

## **“It’s better for me to die”**

### **How structural violence kills HIV prevention efforts for women in Malawi**

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*HIV prevention efforts that promote abstinence (A), mutual faithfulness (B) or condom use (C) to prevent contracting AIDS are irrelevant 196 and thus ineffective 196 for most Malawian women. The A-B-C messages are based on incorrect assumptions because they do not take the structural violence women face into account: the severe socio-economic and gender inequalities keep them and their children poor, sick, suffering and without future perspectives. With the frequent breakdown of marriages, reduced family support and limited employment opportunities for women, they depend on non-family related men for their immediate survival. In exchange for assistance, women barter sex with them. Women’s agency to prevent HIV infection is limited since the structural violence they experience daily also perpetuates the AIDS epidemic.*

*This article is based on research conducted in 1996 and 2002, which studied the changing dynamics of multiple partner sex in randomly sampled high-density urban and trading centres in three districts. Triangulation of researchers and qualitative research methods was used.*

*To mitigate the epidemic, health messages should be down-to-earth and reflect women’s realities. Further, public and private sectors need to reduce structural violence so that women and their children are assured of their most basic human right: to live and have better future perspectives.*

*[sexual networking, poor women, qualitative research, structural violence, human rights, HIV/AIDS, health education, coping, livelihood, condom, Malawi]*

Margaret, in her early thirties, is landless and is unemployed.<sup>1</sup> She has been married “on and off”. ... “All those men were the same: violent and useless. They spent money on themselves for their own pleasures: on drinks and women. Iiiihhh men!!!” She mothers five children from three fathers, but also had one miscarriage and lost one child due to death. With only six years of primary schooling and no business capital to seriously undertake petty trade, she is forced to reduce her cost of living to the bare minimum and to take on any temporal or ‘piece’ job to generate income. “But there aren’t many piece jobs. And we are here with many poor women who are also looking for money. So, there is

much competition”, she informs Mike, a mystery client (see below) who meets her when she is selling cartons of opaque Chibuku maize beer near an informal market in Blantyre. Depending on the season, economic opportunities, her health and capital, she carries water and sand to houses under construction, weeds or harvests on people’s farms or sells someone else’s beer. But what “really helps” her is the MK30.000 (\$20.00) she gets from her man friend, a married man from Zomba, who visits her at least one weekend each month.<sup>2</sup>

Margaret lives with her junior sister Rose in a two-room sun-dried mud house with a thatched roof in one of the poor high-density areas of Blantyre. Rose has four children from two men. She is also unemployed, lacks business capital and takes on any piece job available. To survive, she too has a ‘husband’. He is a married man who visits her irregularly, but who pays the rent for their accommodation and sometimes gives her maize flour, beans or green vegetables. “He is a cook and can easily get those things”, Margaret clarifies to Mike. They also look after one orphan, a child from one of their deceased sisters. Although the ten children help their mothers to make ends meet, to get enough food remains a perpetual problem, especially during the hunger season. “Then we are really starving.”

During their conversation, Mike approaches Margaret for sex. She agrees, but because she is menstruating, she tells him to come back to her “next week”. She would not charge him. “But you can just give me some cash to help me. I have many problems. . . . I am very poor and everything costs money.” He then discusses condom use with her. She knows that condoms can prevent transmission of sexual diseases (STIs) including AIDS. She explains to him where condoms can be bought in the vicinity and at what price. To prevent pregnancy, she gets the contraceptive injection “because I become pregnant easily”.

One packet of Chibuku later, however, Mike asks her how she feels about condom use. Although she knows that condoms can prevent HIV infection, she does not want to use them. “I am not a prostitute.<sup>3</sup> No, I don’t use them.” When Mike tells her that he could be HIV positive and infect her so that she may die in the future, she looks in his face and replies him, “It’s better for me to die”. When he takes her back to her responsibilities at home, she repeats that she has too many problems and lacks the means to resolve them. “We suffer and work hard but the money seems never to be enough because everything is expensive. Poverty is killing us. True! . . . I don’t see a solution anymore. Our problems are only getting bigger and bigger and we are becoming poorer and poorer. The way I see it: there’s no hope for a better future. Otherwise it would have come already when we got the new democracy [in 1994]. . . . So, why should I care about condoms? I will be better off dead” (based on excerpt from Mike’s mystery client field report, 1996).

