell good stories', have good manners, 'good body structure', be respectful, religious and not to 'take beer' or smoke. I suggest, these factors are equally important to girls when considering whether to continue a relationship or not.

Girls attending boarding schools away from home, sometimes mentioned that their boyfriends helped them to buy *ndiwo* (part of Malawian stable food) if they ran out of money or bought what is perceived as luxury food such as soda or biscuits on their school breaks. Whether such gifts should be taken as reciprocity for 'survival sex'[47] depends on the context. Rather than girls being forced to have boyfriends to provide them with sufficient food, I was told about this in the context of how much their boyfriend cared for them. This could be regarded as an exercise in acting out gender roles, in this particular socio-cultural landscape where husbands are expected to provide for their family. When asking boys about their girlfriends, I did not encounter

[47] Much has been written of women engaging in sex work for their survival; not necessarily as working in specific commercial sex setting but as having occasional sex as an income generating project (UNAIDS, 2008; IFRC, 2008; UNFPA, 2008).

that these gifts were viewed as burden but rather as something they liked to give to their girlfriends to make them happy and to show affection.

6.7 Sugar Daddies

A large body of literature can be found on what is in popular discourse called sugar daddies, usually in relation to discussions of higher percentage of girls being infected with HIV than their male peers. Generally, this has been perceived as young girls engaging in sexual relationship with older men because of poverty (Kalipeni *et al*, 2004, Akeroyd, 2004; Mbugua, 2004; Luke, 2005). These intergenerational relationships are considered to be characterized by a great difference in social and economic power and thought to put a young woman in a vulnerable position as to the negotiation of safe sexual behaviour. This phenomenon has received much attention and warnings against 'the sugar daddy trap' are displayed on public posters:

Figure 7: 'Girls, don't be attracted to things that lead to contracting HIV/AIDS and STDs'. Poster found in Mangochi District.

This discourse was also reflected in drawings by a thirteen year old boy in Karombo; Precious. His drawings were supposed to be descriptive of anything, in his mind, related to HIV. He filled a notebook with drawings of how he viewed the situation of

HIV and I was astonished to note how many of his drawings showed rich men tempting young girls with their wealth:

Figure 8: 'I tell you I'm a boss. I have got cars, cow, a plot and also Mount Sochi Hotel is mine. So don't worry, everything is OK.' Drawing by Christopher Ndembe and Precious Phiri.

James, Geoffrey and Morry, who are well into their thirties, echo this rhetoric and regard these kind of relationships as the reason that 'most of the women are dead' (text on figure 30). It is interesting to note that in their view rich men are those who

are HIV infected and infect poor women who think that 'once follows [fall] in love with a millionaire everything will be easy to for fill the wishes'.

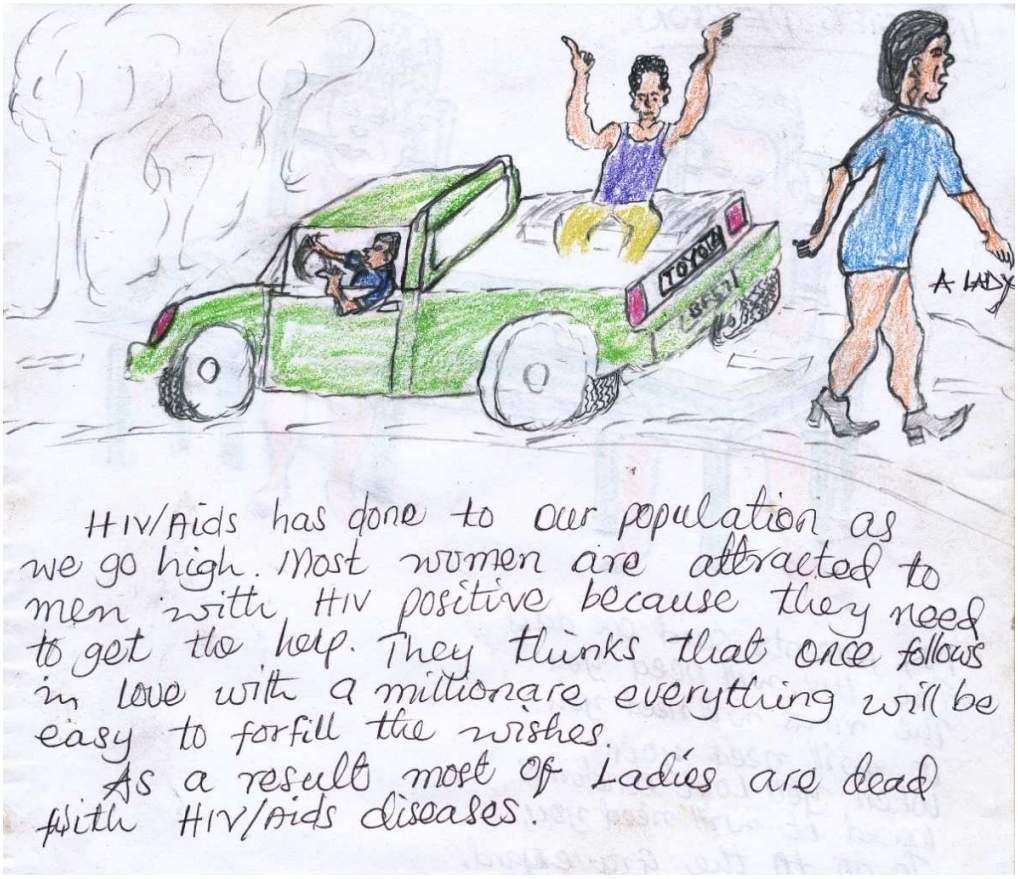

Figure 9: Drawing by James, Geoffrey and Morry.

An interesting aspect of the sugar daddy trap discourse is that few comparative studies have been made as to the use of condoms in relationship consisting of age peers and of those in sugar daddy relationships (Luke, 2005). Judging from the drawing above, the young male artists clearly find these relationships to be very dangerous although there is no mention of condoms or women being in vulnerable position to negotiate the use of them.

Poulin (2007) published a very informative article in 2007. Her findings indicate that it is very common that there is a money transfer from men to women who are in a relationship, but in her view this money exchange does not put women in a less

advantageous position to negotiate safer sex. Her study shows that many young women do have control over their sexual bodies and are concerned about protecting themselves against HIV infection, not by insisting on condom use, but by choosing boyfriends whom they consider 'safe' and by getting rid of partners they no longer trust. Watkins (Forthcoming) concludes that:

> [T]he low HIV prevalence for men and women 15–19 in the MDICP data and the few reports of sexual relationships with categories of sexual partners in which the men are likely to be older (and thus more likely to be HIV positive), suggests that they make a minor contribution to Malawi's epidemic.

6.8 Pleasurable Sex

Figure 10: Photo taken by an unknown employee of ICEIDA. This painting decorated the outside wall of a bar in Monkey Bay, situated on the main road: 'Condom is NOT the answer'.

Condoms are commonly linked to 'deprivation of pleasure', forced family planning, western values and promiscuity in Malawi (Kaler, 2004; Chimbiri, 2007). Condoms

are much discussed among youngsters in Karombo. As is common around the world, condoms are thought to spoil the pleasure of love making. Girls often responded that it was better to make love 'flesh to flesh' or that 'plain' sex was the most enjoyable. When asking men the same question it often generated laughter and I was asked back if I normally ate sweets wrapped in paper. I didn't get the metaphor as quickly as I should, but was explained that like eating the sweet with the wrapper on, condoms distract the true pleasure of sex. This seems to be a common understanding in Malawi (and elsewhere) (Kaler, 2004: 106: Chimbiri, 2007: 1104; Lwanda, 2004: 35). Tawory and Swiddler's (2009) study indicates that both women and men consider the release of the semen into the woman to be the 'sweetest' part of intercourse, semen being a very powerful fluid as discussed previously.

Another barrier for condom use is the general preference of dry sex to generate friction during the intercourse so it is to say the least, paradoxical to sell condoms smeared with oil. I had the opportunity to converse with a technical advisor at the Essential Medical Laboratory Services under the Ministy of Health, at the time. When asked why condoms without spermicide were not for sale in Malawi, he could not provide any answer. We discussed the prevalence of dry sex in the country and his home country (Zimbabwe) and he admitted that this was the first time he connected the two things. Upon leaving, he assured me he would look into this matter. Unfortunately, he shortly afterwards left that office. But these findings are consistent with Bagnol's and Mariano (2008: 48) who conclude that selling lubricated condoms in the area where dry sex is preferred, is 'an absurdity which is difficult to justify'.

But condoms are not only thought to spoil the pleasure of love making but evoke stories of being dangerous, poisonous or even culprits of transmitting illnesses. After interviews, I always asked if s/he would like to add something or ask me questions. To my surprise, many used the opportunity to initiate conversations about condoms. A frequently posed question was '[is] it true that the oil in condoms is poisonous?' The same preoccupation is reported in studies from Southern Malawi (Lwanda, 2004;

Kaler, 2004). Girls also worried that the condom might get stuck in their uterus and other studies report preoccupations of condoms causing cancer, sores, infertility and diseased that can lead to AIDS (Tawory and Swiddler, 2009). Others expressed concerns about condoms breaking. I was actually told numerous stories of condom breakages.

As a research from the United States has shown, reports of condoms either breaking or slipping of are numerous[48] (Bracher *et al*, 2004). Bracher *et al* question the sense of selling to Malawi, or to any African country for that matter, condoms that are made of latex, which needs to be stored below 25 degrees Celsius to keep its' consistency. It is known that most vending places in rural areas do not have air conditioning or fans; hence it is safe to assume that the likelihood of condom breakage or slipping off is higher in Malawi then in richer countries due to unsatisfactory storage. Bracher *et al* argue that the calculation of 10 per cent of all condoms either breaking or slipping off is an underestimation. Condoms made of non-latex material can be kept in high heat without losing their function - but they are not available in Africa sub Sahara. In the midst of a multitude of HIV research I find it peculiar how little attention is paid to the quality of condoms.

As Beth Maina Ahlberg (1994: 234) points out; international AIDS campaigns have been in disagreement about the use of condoms, some encourage condom use while others reject condoms on moral or religious grounds. Not surprisingly, HIV propaganda led by Christian associations do not encourage condom use but promote abstinence before marriage. Even so, it attracted the attention of the world when Pope Benedict XVI stated on a visit in Cameroon in March 2009, that condoms were not a solution to the AIDS crisis in Africa but could actually make the crisis worse (Butt, 2009). This statement led many to doubt the ethical stance of the Pope and the editorials of *The Lancet* (Horton, 2009: 1054) accused the Pope of making an 'outrageous and wildly inaccurate statement about HIV/AIDS'.

[48] Reported as high as 19 per cent of condoms that are older than 5 -7 years (Bracher *et al*, 2004: 29).

Last but not least, condoms are negatively associated with untrustworthy people and those likely to be HIV infected. Studies show that men are willing to use condoms with prostitutes (Tawory and Swiddler, 2009). To ask a partner to use a condom can produce an uncomfortable situation of mistrust between the couple. Most of the people I spoke to, who were in a relationship, did not use condoms. Some claimed they had done so in the beginning but found it burdensome and instead acquired contraceptive medication from hospitals or clinics or, alternatively, used traditional medicine or only had sex during the 'safe days'[49].

6.9 Prostitution

Some academics, arguing that there is a fine line between gift giving and payment, have suggested that, since the tradition of men giving presents to women in sexual relationships is reportedly high in Africa sub Sahara, African women easily turn to prostitution (more easily than women in the West) (Dover, 2001; Leclerc-Madlala, 2000). Oppong and Kalipeni (2004: 53), warn HIV researchers to draw the conclusion that African women easily turn to prostitution. Prostitution is a negatively value laden word in most places, and should not be confused with receiving gifts. In Oppong's *et al* opinion these explanations are 'simplistic and smack of the earlier […] colonial explanation of tuberculosis and syphilis in Africa' but promiscuous African women were accounted for the spread of syphilis at the beginning of the twentieth century (Derbyshire, 2004).