### **The epidemic and national responses**

In 2001, the parliament in Malawi declared the HIV/AIDS epidemic a national disaster (The Nation, 3 July 2001). With a national adult HIV prevalence of about 14 percent 196 some 23 percent in urban and 12 percent in rural areas, the epidemic is one of the most severe in sub-Saharan Africa (UNAIDS/UNICEF/WHO 2004: 1). Some 89 per-

cent of infections have been transmitted through heterosexual contact (UNAIDS/WHO 2000: 6). Without baseline blood tests or detailed and accurate histories on sexual and health seeking behaviours, however, it is nearly impossible to ascertain how and when a person became infected.

The first recognized case of AIDS presented at Queen Elizabeth Central Hospital (QECH) in Blantyre in February 1985. That year, twelve additional patients were diagnosed HIV positive in QECH and in Kamuzu Central Hospital in Lilongwe (Cheesbrough 1986). According to the National AIDS Commission (NAC), the epidemic in Malawi began in 1982 (NAC 2001: 15). Missionary sisters, who worked for many years in Malawian hospitals, however, suggest that AIDS patients may have been dying already since the late nineteen seventies (Van den Borne 2005a: 45). This is not without scientific support. Frozen sera shows that HIV was present in Northern Tanzania at least as early as 1979, five years before the first AIDS cases were diagnosed there (Howlett & Nkya, cited in Setel 1999: 205, cf. Hooper 1999: 31-51).

This scourge in Malawi has since then cost many lives. In 2003, the annual number of deaths among adults and children due to AIDS was about 84.000 (UNAIDS/UNICEF/WHO 2004: 1). Also, life expectancy at birth has been reduced from 44 to 38 for women and from 41 to 37 for men between 1987 and 2000 (MOHP 2001: 8, NSO/ORC Macro 2001: 2).

The government developed the National HIV/AIDS Strategic Framework (2000-2004) and the National HIV/AIDS Policy, in collaboration with the donor community and in response to the national crisis. The UNAIDS reports that the policies are 'home grown', that they emphasize the public health approach and that they respect human rights (UNAIDS/UNICEF/WHO 2004: 1-2). With technical assistance from various donors, including UNAIDS, the NAC mobilized massive funds to implement their programmes. For the next five years, Malawi has been promised US\$ 196 million from the Global Fund, US\$ 35 from the World Bank's MAP funds and US\$ 37 from bilateral donors like CIDA, NORAD and DfID) (UNAIDS/UNICEF/WHO 2004: 2).

Prior to this gigantic mobilization of resources, in 1988, the National AIDS Control Programme (NACP) began its first Medium Term Plan (1988-1993), with Information, Education and Communication programmes for the general public (Hubley 1992: 2). From 1990-2000, the European Commission (EC) provided the NACP with substantial financial and technical assistance through the EC AIDS Project. Since HIV prevention is still one of the nation's priority action areas, it is important to review previous interventions and draw lessons from them. This article intends to contribute to this appraisal and focuses on how structural violence has been preventing HIV prevention efforts from having the desired impact on women.

### **Focus on high-risk groups and peer education**

Although the EC AIDS Project informed the general public, it particularly focused in on the so-called high-risk groups for HIV infection. It aimed at "the prevention of HIV transmission through education on HIV/AIDS and other STDs and the promotion of

behaviour change, safer sex and condom use among groups at increased risk” (Brünger 1995: 1). The identified high-risk groups were bar girls, truck drivers, patients with sexually transmitted infections, armed forces, traditional healers and college youth. From a public health point of view, it is problematic to think in terms of high-risk groups. It focuses negative attention on already stigmatised categories of persons, allows the assigning of blame and lulls the general public into believing that they are safe and innocent (Goldin 1994: 1360).