In short, in the mind of the people I spoke to there is a clear distinction between gifts given in a romantic relationship on one hand and prostitution on the other. In Monkey Bay, the nearest township which is 5 km away from Karombo, there are bars and 'spots' that sell local beer. In these places girls from different parts of the country, hang around in the hope of earning some cash by giving sexual favours to the clientele. The dominating popular image of prostitutes in Malawi is far from being

[49] During the men's focus group discussion, interesting and lively debate took place about what 'safe days' are. The conclusion was that it was safest to have sex five days after menstruation ended to avoid pregnancy.

that of poor and powerless women, but rather that of sneaky and greedy women taking advantage of men who lose all sense in the presence of beautiful women as can be detected in this comics:

Figure 11: Comics from *Malawi News* 21st to 27th of April 2007.

Prostitutes are by most local women not regarded as being 'proper women' and do not mingle easily with other women. To some they occasionally pose a threat by becoming too intimate with their husbands. An assertive lady, who runs one of the most visible bars in Monkey Bay, explained to me in a matter of fact tone of voice, that she had girls to take care of the business, but she herself 'loved for money but did not fuck for money'. In her mind there was a clear distinction between those who sell sex for money and those who receive gifts in relationship.

Karombo village has a unique position compared to many other villages, because of the many 'tourists' who reside there for work for longer or shorter periods of time. The workers normally travel alone, leaving their family in the home town (Mtiki, 2007: 2455). I detected ambivalent attitudes towards local women having relationships with migrant workers. Some were understanding and tolerant while others expressed deep concern for these women. Quite often I witnessed women speaking pitifully of neighbouring women who had relationships with outsiders, claiming that it was a desperate or foolish act trying to find a rich husband, since it

often resulted in them being left in a worse situation than before. However, women seeking out relationships with migration workers were not regarded as prostitutes as far as I know. When pressed to give me an explanation of why it was so common for men to have 'temporary wives' while working away from home, I was without exception told that it was because 'men cannot stay without sex' for long (see also, Mtika, 2007: 2460). There is an implicit understanding that men have a natural need for sex. Apparently, negative physical reaction develops if sex is withheld from a man who has 'tasted'[50] it for a long time. It was disputed whether the same thing applies to women. Even though there is a certain understanding of women seeking out relationships with 'foreigners', others are disturbed by the possible consequences of such relationships. The Chief of Karombo and her family expressed their concerns to a reporter of the *Malawi News* (Munlo, 20th to 26th of January 2007: 8) stating that '[t]ourist are ruining our village'. The Chief and her family blame tourists for tempting young girls with promises of good life and presents, which they later betray when returning to their families. The Chief's family complains of traditional values being disregarded since these relationships evolve without the girls families' awareness[51]. They are not only worried about the reportedly high number of single mothers in the village but are also concerned because as they told the journalist 'Aids has started to eat at their tables' (Munlo, 20th to 26th of January 2007: 8).

6.10 Summation

The meaning of gift-exchange in the formation of relationship is a complex issue. In some situations gifts may be symbolic, while in others economic need may be the prominent reason for a girl to engage in a relationship. The enhancement of socio-economic status can also be important, but one must keep in mind that in most cases no single or simple explanation can account for presentation or acceptance of gifts. The dominant discourse of 'transactional sex' in Africa sub Sahara has fortunately

[50] In a Malawian context, sex is often spoken of as something one eats or tastes. The metaphors of 'tasting sweet' or to 'taste bitter' are used to describe what is considered to be good or bad sex (Tavory and Swidler, 2009).

[51] Paul Dover (2001) reports that elders in Zambia also complain of young people forming relationships without the families' approval or make 'fast marriage'.

moved from uniformly examining this practice as an act of women in the straits of poverty. I must stress Helle-Valle's (2004) point that sexual practices need to be examined in their social context with an emphasis on people having an assortment of motivations for their actions. I find this quite important in discussing this topic. Quentin Gausset (2001) provides us with food for thought by questioning the motives of social scientists in the beginning of the HIV epidemic in Africa. Gausset wonders whether there may have been too much eagerness to find cultural aspects that could explain (or be blamed for) the rapid HIV transmission in Africa sub Sahara, and that this might have led anthropologist and others, to highlight issues that have not been explored in the West. Moore *et al* (2008:11) put forth an interesting observation:

> Many of the studies on "transactional sex" have been carried out in sub-Saharan Africa [...] because there is interest in "transactional sex" only in the context of high HIV prevalence rates and the particular vulnerability to HIV that young women face. For a point of comparison it is useful to note the role of money and gifts in adolescent's romantic relationship in the Unites States, although *virtually no studies examine connection to sexual activity*. (Emphasis mine).

For example the much discussed problem with young girls in southern and eastern Africa forming relationships with so called sugar daddies appears not to be as common as perceived, the vast majority of girls being in relationships with their age peers (Moore *et al*, 2008; Poulin, 2007). Evidence also suggests that receiving gifts in sexual relationships may not be disempowering to women, but can be perceived in the context of girls exercising their agency by choosing certain lovers while refusing others (Moore, *et al* 2008). This argument is a valuable contribution to the discourse, in that it shows that women in Malawi have various means of active control over their lives, within a culturally established framework. What is of concern in the context of HIV spreading among the youth of Malawi, is not related to 'harmful gender norms' in my opinion. What needs to be further explored is both girls' and boys' objection to use condom when initiating sexual relationships.

When speculating about possible causes of why HIV prevalence is higher among young women than of young men, it is important to keep in mind that this difference between women and men is reversed with older age when men are as likely to get HIV infected. Susan Watkins (Forthcoming), when wondering if the higher HIV infection rate among young women is due to harmful gender norms and culture, reaches the conclusion that it is 'puzzling that policymakers and donors mobilizing effort and funds on behalf of vulnerable women did not ask a simple question: what happens after age 24?'

7. Vulnerable Women?

7.1 Marriages in dangerous times

As discussed in the previous chapter, young people engage in sexual relationships during their adolescent years. This is often explained as a protective measure against HIV infection with the words 'it is good to have one partner because of the danger nowadays'. Never the less, these relationships do not always last for a long time and it is quite common for young people to have various partners before marriage. Whether these relationships develop into marriages depends on several factors such as fidelity, personal traits, economic situation, lasting affection, agreements of extended families, educational aspiration, since it is not common for young people to get married while still studying, and age, the median age for first marriage in Malawi being 18 years (NSO, 2004; Chimbiri, 2007).When a couple has been in a steady relationship for a long time or had children they are referred to as informally married but most serious couples do get formally married at some point in time (Chimbiri, 2007: 1103). Traditional marriages are predominant in and most of the people I got acquainted with in Karombo had gotten married in the village, with a ceremony conducted by marriage mediators, normally close relatives (WLSA *et al*, 2005). In the opinion of the Malawian scholar, Agnes Chimbiri (2007: 1103), there has been a dramatic change in attitudes towards the traditional marriage systems in Malawi in that they are not taken as seriously as they were. This is manifested by increased incidents of divorce and 'lineage heads have lost their decision-making powers' (Chimbiri, 2007: 1103). She finds this changed attitude towards marriages to be due to better education, migration, intermarriages between different ethnic groups, economic crises and the HIV epidemic.

Studies have shown that HIV prevalence is considerably higher among women who are married or have been married than among women who never have married (Clark *et al*, 2006). In a survey conducted in three rural sites of Malawi in the Northern, Southern and Central Malawi, the HIV prevalence rate was 6.2% among ever married women compared to 1.5% of never married women (Clark *et al*, 2006). In another

survey from the same three sites, it was found that 5.6% of married women were HIV infected while 7.1% of husbands were HIV positive (Anglewicz *et al*, 2010). Many causal explanations for why ever-married women are more likely to be HIV infected than women who have never been married, can be found in the HIV rhetoric but mainly the ubiquitous male domination over women is blamed. When in marital unions, women's vulnerability is thought to stem from them not being able to negotiate condom use, husbands preventing their wives from accessing VCT centres and other health facilities, the wives' become victims of perpetual domestic violence and the risk of husbands engaging in risky extra marital sexual affairs (UNAIDS/UNFPA/UNIFEM, 2004; Anglewicz et al, 2010). Women cohabiting in polygamous marriages are considered to be particularly vulnerable to HIV infection (NAC, 1999, 2003; WLSA, 2005).

Linda Tawik and Susan C. Watkins (2006) examined texts produced within multinational aid agencies and local aid agencies in Lilongwe about women's social status in Malawi and their agency (or lack of it) and compared it with their study conducted among rural populations in Malawi. Their informants in the rural South did not see themselves as 'powerless and passionless' (2006: 1099) as depicted by aid agencies. Tawik and Watkins recommend that more attention should be paid to the interpretation of social status and agency of the women themselves in order to make a successful HIV prevention policy and I will add that a better understanding of marital communications is necessary.

Epidemiologists have stated that further investigation is needed to explore why HIV prevalence is much higher among ever married women than unmarried women. Some of the areas that need further examination is to explore the life trajectories of the women who are HIV infected and are married, widows or divorced (Boileau *et al*, 2009). There is a strong correlation between widowhood and HIV infection since death of spouse may be traced to AIDS. HIV prevalence may be higher among divorced women since separation may be brought on by the infidelity or other risky behaviour of the partner. It is important to take this into consideration when

discussing increased risk of getting HIV infected when married. I will suggest that married women do take active measures to preserve their own health within the culturally acceptable framework they live in.

7.2 'Good woman / Good man'

I had read extensively about gender relations and women's social status in Malawi upon arrival. Much of this discussion emphasises the underlying gender-inequality in Malawian society, not only in relation to the HIV pandemic but also in general discussion. In much of the literature women are considered to be victims of male dominated culture with no agency themselves. This view of Malawian women can be summed up with Paul Sturges' (1998: 199) words:

> The role of the Malawian woman has traditionally been one of subservience to the man. She is regarded as his sexual servant, spending hours in youth preparing her genitals for his particular delight, culturally conditioned to grant sexual access whether particularly willing or not. […] In traditional communities a woman will still not presume to meet the eye of a man in discussion and will still often greet a caller at her home in a semi-kneeling crouch of obedience.

This view is echoed in HIV policy papers as well as in national newspapers. In an article in *The Nati*on (26th of February, 2007: 18) it is maintained that:

> Women's vulnerability to HIV infection is a gender issue because the structure of many of our societies strongly limits the capacity and role of women in decision-making towards issues that affect their own sexual bodies. Women frequently lack information on access to HIV-prevention measures and to health care as to support and give medication after infection.

In the first interviews I conducted in Malawi, we did not talk about HIV or AIDS explicitly. I wanted to get to know the women and allow them to know me. In the beginning we mostly discussed their marital relationships and daily life. I found it interesting that in all the interviews the notion of a 'good woman' and 'good man'

was brought up. It surprised me to find how consistent women's responses were when asked what they considered appropriate behaviour of women and men. Much of the answers' resonated, to my ears, what Sturges described. All the women mentioned that in order to be a good woman one has to be respectful. According to my informants, a respectful woman welcomes her husband when he comes home, carries his things, makes good food, takes good care of the house and children and is courteous. She has to dress well; wear clothes that are not revealing, 'be charitable' and not 'selfish', to greet everyone nicely and share her things with others and not to demand too much money from her husband. June, who is a mother of three children and has been happily married to her husband for twelve years, phrased it like this:

> If you force your husband saying 'I want new clothes, I want new cloth...I want new shoes' and maybe force your husband to buy things and maybe he doesn't have the money. And you say, 'If you don't have money, I will go back to my parent's house'. That is not good. It is better to listen to your husband and respect him. And if your husband is coming home, it is good to take the water and put in the bathroom before your husband wants to take a shower. And cooking *nsima* [Malawian stable food], a very good *nsima*. And putting on the table and give to your husband. That is a good woman who behaves like this.

Further, I asked a group of women of diverse ages, what they perceived to be a good woman. They came up with a long and very thorough list, from how to behave to physical appearance. The first issue of many was that: 'A good woman remembers that her husband is her boss and it is not good to answer him back if fighting'. This statement generated some discussions and they admitted that it was sometimes hard to control the urge, but one should try as much as possible. The list of how a good man behaves was much shorter and consisted more of things good men don't do. Primarily, a good man does not get drunk. Notoriously, drunken men are not trustworthy since they are prone to spend money on bar girls or prostitutes, and can get temperamental and violent. There was a general agreement that a good man helps his wife with the household chores but that it would be embarrassing for both partners if others witnessed that as they stated: 'A woman should cook for her husband, in

particular if there are visitors; because otherwise people might think that the wife is giving her husband love me'. As mentioned in the previous chapter, love me or love poison is a traditional medicine which has the effect of making the partner, of the person who consumes the medicine, fall blindly in love. The women in the focus group were convinced that no man would humiliate himself by doing housework unless he had been charmed by his wife.

When discussing the same topic in a focus group which consisted of men; their list was short and to the point. Their description of a good woman was to be respectful, physically beautiful, to behave courteously, to dress fairly and lastly to always remember *kusunga mwambo* or as the meaning was translated to me: 'not to take the problems within the marriage outside of the house'. In agreement to most of the women informants, the men's focus group concluded that a good man does not drink beer or smoke and should be financially responsible.

7.2.1 In Praxis

After the first round of interviews I was quite confused. I was particularly puzzled that women regarded their husband as their boss and more bewildering still, they repeatedly told me stories of how well they treated their husbands and laughed at other women who complained if their husbands showed them roughness. Ribohn (2002) recounts the same reflections while contemplating why Malawian women don't put more effort in pursuing better social status. After some speculations, Ribohn concludes that women's positions are reinforced by the respect and status they achieve from other people if they behave according to local value standards and therefore gain higher social status within the community. With much emphasis on women's rights it has often been neglected to look at the socio-cultural setting. In general there is much hierarchy in Malawian society and to focus on women's behaviour towards men regardless of wider social interaction is too simplistic. It should not be forgotten that there are influential factors other than gender that shape a person's social status such as race, education, age and economic means.

In all societies people behave according to what is perceived as socially acceptable behaviour and as Ribohn (2002: 176) views it: '[…] ordinary Malawians continue to pursue elusive dignity and respect through culturally salient notions of what it entails to be a good man and a good woman'. That being said, it is important to bear in mind that even though there is a common notion of what good women and good men constitute of, lived realities are more complex and people do not adhere to these ideals at all times. It is important to take socio cultural factors into an account when discussing HIV transmission within marriages since this will reveal different manifestations of strategies women apply to protect themselves from HIV (Schatz, 2005; Anglewicz *et al*, 2010).

7.3 Trust in Relationships

There is common agreement that a good man does not initiate sexual relationships outside of the marriage. But at the same time there is a relative understanding of men not being able to 'control nature' and fall into temptation if they reside for work away from home for longer periods. This did not come up as a problem in the interviews I took, but most women implied that extra marital affairs under these circumstances were understandable, and the same applied for women according to some informants. However, having an affair in the nearest surroundings of the family's home was considered to be highly inappropriate. It is common to hear that rich men have many girlfriends. Apparently, it is also risky to marry a man who is prone to drinking because drunken men are known to 'make mistakes' with other women. Men who can afford buying drinks at a bar, are likely to spend money on prostitutes and 'bar girls'. When asking young women if they would like to marry a wealthy man, a common response was that they would not like to do so, but rather marry a 'medium' rich man to avoid this problem. As to the economic situation of the husband, older women stressed the importance of maintaining good relations in a marriage at any cost, like this excerpt shows:

> If you are married, it is better to make good relationship between you and your husband. Because some men here in Malawi, if they have gotten some money,

> they go outside and make a relationship with new women and sometimes they forget about the housewife. So maybe it is better to make good relationship, so a good man does not go away. The man who has money, maybe he says 'no I don't want to eat here' and take the money and do something outside. If the man has finishing he will come back to you. So it is better if your man has got money you should make the relationship good, no money – make the relationship good.

Bignami-Van Assche *et al* (2007) report interesting findings from Malawi. Over two thousand people were asked to assess the likelihood of themselves being HIV positive and subsequently tested for HIV. Results were quite surprising, but 88 per cent of the participants who incorrectly estimated their status, thought they were HIV infected when not. Women were more likely to incorrectly think they were HIV positive then men. This is thought to stem from women not being able to estimate their HIV status from their own behaviour, being insecure of their husbands' faithfulness and therefore estimating themselves to be in a greater risk.

HIV prevention programmes have concentrated their efforts on encouraging condom use, fidelity or abstinence. These recommendations are not practical for married women. Abstinence is not a viable option (unless temporarily, like postpartum abstinence) and faithfulness has to be practiced by both partners in the relationship to be an effective prevention against HIV infection. Emphasis on condom use within marriages has not been successful, since it is largely rejected by both women and men, even by those who consider themselves at risk of becoming infected (Tawik and Susan, 2006; Schatz, 2005; Tawory and Swidler, 2009). Studies of attitudes towards condom use clearly show that using condoms is not appropriate in long term relationship, since condoms are associated with risky behaviour. Tawory and Swidler (2009: 181) suggest that use 'of a condom relegates a relationship to an inferior status' and is therefore avoided within marriages, but recent studies imply that condom use is becoming more acceptable when having casual sexual relations with what is considered risky partners, like prostitutes (Tawory and Swidler, 2009). Therefore, resistance to condom use within marriages is a result of culturally

contextualized meanings of condoms rather than women's lack of empowerment (Schatz, 2005).

7.4 Socially Acceptable Strategies

Few of the women I spoke to, admitted to having a husband who had committed adultery. Most of them did not respond assertively but rather implied that they did not know, since they had never caught them in the act. When pressed, most of them did not expect them to do so, but nonchalantly said they could never be sure. Influenced by Enid Schatz's (2005) study, I explored what women said they would do if they found out their husband was unfaithful to them. Schatz conducted both qualitative and quantitative studies in the northern and southern parts of Malawi and found that women employ four different strategies to influence their husband's behaviour if he is unfaithful. Those are firstly to sit and discuss with their husband, secondly to involve their family counsellors, thirdly to confront the mistress of their husband and lastly to initiate divorce. Her findings concur with much of the responses the women in Karombo gave.

Zulu and Chepngeno (2003) found that marital discussions about the risk of contracting HIV were more common in areas where mixed kinships and linage systems coexist. When speaking of unfaithful husbands with the women in Karombo, they always put it into the context of increased danger of becoming HIV infected and stressed the importance of having good communication with the husband. In order to persuade their husbands to better their behaviour I was told that it was important to make 'good conversations' and 'not to shout at your husband like he is a kid' when wanting to discuss serious things. Finding the right time to initiate these conversations is important and to bring the husband's attention to the fact that his behaviour can be dangerous to their health.

> It is good to talk to him. Maybe after eating you can discuss 'oh my husband, now you are becoming rich, take care for yourself, don't make any relationship outside with some girls. You know it is positive [AIDS] outside, and maybe

Figure 12: A drawing by Geoffrey, James and Morry; stressing the importance of good communication between husband and wife.

you can take it and give it to me and the children. My parents are old now'. So that is what you can say to your husband. (Respondent, 22 year old divorced woman.)

Zulu (2003) reports that most conversations about how infidelity can cause both partners to get infected with HIV is initiated by women. However, I sensed that 'telling a good story' was a desirably quality found in boyfriends. Some young men told me that they liked to discuss the 'ways of life' with their girlfriends to bring them closer and to better their relationship. A young man explained this:

> R: What stories I tell her? Chatting, telling in this life you should not do this, this, this, or go this way but you should do this and that. That way we can stay together for a long long time. Maybe like an old man, walking with a walking stick.
>
> I:And what is it that you tell her that she should not do?
>
> R: I do tell her, because of this disease. Like not to go around for boys and such and such. Something like it is OK to go and chat with her friends if she wants to do that, she can do that but with no boys. Don't go with them and make sex. That is not good. Don't trust much the men, and don't go around. If you do, use your condom, so you can keep your life. And she says 'that is a good plan and all, but you know what? I love you so I can't go around and have sex with someone else'. So I say 'ahhh, that is nice'.

Strategic methods to impose one‘s will upon a partner can have different manifestations. Sitting around and sulking could be interpreted as the act of a person that has no good options, so I was surprised to hear women stating that should you suspect your husband of having an affair, the best strategy would be to give him the ‘silent treatment’ as this married woman described it:

> You should just stay in your house. Because if your husband is making something you should stay in the house [making a sad expression] and then your husband will think ‘oh why is my wife not asking where I’m going?’
> I: So if you don’t ask your husband, he will leave the other woman?
> R: Yes, yes, if you don’t go there and go shouting and doing this, then your husband will be [wondering], what is wrong with my wife? Maybe it is better to stay with her and go back to her.

There are other ways women employ to force an unfaithful husband to listen. I read a short story in a Malawian newspaper about a woman who was worried that her unfaithful husband would bring AIDS to their home. After she had unsuccessfully tried to talk him into better ways, she made up songs about her husband and the mistress and about the risk of him contracting HIV, which in turn could transmit to herself. I asked several women if they had heard of this strategy, which they all had.

> ‘Yes, it is very good, then the husband can really hear you. He will not want all the people to hear the song. So yes. It is very good to sing. Like when you are making *nsima* and he is just sitting.’ (Respondent woman in her thirties)

One woman told me that it was very easy to control unfaithful men. A special medication from the *sing’anga* would do the trick she claimed:

> You just have to watch your husband very well. And follow him to see when he is going to the house of the woman. Then you take the medicine from your *chitenje* [a cloth women were around their waist] and the medicine is like a small wooden stick. Then you wait…and prrik…you break the stick. Then the husband can do nothing in the house and the woman is just laughing at him. He will then come back to the house of his family.

Apparently, breaking the wooden stick from the *sing'anga* will make the husband incapable of having an erection. When asking other women if they had come across this particular medicine many replied that they had heard about it but did not believe it worked.

Even though some traditional values concerning marriages have been undermined in modern times, the extended family still serves as a foundation for the nuclear family. In Chimbiri's view (2007: 1112), the extended family has lost their value with intermarriages becoming more common; however I still find that the extended family plays an important role in the marital relationship for most couples. The family elders, most commonly the maternal uncles serve as consultants in family disputes. I was frequently told that if a couple's discussion about the importance of fidelity would not influence the husband's behaviour, the traditional marriage counsellors would be called to settle the case. June explained to me:

> When you have problems, it is important to take it to your big parents [marriage counsellors]. Don't go running and shouting all your problems to your friends because they don't know how to solve the problem and just tell you to do something. The old people have been here long and know what is best to do and make it OK.

With the HIV epidemic, the extended families' role has increasingly revolved around taking care of orphans. A lady, who claims she is too old to remember her age, told me; 'some people just remain (become) orphans, the old ones like me have to take care of them and we are suffering. So I am always talking to the children, be afraid of the girls and be afraid of the boys'. Another lady in her early seventies is taking care of the children of her deceased brother and her sister. When discussing the issue she told me quiet harshly 'I'm tired of talking of those with the disease. I do not feel sorry for them. What about us? What about us, who have to stay here with all the children and suffer? With no help'. The alarmingly high number of orphans in Malawi has put an overwhelming burden on many extended families in Malawi, and as a result child-headed households and child labour has increased (Munthali *et al*, 2004). The

situation is especially grave in Mangochi District, as stated in the *MDHS* (NSO, 2004: 11), where children are least likely to live with both parents. Instead of talking directly about the husband's unfaithfulness, some women mentioned that they would talk to their husband about how important it was for them to be healthy and alive to take care of their children.

If both partners are not HIV infected when married and they remain faithful to each other, marriage can provide a very good protection against HIV. The consequences of being diagnosed with AIDS are very real to the people of Karombo and women are aware that unfaithful husbands put them at risk of becoming HIV infected. To decrease the chances of becoming infected through husbands' infidelity, women try to influence their husbands' behaviour by appealing to the notions of how good men behave. It is intriguing when reviewing HIV policies, that there is no mention of married women contracting HIV by having extra marital affairs. Culturally it is much less accepted for women to have an extramarital affair than men, but studies indicate that it is not that uncommon and is even socially acceptable under certain circumstances such as if the husband is wasting money on beer or other sexual partners (Tawik and Watkins, 2006). Tawik and Watkins find that women in Malawi do not only engage in extra marital affairs because of poverty but also 'by aspirations for a higher standard of living, by love and lust, and by revenge for a husband's infidelity' (2006: 1098). HIV prevention programmes' emphasis on perceiving women as without sexual agency of their own is interesting and would be worth exploring further.