The EC AIDS Project used the peer education approach: a popular health education method that has been promoted among homogenous groups with similar shared health problems, in this case an increased risk of becoming infected with HIV. The method assumes that mutual solidarity helps in teaching and learning from peers how to prevent HIV infection (cf. Van den Borne 2005a: 1, 9-10). The ‘bar girl component’ had the biggest budget. Bar girls are women who work in bars and taverns and sell drinks. To make ends meet, they barter sex with men. Bar girl peer educators were to teach other bar girls about AIDS. Because abstinence and mutual faithfulness were no options for them, they emphasized “the skills to negotiate condom use” (The Project Team 2000: 1).<sup>4</sup>

The “encouraging results” from the pilot study led to a nation-wide expansion of the bar girl component (Hubley cited in EC AIDS Project 1996: 11-2). In reports to the donor, the peer education method for bar girls was praised. Hubley, a short term consultant from Leeds University, observes that the “peer group leader concept appeared vindicated by the group solidarity among the bar girls who claimed to actively negotiate safer sex and refuse sex from men unless condoms were used” (Hubley 1992: 8-9). He describes the EC AIDS Project as an “exciting and innovative programme that is making a substantial contribution to the control of AIDS and STDs in Malawi” (Hubley 1992: 7).

During the mid nineteen nineties, the number of bar girls began to decrease and that of freelancers began to increase. A ‘freelancer’ is a woman who moves from one sex partner to another. Freelancers solicit sex from men anywhere but they often operate in and around entertainment places and surrounding streets. They secure their own accommodation and may move more frequently than bar girls do.<sup>5</sup> Margaret, for example, was willing to freelance when Mike approached her for sex.

## **Research background, design and methodology**

Under auspices of the NACP, the European Community and the EC AIDS Project, a qualitative study was conducted from July to December 1996. As principal investigator, I was hired to design the study, be in charge of all the stages of the research process and write up and disseminate the research findings and recommendations (Van den Borne 1996a, 1996b, 1998).

The purpose of this study was to provide information for improved evidence-based public health policy and programming, in particular HIV prevention. The focus was on women and men involved in multiple partner sex. The women were sampled from

among poor single women, bar girls and freelancers in high-density and trading centres of Lilongwe, Blantyre and Zomba district. The men were purposefully sampled in and around drinking places and resthouses in the same locations.

Who were these women, where did they come from, where, with whom, when, how and why did they network sexually? How did these women perceive the advantages and risks of bartering sex? What did they know about HIV/AIDS, and how did this affect their sexual practices and their condom use? Why were the numbers of bar girls and freelancers changing? Who were these men and why did they have sex with different women while AIDS was prevalent?

Research methods included consented series of audio-taped and verbatim-transcribed semi-structured focus group discussions (FGDs), serial in-depth conversations with individual women to develop their life histories, and diary writing by male and female field assistants. We also used the unconsented focused observation and the participant observation method including the covert mystery client method. For this last method, I trained five male field assistants to operate under cover as fake clients to get information 196 in hopes of increasing the face validity 196 on how women negotiate condom use and to assess how their condom possession influences their negotiation skills. The men were told NOT to have sex with their female informants and the women were never told that the men were researchers. Although I faced several ethical ambiguous and dubious situations during all stages of the research process, I extensively wrote about the ethical dilemmas of the mystery client method and about why and how I used this more aggressive type of participant observation (Van den Borne 2005a: 14-22, 2005b). Also, for six months, I stayed in various low cost rest houses 196 usually associated with multiple partner sex 196 to conduct in-depth interviews and chat with numerous men and women in and around drinking establishments (Van den Borne 2005a: 11-4).

All field assistants were trained, pilot tested and based on the results from the pilot study, trained for three additional days. They were closely supervised and daily debriefed by assigned supervisors. Female assistants conducted and transcribed the audio-taped in-depth conversations with consented poor single women, bar girls and freelancers, and developed 97 life histories: 68 with poor single women, 23 with bar girls and 6 with freelancers. They further directed and transcribed nine audio taped FGDs with representatives of these three groups of women. Male field assistants operated as mystery clients for 4 weeks and developed 101 field reports: 23 of bar girls and 78 of freelancers.

Further, I lived in Malawi over four years between 1996 and 2002 and worked in 1996 for the NACP and then, from 1999-2002, for the Ministry of Health and Population as technical assistant for the Lilongwe District Health Office in the context of health sector reforms.

As a result of my interest to delve more into the topic, I carried out additional research, from April to August 2002. During this research period, I placed multiple partner sex in context and studied it from perspectives of history, culture and political economy, and assessed how AIDS organizations influence the Malawian health system. I conducted a series of semi-structured interviews and FGDs, and spoke with mar-

ried and single women and men from all strata of society about the research topic. I used the multilevel perspective whereby informants were purposefully sampled (Van der Geest et al. 1990). Representatives from various levels and interest groups within society were incorporated because of their ideas about, experience with and interest in the topic of the study. Some of the results of these two fieldwork periods are published somewhere else (Van den Borne 1998, 2003, 2005a, 2005b).