7.4.1 Other Strategies

As discussed previously, good women respect their husbands and avoid arguments with them. The strategies described here are in line with culturally salient notions of how gender communications should be. But with the devastating effects AIDS can have on families, social justifications for drastic actions have become more acceptable. Public display of anger is rare in Malawi but some women claimed that should they suspect their husband of infidelity, they would confront him when he was

with his mistress and beat the husband or the mistress or even both. Some said they would beat the mistress to teach her and all other possibly interested women to leave their husband alone, others claimed they would punish their husband for his wrong doing. A determined woman in her forties explained this to me:

> I: Has your husband had another girlfriend?
> R: I don't know. I have never heard it. Maybe because they keep it as a secret. But if I would hear it, it is not good to ask. I would just look after him when he goes to the girl. I would follow him quietly at the house – and if you see him – I would punch him! [laughing]. And then I would go to the girl and beat her. Go to my house, take the clothes and leave him.

Others expressed longing to punish their husband physically should they catch him with another woman but would not do so because of the risk of humiliation.

> You should just stay in your house because the other woman can be selfish and say 'who are you? You are not ok, why your husband left you, I think there is something wrong with you. Maybe you have something wrong in your vagina' [laughing a lot]. So maybe it is not good to make a follow up. You should just stay in your house.

In accordance with Schatz (2005) findings, both women and men find infidelity to be a justification for divorce should all attempts to restore the marital relationship fail. In a survey conducted by Zulu and Chepngeno (2003) a great majority of respondents thought divorce not to be appropriate should a partner be diagnosed with HIV, but in the same survey both men and women justified divorce if a partner is unfaithful. Since most marriages in Malawi are traditional marriages, divorces are relatively easy to obtain, in particular in the Central and Southern region where bride wealth is not paid (Reniers, 2003). Studies indicate that divorce rates in Malawi have increased over the years, and some suggest, that divorce can be viewed as a tool of empowerment Malawian women employ in order to protect themselves against HIV (Schatz, 2005; Zulu and Chepngeno, 2003; Reniers, 2003).

7.5 Polygamy

All marriages that I know of in Karombo are monogamous[52]. Polygamy is known in Malawi, particularly in the Northern District but is most common in Mangochi District[53], whereby 24 per cent of all marriages consist of either one or two co-wives (NSO, 2004: 95). The practice of polygamy has been associated by many with high HIV prevalence rates and thought to be a harmful cultural practice which serves as a barrier for HIV prevention (NAC, 2003; Dzimnenani, 2007; Kondowe, 1999). In a report published by UNESCO/UNAIDS named *A Cultural Approach to HIV/AIDS Prevention and Care: Malawi's Experience* the authors rationalize that polygamy is a practice which is believed to curb infidelity because the man has more than one wife and so would see no reason not to go out with other women (Kondowe, 1999). I do not know on what evidence this assumption is based, but as Gausset (2001: 512) claims, polygamy does not put partners in more risk of attracting HIV than monogamous marriages if all partners are faithful. But in Karombo, polygamous marriages are considered to pose a threat to women, not due to HIV but because of witchcraft. Even though polygamous marriages were unknown in the village at the time I stayed there, the considerable high number of Muslim men in the area means that women can expect them to take a second wife. All the women expressed strong opposition to polygamous marriages. Muslim women admitted to me that they could not prevent their husbands from taking a second wife but they said they would do anything to avoid that from happening. The biggest obstacle they stated in cohabiting with a second wife was their fear of witchcraft. Belief in witchcraft is common in Malawi across all religious groups[54]. The fear of being bewitched by a new wife in

[52] Although as discussed earlier, many of the informal marriages between local women and migrant workers are in praxis polygamous since the migrant workers often have wives in their home residence.

[53] The southern part of Mangochi District is mainly inhabited by Muslims, which explains the high percentage of polygamy in the District. Chewa people are more numerous in the northern part of the District.

[54] An illustrative example is the on-going revision of the Witchcraft Act. As stated in the Witchcraft Act Review Programme (2009) by the Malawi Law Commission, there is a conflicting interest between international law, Malawi current law and local understanding of witchcraft: This legislation was enacted on 12th May 1911 with the aim of eradicating what the colonialists referred to dangerous practices such as trial by ordeal, the use of charms and witchcraft itself. The Act assumes that witchcraft does not exist. […]However it has been argued that most Malawians believe that

the household is very real or as June, a Christian woman in her thirties, married to a Muslim, puts it:

> If the husband says he wants to take another woman, you can say 'no problem' and then just take your clothes and leave the house. The problem, is that sometimes you can make problems with the new wife. And also there is the problem of being positive, HIV. You don't know the woman and how many men she has been with. So it is better to let your husband go to be with her.

So, do you really prefer to be alone rather than living with your husband and the new wife? I asked. She responded:

> If my husband takes a new woman, he is taking a full change. It is like you when you have a new dress, you also like the new dress. So you will forget about the old one, so I think it is better to be not to stay with the husband if he likes a new wife. And maybe to solve this you can say to your husband, 'maybe it is better for this women to go back to her parents because nowadays it is dangerous to this new lady can take the medicine and kill me'.

When I asked her if she referred to witchcraft by talking about medicine she said:

> Aha. Eeee. Yes. Like maybe put smoke in the house and she is calling 'my husband, come here'. She will do this to kill the other woman.

Flora, a young Muslim girl, shares June's opinion and states that polygamy is mainly a tradition that benefits men and that she would not accept her future husband to take another wife:

> There is another medicine that the woman make, that you put in the food or in a bucket of water to kill this lady so the second lady will be number one. So if the

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witchdoctors are experts on witchcraft and that they alone are the ones who can protect people from the ills of the practice (2009: 6-7). 'The revision of the law, hopes to address the short falls that the legal regime on witchcraft in Malawi has' (2009: 21). While staying in Karombo, a case of witchcraft came up, which the Monkey Bay police took very seriously and conducted interrogation of all involved parties. In the end, the accused witch was not charged.

> first one goes and says she wants to have sex with the man, he will just be shouting and tell her to go. I would rather be alone than share my husband. It is too dangerous nowadays.

It is interesting that women talk of the danger of having another woman in the house, and phrase it the same way as when speaking of AIDS as 'the danger of nowadays'. June, mentioned that the hypothetical new wife could be an HIV carrier and at the same time, worries she might poison her. It is interesting to compare the effects of witchcraft, AIDS and *mdulo*. All – in theory at least – have similar affects on people, they 'loose weight, have pale skin and hair that has lost its texture' (Munthali *et al*, 2004: 26).

7.6 Domestic Violence

It has been suggested that there is a link between domestic violence and women's vulnerability to HIV infection (Dunkle *et al*, 2004; Kathewera-Banda *et al*, 2005). UNAIDS (2008: 69) estimates that fighting against gender based violence is one of five milestones needed to reduce gender inequality and subdue HIV infections, since it is reported that women living in the fear of violence at home might not be willing to disclose their HIV status, are afraid to go for HIV testing if the partner doesn't allow it, and complicate negotiation of condom use. UNAIDS (2008: 72) further claims that sexual violence often accompanies domestic violence and could therefore increase the likelihood of women becoming HIV infected if the partner has HIV.

Questions about domestic violence[55] were included in the *MDHS* (NSO: 2004: 265) for the first time in 2004. It is stated in the report that 'in traditional Malawian culture, wife battering is regarded normal'. The study showed that 20 per cent of women who were married, or had ever been married women, had at some point experienced violence from their partner since the age of 15. About a third of these women reported it had happened once or twice in their lifetime. Roughly two thirds of the women questioned had never been abused (NSO, 2004: 274).

Domestic violence was not brought up in the interviews as a problem *per se*, but when I asked the women's focus group to explain *kusunga mwambo* (which was translated to me as 'don't take your marital problems outside of the house'), I got this explanation:

> It is like, if the husband beats the wife she cannot tell her friends and family about it unless she calls the uncle [marriage counsellors] to talk to the husband. When the man is beating the wife she just has to bend down and say 'sorry, sorry, sorry'. And if the friends ask the day after, you can say you just walked on something. You see? It is not good to take the problems outside of the house [Laughing while giving the answer].

Evaluating the ethnographic material I gathered in Karombo, I notice that people speak freely of domestic violence. It is somewhat frowned upon, but at the same time, both men and women defend domestic violence as justifiable under certain circumstances. [1] Interestingly, no one could give me an example of 'real' reason for a husband to beat his wife. When having a conversation with young man about how a good man treats his wife he explained to me that:

> R: Before marrying, the big people tell me how to behave. Like respect my wife, don't take beer and don't beat my wife. But sometimes I can beat her but for a real reason. Not just going like 'ahh...where have you been?' And she says she was just chatting...then you cannot just start the beating. That is no good. We need to respect each other, then we can have a good relationship. So this is what the people in the village are saying, things like that.
>
> I: But what is a real reason for beating your wife?
>
> R: Actually, she is making a big mistake for you. Doing something that is really bad for you. Then you can say 'see my wife' and than you can beat her so she has to listen and not do it again.

The Demographic Heath Survey Team (DHS) (Kishor *et al*, 2004) showed that domestic violence is highly correlated with a husband's drunkenness and controlling behaviours. The study team proposes that the correlation between domestic violence and HIV infections might need further examination since their report *Profiling Domestic Violence: A Multi-Country Study*, did not find that domestic violence consistently elevated women's risk of being infected. It is difficult to estimate the correlation between domestic violence and HIV infection of women and Watkins (Forthcoming) warns against generalizing on the relationship between the two without further research.

During my stay in Malawi, there was an extensive campaign going on against domestic violence following the act passed in 2006, known as 'Protection against (Prevention of) Domestic Violence Act 5' (UNDP, 2008c: 174). Posters in towns and stickers on cars were very visible, stating that 'real men, don't beat women' and Oxfam sponsored awareness campaigns in radio as well as meetings with MP's involved in the issue, Chiefs and other influential people (Green, 2009). This Act was forced through parliament by the former Minister of Gender, Honourable Joyce Banda[56] who also actively brought this issue to public awareness. This act had many opponents in the parliament who were 'accusing the bill's supporters of attacking Malawi's culture' (Green, 2009). It is to no surprise that some MP's would view this law as going against traditional culture, as Ulrika's Ribohn (2002) demonstrates in the chapter 'Human Rights and the Multiparty System Have Swallowed our Traditions: Conceiving Women and Culture in the new Malawi'. Ribohn traces how international human rights and culture have been presented as dichotomies by Malawian politicians, with the former ruling party UDF 'intent to liberate Malawi from culture' (2002: 168) in order to enhance human rights and gender equality. The ruling party DPP is even more progressive. Ribohn detects tension between the two discourses on human rights and on culture, since many Malawians regard traditional values as the core of their society. In her view 'implementation of human rights

[56] Currently the Vice President of Malawi.

becomes a double edged sword as long as human rights have Western connotations and are introduced in contrast to local cultural values' (2002: 177).

I witnessed an interesting example of how people take on different positions regarding western notion of gender equality and cultural norms, depending of the situational context they find themselves in, while walking with my friend Lisa one afternoon in the village. I wrote this down in my diary on the 15th of May 2007:

> Today, Lisa confided in me why she separated with her husband for a short time. She explained to me that at the time her husband had temporary work, but had spent most of the money on beer. She had not been happy with his arrangements but hadn't complained to him – until he had beaten her several times while drunk and she decided to leave him. She told me 'You know, nowadays we have gender' (equality). 'I didn't want to stay with him anymore, because I don't know if he would kill me the next time'. Lisa confidently went on explaining to me that 'the government is now doing gender' and how much difference it has made for women in Malawi. On our walk, we passed by a middle age man kneeling down in a stream of water, washing clothes. We both greeted him in Chichewa and the man replied and then Lisa added something, which I didn't understand, but I could detect from the man's facial expressions that he didn't appreciate her comment even though she was laughing. Later I asked her what she had said to the man. 'I asked him if his wife was dead' she replied in a mocking way – 'why would he otherwise be doing the washing himself?'

My friend Lisa, was pleased with the government for bringing domestic violence in to public discourse, probably because of her own experience living with a violent man. At the same time, Lisa adheres strongly to traditional gender roles and bluntly makes fun of men who do house chores. Without diminishing the problem of domestic violence, the figures from *MDHS* (NSO, 2004) show that domestic violence could

hardly be described as a culturally accepted norm in marital relationships in Malawi. Whether married women are in increased danger of getting infected by their husbands if also victims of gender based violence, is hard to tell. If a husband is HIV positive, the likelihood of his wife getting infected as well is quite high, irrelevant of her being a victim of domestic violence or not. Malawian rural women do have considerable agency in initiating divorce if they strongly disagree with their partner's behaviour and 'unjustified' violence is one of the reasons my informants in Malawi mentioned as a reason for demanding divorce (see also Schatz, 2005).

7.7 Summary

In order to have an understanding of how women in Karombo respond to the danger of HIV infection, an understanding of gender relations and gender communication is necessary. The likelihood of getting HIV infected is considerably higher among married women (Anglewicz *et al*, 2010; Watkins, Forthcoming), but the ABC prevention method does not provide married people with realistic strategies to protect themselves against HIV infection. The Karombo women's suggestion of possible strategic actions indicates that people are developing their own couple-level protection strategies. In a preventative response to the risk of becoming infected with this fatal disease, AIDS, women are actively challenging and confronting local gender norms. Discussions within the marriage of the increased danger of getting infected with HIV if engaging in extra marital affairs and stressing the importance of both parents being healthy to take care of their family are the first measures women employ; should that not be effective, interventions from the martial counsellors are sought or divorce is initiated. Anxiety of being physically abused by a husband was not mentioned in this context in the interviews in Karombo. These strategies may not have immediate effect or provide total protection against HIV within a marriage, but they are the applied methods available in a particular cultural context. Schatz (2005) concludes by stating that women in Southern Malawi:

> spoke boldly about strategies they would (and have) employ(ed) to protect themselves from HIV/AIDS. Their boldness was sometimes undercut by

contradictions, moments when they vacillated about these strategies, their ability to enact them, or the futility of even trying; yet, many told stories of their own or others' actions.

As a last thought, it is interesting to wonder why women are often labelled as 'particularly vulnerable' in HIV policy papers. What is we take Anglewicz *et al* (2010) seriously? They find that 7.1 per cent of married men are HIV infected and 5.6 per cent of married women. Would it then be more accurate to think of men as vulnerable?

8. Voluntary HIV testing and counselling

8.1. Personal service

It is essential to bear in mind that cultural factors shape people's behaviour, knowledge and choices and it is therefore important to adapt HIV programs to local situations (Castle, 2003; Chimbiri, 2007; Kaler, 2003; Campbell, 2003; Lwanda, 2002; Schoeph, 2004a). Voluntary Counselling and Testing (VCT) clinics evolved out of the need to combine HIV prevention with promoting people to go for HIV testing. There are several types of VCT services but the most common is when counselling and testing is integrated with other health care services (UNAIDS, 2001). The VCT's purpose is to inform people about HIV and enable individuals / couples to make an informed decision whether they want to know their HIV status. When the test results are known, counselling is offered. That way the VCT counselling contributes to prevention for people who are found not to be infected; in case the person is infected by the HIV virus she / he is given advice about how to live with the virus, e.g. regarding nutrition and family planning. VCT emphasizes confidentiality and respects people's choice (Baggaley, 2001).

VCT centres are thought to have shown good results in Africa and are one of the main tools in the fight against the HIV epidemic (UNAIDS, 2004). The VCT settings within Africa or within a given country can vary substantially even though the idea remains the same; to test people and provide counselling. Among the things that can vary are whether test results are ready the same day or within a week, how much emphasis is put on confidentiality, whether the counselling is done privately or in a group, the experience and education of the counsellors and whether the VCT is a part of an antenatal care unit to (UNAIDS, 2004). Not surprisingly, lack of financial recourses in health care settings puts strains on many of the VCT centres in sub Saharan Africa. Ideally, the VCT has many positive effects such the counselling being personal and interactive and it also supports open dialogue about the transmission of HIV (UNAIDS, 2001:13). However, it is difficult to measure some of the effects of the counselling such as changed attitudes towards sexual behaviour. The

efficiency of the VCT relies much on the counsellors. Their role is to be aware of people's different situations and cultural views and to bring about the best way to convey how one can avoid HIV or to live with the virus. In a way, the VCT centres are *glocal* phenomena in the sense that the settings are found globally but work within a local context.

8.2 VCT clinics in Malawi

The accessibility of VCT clinics nationwide in Malawi is a relatively recent development. In 1995 a non-governmental organization, Malawi Aids Counselling and Resource Organization (MACRO) introduced the first VCT sites in Lilongwe and Blantyre, the two largest cities of Malawi. Another clinic was opened in 1999 at the Bottom Hospital[57] in Lilongwe, called the Lighthouse. The clinic received people from the capital city and surrounding communities and is still one of the busiest centres (Mwale, 2006: 15). From the beginning these VCT centres attracted quite a lot of people but in 2000 the number of patients multiplied when whole-blood rapid HIV tests were offered. These rapid tests show the HIV result in a matter of minutes instead of patients having to wait for a few weeks to get their result (USAID, 2002).

In 2000, the GoM committed itself to expand VCT sites country-wide and with financial support and provision of locales from various NGO's and other donor agencies; VCT is now offered widely around the country (Yoder and Matinga, 2004). To obtain an understanding of how much the VCT centres have grown for the last few years, the manager of the Lighthouse clinic explained that in the 2001, they received one thousand people monthly, but since the antiretroviral medication was made available in 2004, over 4000 patients come every month and they had to add buildings to the site. Same results have been evident worldwide, where there has been a dramatic increase in HIV testing if medication is provided since many do not see the purpose of knowing their HIV status if nothing can be done (Irwin *et al*, 2003: 60-67).

[57] Now called Bwaila Hospital.

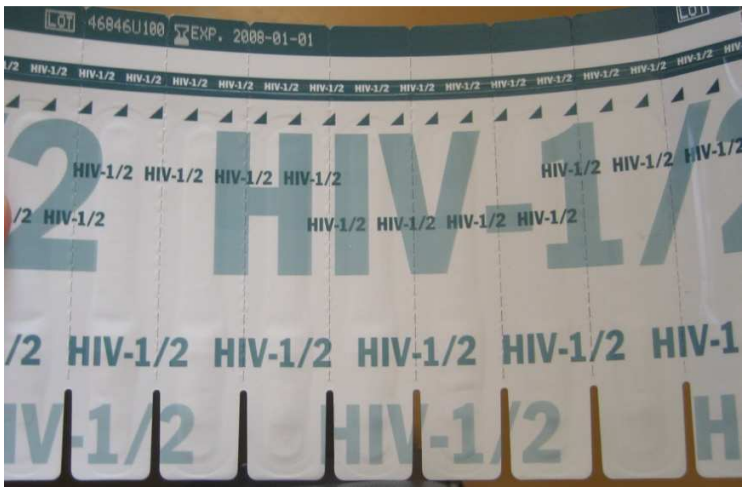


Figure 13: HIV Rapid Test. A drop of blood is put on the strip and the result is ready within 5 min.

In conversations with various people I detected that it was common to hear people thank the Malawian government for the ARV medications, while it is provided by various donor agencies in Malawi, in particular the Global Fund. When receiving ARV treatment, it is extremely important to adhere constantly to the treatment schedule since any disruption can cause drug-resistant strains of the HIV virus to emerge (Irwin *et al*, 2003: 75). Therefore, reports of the Global Fund not being able to disburse the ARV supplies needed, as a setback of the global crises[58], causes considerable concern. Already there are shortages of ARV treatments at various clinics funded by the Global Fund around the country, which Médécins Sans Frontières have been compensating for[59]. But fortunately the World Bank and PEPFAR have stepped in and pledged to raise their donation to Malawi (Hecker, 2009).

[58] The UNAIDS in co-operation with the World Bank and WHO released a Report in June 2009; *The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerability and Impact*, which published the outcome of a survey conducted in 71 countries. According to the report, one third of the respondent countries expected donors' withdrawal over the next years which would affect both availability of treatment and continuing HIV prevention campaigns.

[59] Eleven per cent of the UNAIDS participating countries reported that had already had setbacks in ARV treatments.

The people from Karombo village have various options if they want to go for HIV counselling and testing. Mangochi District is divided into five health zones, and Karombo is situated within the Monkey Bay Health Zone. There are five small governmentally run clinics within the Monkey Bay Health Zone approximately 30 km apart from each other. During my stay in the area, four of these clinics offered VCT; Nkope, Malembo, Nankumba and Monkey Bay Community Hospital (MBCH). Preparation to open VCT at privately run clinics and those run by Christian associations in the area was underway. Clinics run by the government do not take any visiting fee and medication is free, while privately run clinics charge for the same service.

8.3 VCT at Monkey Bay Community Hospital

My interest lay in Monkey Bay Community Hospital (MBCH) for two reasons, firstly because it is the nearest clinic to Karombo village and secondly because it is supported by ICEIDA. MBCH is situated on the outskirts of Monkey Bay township and serves about 110,000 people in the area. ICEIDA got involved with MBCH in 2000 and the hospital has grown substantially since then. New buildings have risen and service has been extended. Now MBCH consists of a general out-patient department (OPD)**,** an antenatal care unit, wards for in-patients (maternity, nursery, children, male, and female), a laboratory, an operational theatre, a mortuary and a facility for VCT and ARV medication for HIV patients. HIV tests were first available at MBCH in 2005 and ARV medication in 2006.

To my surprise, most of the people I spoke to in the Monkey Bay Area were familiar with the VCT service offered at the MBCH even though the service had only been open for less than two years when I first came to the area. General contentment was expressed that ARV medication was available at no cost, while a few claimed they had heard rumours that the ARV drugs were being distributed for free because they

were outdated[60]. However, few of the people I spoke to had personally visited the VCT, except for some women who had taken HIV test while attending antenatal service. A common response was that the service was very important for 'other' people and that they would use it themselves if they had reason to believe they were infected. This comment is in line with Mabunda's (2006) conclusions from rural South Africa, whereby she found that people hesitated to go for VCT unless they strongly suspected being found positive with HIV.

The VCT and ARV facility improved over the two years I spent observing the MBCH. When I arrived in February 2007 the HIV pre-counselling commonly took place under the shade of a tree in the back garden of the hospital since the assigned room for counselling was often occupied for some other function. Pre-counselling most commonly took place in a group early in the morning, and then people took their place and waited for testing and post-counselling. The testing took place one-on-one in a small room. Patients then waited either in a narrow and very crowded hall or in the garden outside for their results. They were given the HIV results and post-counselling in the same room, again one-on-one, except for couples. The whole process could take from one hour up to a few hours. In October 2007, a new building became available for the VCT as well as a treatment room for the ARV medication, a great improvement. In the new building people wait in a big reception room for their HIV testing and get counselling at the same time. The VCT's advertised opening time was from Mondays to Fridays from 7.30 am until 17.00 pm even though I observed that the actual opening hours were irregular. Tuesdays were hectic days at the VCT since that was when prospective mothers attended the antenatal care unit and they were strongly encouraged by health staff to go for HIV testing.

[60] Those who made these claims did not know people personally who were receiving ARV treatment. I did check the dates on the medicine on two different occasions and the dates showed the medication to be far from expired. These statements however could indicate that people are weary of public health centres.

8.4 The counsellors

While I conducted my research at the MBCH, 6 counsellors were working at the VCT unit, either one or two at the time, with 5 hours shifts normally changing during midday. The group of counsellors consisted of five women and one man, who all lived in the area. They have various professional backgrounds; two are health surveillance assistants (HSAs), two are nurses, one is a youth counsellor and one works as a laundry assistant at the hospital besides counselling. All of the counsellors had attended a six-week long training course in the former capital, Zomba, sponsored by ICEIDA. Being a counsellor at a VCT clinic is a highly demanding position. The workload is enormous and the success of the counselling depends of how qualified the counsellor is (MOHP, 2003: 13).

All of the six VCT counsellors at MBCH expressed general satisfaction with their job. The feeling of being able to help others was one of the first things they mentioned as a pleasant part of their job, especially after the ARV treatment was available. Interaction with different people, likeable co-workers and gratification for just having a job was also brought up. However, complaints of too much workload, low salaries and little chance of being upgraded to higher positions within the hospital were considered as negative aspects of the job. One of the counsellors was discontent with the low pay compared with the job description:

It is difficult not to get some allowances. [Working as a counsellor] is more responsibility and sometimes it is dangerous when you get very sick people from the ward and there is a danger you can prickle yourself and get infected. It is a dangerous job and you have to take care of yourself. But small allowances.

8.5 HIV counselling

The main advantage of VCT clinics is considered to be the combination of counselling with testing since the personal counselling provides a unique opportunity for the concerned person to have a one-on-one conversation with the counsellor and attend to whatever preoccupation she or he may have. At the same time, the VCT counsellor can address relevant cultural practises in the area, not in the attempt to

eliminate them but rather to encourage them being practiced more safely (MOHP, 2003: 12). VCT's counsellors therefore have the opportunity to fulfil Lwanda's (2004: 41) recommendation of HIV education in Malawi being culturally sensitive and, most importantly, have the educational message adapt to different circumstances in each locality.

In March 2007, I spent three weeks at the MBCH. This granted me the chance to hang around the hospital and especially the VCT unit for days on end, sit in on counselling sessions and testing room as well as to get to know the counsellors and other medical staff quite well. I was impressed how well the counsellors dealt with the pressure of having up to 30 people sitting outside waiting for their services. I also observed that Lwanda's ideas of culturally sensitive and locally centred HIV counselling is perhaps harder to gain in praxis than set forth in theory. Even though I did not understand what the counsellors were saying since it took place in Chichewa, I could clearly sense that many of the patients felt shy in these clinical settings and it must have been strange for them to have a white woman present while they were being informed whether they had HIV or not.

In the VCT sessions, it struck me that I could hardly ever tell by the body language if a person had been diagnosed HIV positive or not. The voice of the counsellor did not change, the counselling sessions did not take any longer and people usually did not ask a lot of questions, irrelevant of whether they had been diagnosed with HIV or not. The counsellor I spent the most time with initially wanted to translate into English what he was saying during the counselling session and then translate the patients' response, as the session developed. I did not feel comfortable with that arrangement since I felt it would affect the confidence between the counsellor and the patient and people would not express themselves as freely. But, most importantly, I understood that for those who were told they were HIV infected, this moment would stay in their memory for the rest of their lives. I was quite surprised that the counsellor did not view the situation in the same light.

Pre-counselling sessions took variable time, and sometimes due to time constraints they had to be shortened. I asked several counsellors what were the most important messages they had to convey during these sessions. According to them, firstly it is very important to familiarise the patients with the HIV testing kit, explain the testing procedures and how the results are obtained from the test kit. Secondly, they had to explain the difference between HIV and AIDS (and the various modes of infection). Thirdly, the counsellors had to talk about other STD's and their symptoms. Finally, they explained how to protect oneself from HIV infection. The counsellors seemed to me to be very professional during their pre-counselling sessions and the counselling was fairly standardized. During the counselling sessions I witnessed, there was not much interaction between counsellors and patients since visitors did not ask many questions.

8.6 Cultural practices and counselling

As has been discussed previously, NAC in Malawi has prioritized the discouragement of several harmful traditional practices. The counselling sessions would be an optimal place to address these practices should the counsellors see the need. I asked a counsellor what he thought were the main modes of HIV transmission in the area, to which he replied:

> R: The most important is to tell the people that they can get infected by sharp piercings, razor blades, unprotected sex, polygamy and initiation the Yao people do, and the *fisi*[61]. So you have to make risk assessment and then to decide how the people can make risk reduction.
>
> I: How can you do that?
>
> R: Like by using condom, abstaining from sex, always using new razor blades, avoiding blood transfusion and take care for the window period.

[61] A practice whereby a married woman has sex with another person in the hope of getting pregnant if their partner is sterile.

It is interesting that the respondent mentioned two cultural practices as a culprit of HIV transmission as well as polygamy but did not elaborate further on these issues. I do not know if our previous conversations about cultural practices in the area influenced his answer. It is truly important to use a new razor blade for each boy that undergoes circumcision in the Yao initiation ceremony. However, it is not as clear how the risk reduction strategies he suggested, i.e., new razor blades, abstinence and condom use, are pertinent considering *fisi* or polygamous marriages. This particular counsellor did not mention the importance of being faithful to one's partner. Should the topic be brought up, it might initiate fruitful conversations of how a person could react if they suspect a spouse to be unfaithful. It could also lead to conversations about postpartum abstinence.

Another counsellor I spoke to, appears to have forgotten his B's and C's in the ABC[62] since he bluntly told me that the advice he gave people attending VCT was 'I tell people not to engage in sexual activities'. This counsellor had received 16 pregnant women that same morning and I would have liked to hear their responses to his advice. The HIV personal counselling could be a good venue to address the concerns many people have of condoms being poisonous and hazardous to their health. Open discussion about the practice of *fisi* could also be beneficial, emphasising the importance of not having sexual relations with a person who does not know his HIV status.

[62] ABC is the most recognized HIV prevention slogan: A for Abstinence, B for be faitful and C for condom.

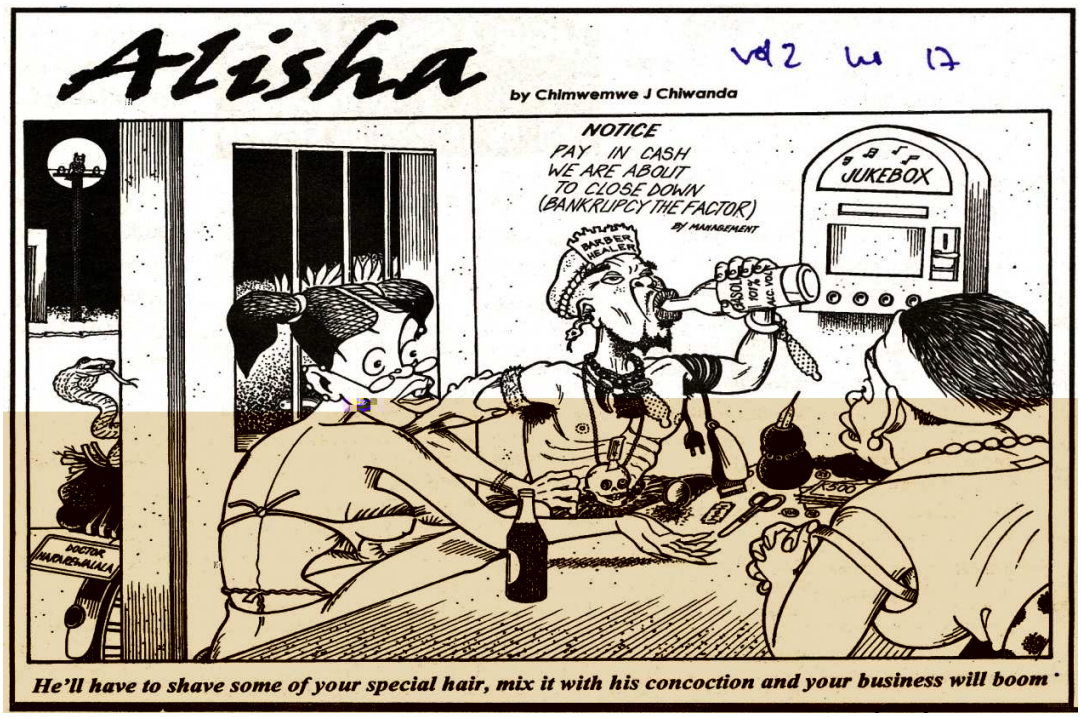


Figure 145: Comic showing a *sing'anga*, who has tied condoms on his body, from *The Nation* 29th of April 2007.

There is a multilayered system of knowledge regarding health and illnesses in Malawi, with western style health care clinics and different types of traditional doctors (*asing'anga*). These *asing'anga* have their specialities; some cure illnesses with help from ancestral spirits while others are equipped with tools that enable them to 'see inside the body' and detect what is wrong. Still others cure diseases with herbal remedies or can offer protection against witchcraft. According to Lwanda (2004) there is strong faith in traditional healing in Malawi irrespective of gender, age or class. Lwanda (2002) identified contradicting discourses concerning AIDS in 2002 when many traditional healers claimed they could cure AIDS with special medicines or cure it with witchcraft cleansing. However, this has changed dramatically with increased access to ARV medication at public health centres after 2004. Most people I spoke to were astonished to see the improvements of people with AIDS after receiving medical treatment. But on the other hand, certain distrust of the VCT clinics was sometimes reported. When having a conversation with a man at a temporary VCT centre in Nankwale, a neighbouring township of Monkey Bay, he commented

on how brave he had been to go for the testing since rumour had it that the counsellors took a whole bottle of blood when testing to 'use for different things'. Now, he said, he was going to correct this rumour.

8.7 Sexually transmitted diseases

The VCT counsellors at MBCH put much emphasis on speaking of other STD's during the counselling sessions. This emphasis is relevant since sexually transmitted infections increase the risk of contracting HIV infection (Rotchford *et al*, 2000; Fleming and Wasserheit, 1999). It is hard to come by recent statistics of STD's prevalence in Malawi but in the *Malawi Demographic Health Survey* (NSO, 2004: 207-8) respondents were asked if they had had any STD in the past 12 months or if they had experienced abnormal genital discharge or genital sores/ulcers[63]. Only one per cent of participants professed having been infected while eight per cent of women reported discomfort in the genital area and six per cent of the men asked. According to *MDHS*, men are three times more likely to rely on modern health care systems in case of illnesses than women who are more likely to seek treatment from traditional doctors.

The *MDHS* results do not concur with what I was told in Karombo village, where men repeatedly told me they would seek treatment from *asing'anga* in the case of acquiring STD, whereas women expressed more willingness to seek treatment at hospitals. On several occasions it was explained to me that *sing'anga* could not effectively treat AIDS and that one should not believe those who claimed to be able to do so, but that most *asing'anga* had very much experience in treating other STD's. A smiling young man in his early thirties explained:

> The difference was that you should go to the hospital if you have AIDS, but not if you have other STD's. If you go to the *sing'anga* if you have AIDS you are always just curing the side effects. Soon the doctor would be tired of you! If

[63] Which are common symptoms of STD's infections.

> you come today with headache and the next with diarrhoea...he will tell you to go to the hospital!

While there was an agreement on the efficiency of western medication in treating AIDS patients, the same did not go for other sexually transmitted diseases. I was told that it was cheaper to look for remedies from *asing'anga* than hospitals if experiencing any discomfort in the genital area, and that treatment provided by the hospital staff took longer time to work. I also got the feeling that *asing'anga* were preferred by some men because they asked fewer questions, as these two excerpts illustrate:

> At hospital you get more shy. Maybe there is a woman nurse who wants to see your penis and there are more people there. (Respondent: Unmarried man in his late twenties)

> At the hospital they ask you to bring your partner with you. But if you had sex in Blantyre, how are you going to get the girl? (Respondent: 31 year old man, married.)

When asking a group of young women if they knew some sexually transmitted diseases they named 'syphilis, gonorrhoea, HIV/ AIDS and wound in the vagina or like hole in the vagina'. I further asked what they would do if they experienced discomfort in their genital area and the women agreed that:

> Sometimes it is good to go to the hospital to see if you have AIDS. But if it is something else you can go to the *sing'anga* because he can catch the thing inside your vagina.

Judging from these responses, one would assume it was important that VCT counsellors addressed these issues while explaining the correlation between sexually transmitted infections and HIV[64] but as the manager of the Lighthouse clinic, stated;

[64] While I have no ability to estimate the effectiveness of traditional medicine, in my opinion, counsellors should initiate conversations about the topic.

Most people don't want to talk about seeking help from traditional doctors, to do so, people need to have a lot of confidence with the doctor. You need to talk to the *sing'anga* to change this.

8.8 Couple's counselling

Figure 15: 'Did you know that most couples that go for HIV testing are found negative? Poster found in Mangochi District.

It has been a widely reported problem that those who are diagnosed HIV positive, do not inform their spouse or partner (UNAIDS, 2001). When health care workers became aware of this problem, couple counselling was promoted (UNAIDS, 2001: 23). In the Malawian VCT guidelines it is declared that 'Partner disclosure and Couple counselling should be encouraged in all VCT sites' (MOHP, 2003: 9). Couple counselling at the VCT centres provides a good opportunity to address the problem of adjusting sexual behaviour if one or both of the individuals are positive, as well as to address childbearing issues, any misconceptions the couple may have about HIV/AIDS and discuss how to provide emotional support to each other (Chippindale and French, 2001). If both are found negative, the counselling is a good opportunity to open up a discussion about the importance of fidelity.

The counsellors at MBCH remarked that it was becoming more common for couples to come for HIV testing before getting married. However, according to them, most couples came to the VCT because either of them had been diagnosed HIV positive before. But the HIV campaigns promoting couple counselling are widely known and I frequently encountered people who recited the campaigns saying it was the right thing to do before getting married. If couple's counselling becomes an accepted part of the pre-marital process, I find it very likely this will be a very effective tool in the combat of HIV.

8.9 Women and VCT

It is commonly stated that HIV prevention programmes need to take special measures to have women participate in VCT settings and to take HIV tests. Women are said to be reluctant to go for testing because they are afraid their spouse will leave them if or he will abuse them physically (UNAIDS, 2001; UNAIDS, 2008; Gupta, 2002). Contrary to this perception, there are more women than men who go for the testing and counselling at MBCH. This is due to all pregnant women being encouraged to go for testing when attending the antenatal care unit. Or as one nurse phrased it: 'it is strictly speaking not compulsory to go for testing, but much recommended', with emphasis on much[65]. The counsellors agreed that it had been difficult to convince pregnant women in the beginning of the VCT's services to take the HIV test but that it became easier 'as they get used to it'. In the surrounding VCT centres, counsellors reported a similar progress, with all pregnant women now going for testing and counselling as part of the antenatal programme. The counsellors gave various reasons why women had been hesitant to go for testing. Most were of the opinion that people were in general afraid to go for the testing because they were 'thinking too deep', meaning worrying too much. They suspected that the expecting mothers were afraid to find that they had an incurable disease. Given that women tend to overestimate the likelihood of being HIV infected, it is likely the outcome must come as a great relief

[65] At the end of my stay in Malawi, I noticed that there was a new sign on the counselling room stating HTC (HIV Testing and Counselling) instead of VCT (Voluntary Counelling and Testing).

to those not infected. This also indicates that the success of VCT increases with the length of time it operates.

8.10 A view from the VCT waiting room

In June, or two months after my initial study period at MBCH ended, I decided to go to the hospital to spend the day in the waiting room among the patients. When I arrived on a Tuesday morning at nine o'clock (one and half hour after advertised opening) there were a lot of women waiting, but the door to the counselling room was still closed. By asking around, I found out that the counsellor had not showed up for work. The women waiting seemed confident that the counsellors would come that day, but they did not. Neither did they show up the day after nor the day after that. I went to the VCT centre for two weeks in a row. I found out it was closed during nine working days. Every day there would be someone waiting from early morning until noon without being told that the service was closed. It was quite an ethical dilemma for me if I should talk to the manager, whom I knew quite well, and inform him that the counsellors were not coming to work or whether I should be a silent observer of how things eventuated. I opted for the latter. Women were in great majority waiting. Many of them had been sent for testing by their health professionals because they were suffering from chronic illnesses, had severe skin problems, tuberculosis or other persistent symptoms. Others were there because their husbands had been diagnosed HIV infected and some already knew they were HIV positive, but had brought their children for testing.

Understandably, some of the women I spoke to expressed their frustration about the VCT being closed. Even though the service is free at the MBCH, it is quite costly for a person to go there since she or he has to pay for transportation and spend valuable time away from work. The journey can take several hours and it is necessary to bring, or purchase, food and drink. I encountered twice the same mother who had travelled over 30 km each way to take her daughter for HIV test without success. This brings up another aspect of the counselling. Because of the high cost of transportation, I was surprised to find people from other health zones, waiting for the VCT in Monkey

Bay. They told me that they did not feel comfortable to attend the clinic in their village because they did not trust that the outcome of the test would be confidential since the counsellors are from the area. I frequently encountered worries of confidentiality not being kept. Many do not find it comfortable to talk to HIV counsellors if they come from the same area. Sensitive to this, counsellors at another clinic at Malembo (neighbouring area) 'wished the government had funds to find people from other area because of confidentiality problem'.

When the VCT opened again on the tenth day, I enquired why it had been closed for so many days. The explanation I was given was that the key to the counselling room had been lost, and when another staff member of MBCH found the key he forgot to tell the counsellors. When the key finally materialised, the person who was supposed to work that day fell sick but could not advise anyone of his situation. I got permission from the hospital's manager to review the VCT's attendance books for the last three months. Fortunately the ten days of counsellor non-attendance I had witnessed was an unusually long closing period as can be seen on the following graphs:

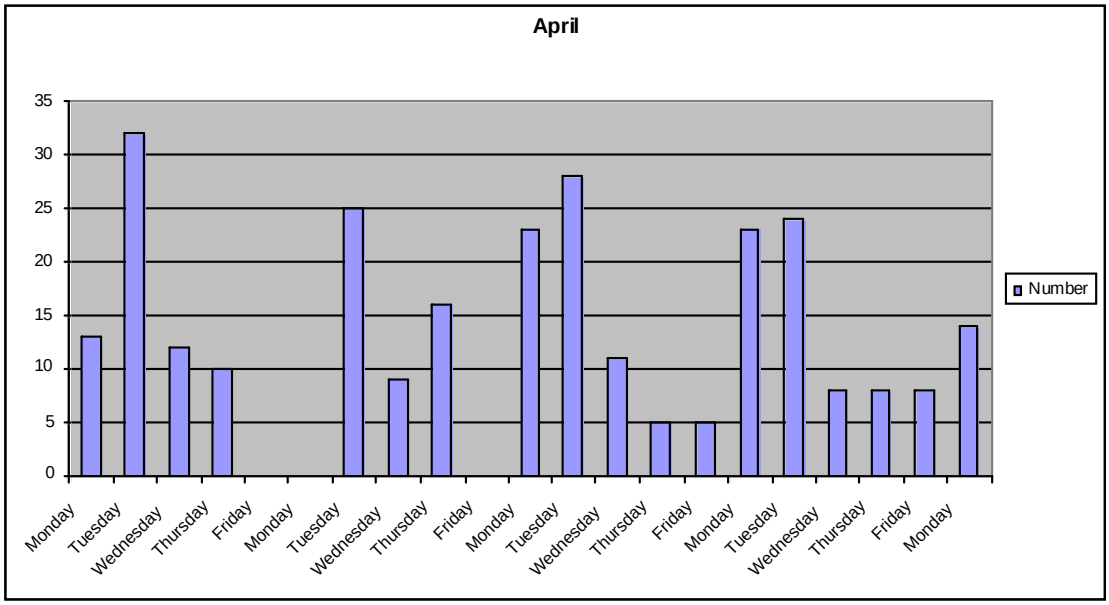


Figure 16: 254 people visited the VCT service in April. It was closed 3 working days.

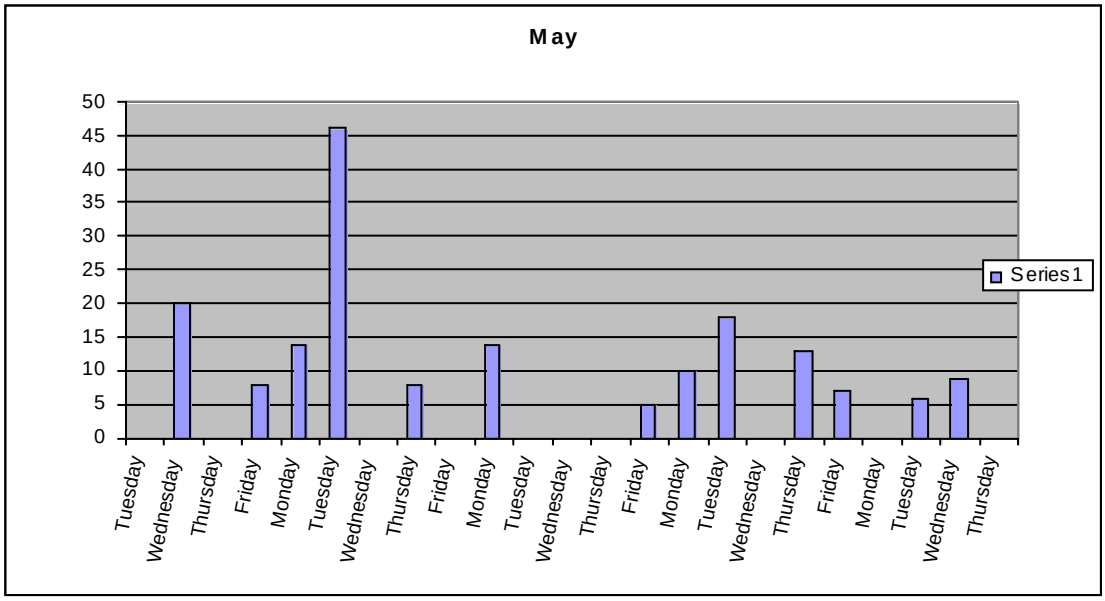


Figure 17: 178 people visited the VCT in May. The service was closed 10 working days.

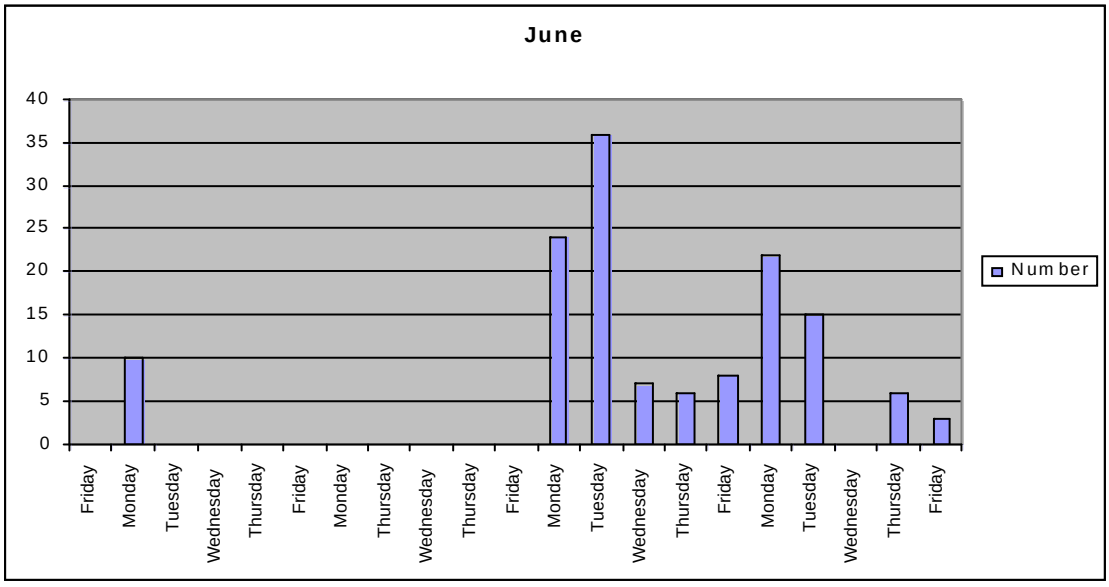


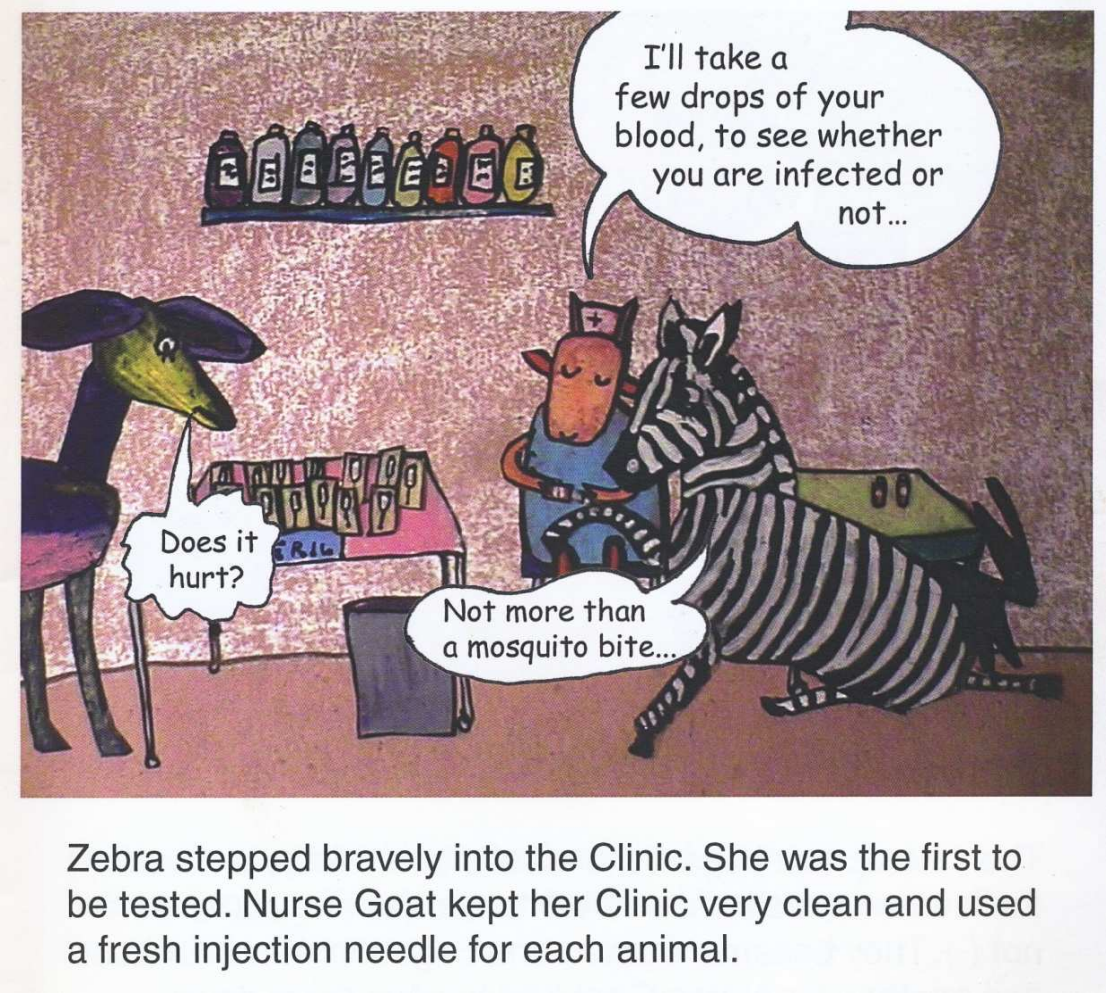
Figure 18: 137 people visited the VCT in June. The service was closed for 11 working days.

In total 589 people were HIV tested during these 3 months and close to 30 per cent of them were found HIV positive. 254 people got HIV tested at MBCH in April but only 137 in June since it only operated in ten out of twenty working days. When examining closer why the service was closed on certain days, lack of HIV testing kits or lack of rubber gloves for the counsellors to use while taking the tests were most commonly given as explanations. When speaking about this problem to the managers of the MBCH, they were surprised to hear of it. They were not aware of these recurrent periods of closing the VCT centre. Still, despite all the inoperative days, it is fairly impressive to note that 600 people in the area went for HIV testing during these three months and there of close to 430 people were found not to be HIV infected.

I will conclude this chapter by three pictures taken from a schoolbook *The Hiding Hyena* (2004), made by children from the primary school in the nearby area of Monkey Bay. The book discusses the importance of knowing one's HIV status:

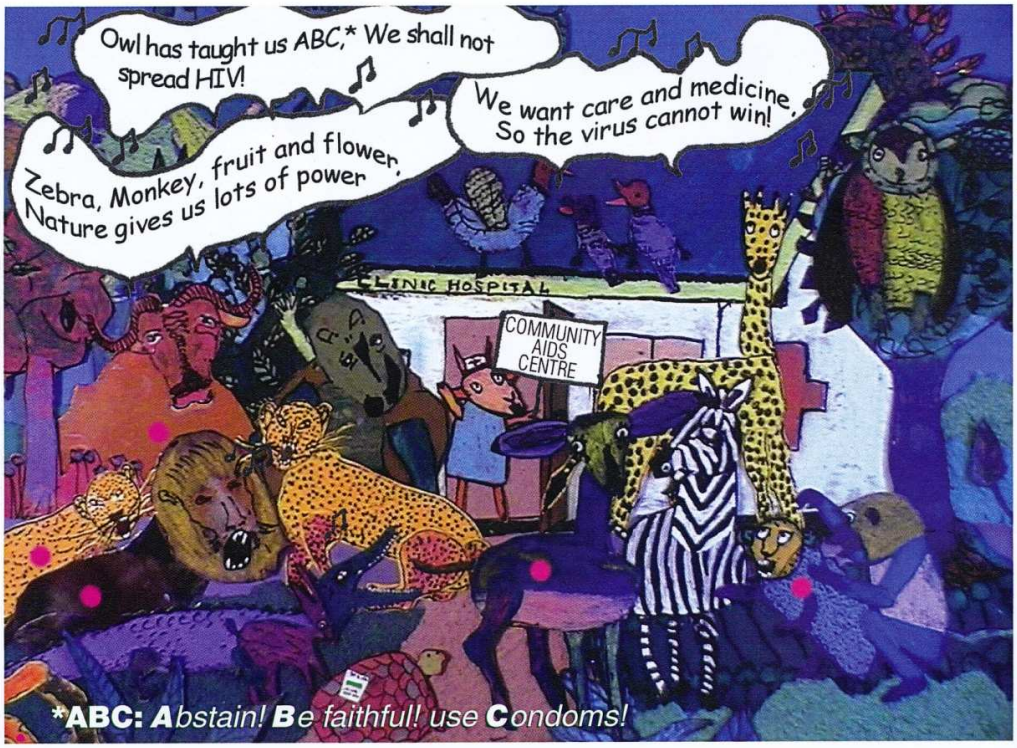
Finally Owl sternly commanded the animals to be silent and to listen carefully…

Figure 19: Page 3 from *The Hiding Hyena* (Ringbom *et al,* 2004).



Zebra stepped bravely into the Clinic. She was the first to be tested. Nurse Goat kept her Clinic very clean and used a fresh injection needle for each animal.

Figure 20: Page 37 from *The Hiding Hyena* (Ringbom *et al*, 2004)



At last Nurse Goat was able to tell them about the new Community AIDS Centre and how everyone could live together. The animals now felt calmer. Soon the lively group began discussing new plans for the future and they celebrated by singing and dancing all night long…

Figure 21: Page 44 from *The Hiding Hyena* (Ringbom *et al*, 2004)

9. Conclusions

What we have learned over the last twenty-five years in relation to the AIDS is that there is no one easy solution to stop the epidemic. Since the first HIV cases were diagnosed in the U.S and Europe, mostly among gay men, AIDS has been accompanied by moralizing messages, shame and stigma. Because of the strong association between HIV and homosexuality, which is relatively uncommon in Africa, the medical doctors did not realize that the 'slimming disease' was in fact AIDS. The political situation in Malawi was ill-disposed to tackle the HIV pandemic the first years, since 'the president for life' at the time, Dr. Banda, tried to shy away from the problem. Under Banda's regime the HIV prevalence rose from 2 per cent in 1985 to 19 per cent in 1989, when he was forced to take some actions (Yoder and Matinga, 2004).

The Malawian governments' inaction is understandable and not unique. The international community took long to realize the complications of this epidemic. The first years were characterized by faith in scientific and medical technological solutions and less emphasis was put on prevention of the disease, at least in Africa. This however, radically changed around the millennium when HIV and AIDS gained much attention from UN agencies and a special body, UNAIDS was established to focus on the issue. In 2003, the U.S President's Emergency Plan for AIDS Relief (PEPFAR) set an example and increased its' donation to combat the HIV epidemic, and more donations followed from other agencies. The last ten years, funding for HIV projects has been relatively easy to access, to the extension that it is been labelled 'fashion disease' in popular discourse. The increased funding has enabled millions of people with AIDS in Africa, to get medical treatment although it is still not available to all.

With time, more importance has been attached to HIV prevention programmes. How these prevention programmes should be set up has been debated. The U.S based

agencies; PEPFAR and USAID have promoted the so called ABC method; encouraging people to abstain from sex before marriage, be faithful to their partner and use condoms when engaging in casual sex. Although this message sounds easy to follow it has been criticized for not taking into account the multilayered and often contradictory understanding of condom use, abstinence and fidelity in different cultural groups around the world.

Development aid agencies and NGO's, have been accused of overemphasising the role of culture and cultural practices in the spread of HIV in African societies. In this rhetoric culture is defined as 'traditional', as a static and unchanging phenomenon. Certain practices have been labelled harmful and should be discouraged. This has been harshly criticised by many academics who point out that there is a tendency to overgeneralize and to exaggerate, both the actual performance of such practices and the extent to which they influence the spread of the virus. Others draw attention to the contradictory messages of, on one hand, eliminating cultural practices in Africa while on the other, promoting preventative measures in the West.

In the case of Malawi, certain cultural practices have gained attention from both national and international aid agencies as well as popular media. Sexual intercourse with girls at initiation ceremonies, widow inheritance, widow cleansing and dry sex, have achieved much interest. However, much of what is written of these practices is inaccurate and not based on empirical studies. John Lwanda (2004), has traced how cultural practices were hidden from the colonial gaze in Malawi when authorities tried to ban and eliminate certain practices without having an understanding of the contextualized significance of the practices. It is my feeling that the discourse of harmful traditional practices during the colonial times can be reflected in the discourse of AIDS in Africa.

The phrase that AIDS has a woman's face in Africa has been popular for a reason. The number of HIV infected young women is higher than among their male peers. Much attention, effort and money has been put into designing HIV prevention

programmes thought to empower women to defend themselves against infection. Scholars have questioned the emphasis on portraying women as particularly vulnerable and it is interesting how much attention is paid to young women in relation to HIV when in fact the gender difference of HIV prevalence decreases rapidly among people 24 years of age and older. Despite 'gender mainstreaming' being promoted within development agencies, the focus on women in relation to HIV is accompanied by a tendency to ignore that men are victims of the disease as well. Most prevention programmes aim to protect women from getting infected from men; as if men's privilege and power only makes them active transmitters but not valid to be incorporated in prevention programmes.

It should not be undermined that women are disadvantaged in many ways in Malawi, especially as to access to economic resources, but feminists, especially from third world countries, have criticized the prevailing image of women from poorer countries as defenceless victims. Chowdhry (1995) defined three dominating images in western discourses of Third World women, which all have in common a portrayal of Third World women as inferior to women in the West. In Chowdry's opinion these images depict women as having no control over their lives, being dominated by men, oblivious to the outside world or controlled by cultural traditions and in dire need to be civilized. Such images can be detected when reviewing HIV policy papers. This criticism coming from third world feminists has widely been accepted within the academic community but largely ignored by development aid agencies.

The aim of this study was to explore how development discourses of HIV and AIDS in Malawi fit the lived realities of people in Karombo village. Due to the particular emphasis HIV programmes place on women, girls and culture, I paid much attention to their point of view concerning gender relations, sexuality and cultural practices. The conclusion which can be drawn from this study is that HIV awareness campaigns have been successful and that there is a now universal knowledge of the disease and its modes of infection. Still, too much emphasis is placed on certain gender norms and cultural practices as culprits of the HIV epidemic in Malawi. Further

understanding of local power dynamics is needed before making any conclusive claims as to their effect. The voluntary counselling and testing centres can be a very effective tool in promoting safe sexual behaviour, addressing risk factors and providing personal counselling. It is important to be aware that how sexuality is expressed and experienced is both highly personally motivated and culturally conditioned.

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Appendix

Glossary of Chichewa terms used in the text:

chinamwale	Puberty initiation rite for girls
Chokolo	Widow inheritance
fisi	Hyena (*afisi* plural)
kuchotsa fumbi:	'sex without the consent after first menarche for initiation'
Kukuna	Elongation of the labia *minora*
kupita kufa	Widow cleansing
kusunga mwambo:	'not to take the problems within the marriage outside of the house'
kutenga mwana	Sexual cleansing ritual for parents
Matola	Public transport
Mdulo	Illness stemming from breaking sexual taboos
ndiwo	Relish
Nsima	Maize porridge
Sing'anga	'Traditional African doctor' (*asing'anga* plural)
Tsempho	Illness stemming from breaking sexual taboos
Usipa	Small fish (finger size)