### **Suffering because of structural violence**

Margaret, Rose and their children suffer because of the 'hidden' structural violence in their society. Structural violence does not hurt or kill through physical beatings or weapons, but through socio-economic and political structures that produce social injustice. These structures 196 normalized by stable institutions within and between societies 196 breed abuse: they give rise to disrespect of human life and dignity, violate human rights and augment slavery, racism and terrorism. Yet, these structures are man-made: created, maintained or changed by humans.

Structural violence 196 a term ascribed to the Norwegian peace researcher Johan Galtung (1969) 196 prevents people from achieving their full potential. It infringes on and violates their most basic right 196 the right to survive 196 due to an unequal distribution of resources in an age of great affluence and scientific advancement (Farmer 2003: 6). Social responsibility and caring governance are absent as well (Sen 1998: 2).

Classic examples of this 'hidden' and 'silent' violence are severe poverty, starvation, suffering and brutal death from preventable or curable diseases. Unequal access to resources, to political power, housing and sanitation, employment, social services and to legal standing are other examples of structural violence. HIV/AIDS and other modern epidemics are some of the many "symptoms of deeper pathologies of power" (Farmer 2003: 7). These structures build socio-economic and gender inequalities that become risk factors for spreading the AIDS epidemic.

### *Socio-economic inequalities*

Malawi is one of the poorest countries in the world. This is reflected in poor socio-economic and health indicators. In 1998, 65 percent of the population was classified as poor (Benson et al. 2002: 25). Poverty is deeper and more severe in female-headed households like that of Margaret (NEC 2000: 17-8, 49). Malawi has with 83 an 'extreme' human suffering index (HSI).<sup>6</sup> Some ten percent of the world population 196 in 37 countries – suffer like this with scores between 75 and 100 (Philippine Legislators' Committee on Population and Development Foundation 1992). Malawi also numbers 161 out of 176 on the UNDP's Human Development Index (Tsoka & Zoani 1997: 9).<sup>7</sup>

In reality, this means that people can no longer grow enough food to support their families for an entire year: they lack land, money and buying power to buy seeds and fertilizers. The population pressure has increased with about 80 percent in the period from 1977 to 1998 from 59 people per square kilometre to 105 (NSO/ORC Macro

2001: 2). Malawians increasingly experience the consequences of environmental degradation, including pests, progressive and irreversible soil erosion, draughts and floods. Food insecurity is a recurrent problem, resulting in hunger especially during the period January through March.

The country has been borrowing heavily since the early nineteen seventies. International debts increased to US \$ 2.9 billion in 2002. To ensure that these were serviced, Malawi was forced to introduce structural adjustment programmes (SAPs). SAPs failed to restructure the economy, however. They kept the economy dependent on tobacco for its foreign earnings (Chilowa 1991: 11). Furthermore, exports, income, employment, Gross Domestic Product and macro-economic stability did not improve.<sup>8</sup> SAPs were also unsuccessful in increasing equality in the economic distribution and to provide safety nets for the poor. On the contrary: jobs became scarce, wages and purchasing power fell, the cost of living rose and socio-economic and health indicators worsened (Onimode 1991: 60, Turok 1991: 8-9, Roe 1992c: 6).

At the same, however, globalisation processes got Malawians introduced to new desires, tastes and needs. Farmer (2003) refers to Briceño-León & Zubillaga who explored the link between rising inequality and globalisation of desires, and violence:

The social process is a two-directional encounter in which individuals' expectations increase but their chances of satisfying those aspirations diminish. The friction between the two processes provokes tensions which are unprecedented and very difficult to beat (Briceño-León & Zubillaga cited in Farmer 2003: 291).

After thirty years of president Banda's dictatorship, Malawians hoped that president Muluzi 196 with his new democratic government (1994) 196 would give them a better future. Soon, however, they began to voice out a wide range of problems and summarized their frustrations as, "multi-party: multi-problems" and "*Maluzi ndi Muluzi*" (with Muluzi there are lots of monetary losses).

The country's health indicators are among the worst in the world. They are likely to worsen due to increased poverty and the AIDS scourge. The estimated maternal mortality rate, often used as a proxy indicator for the quality and coverage of health services, has worsened by 80 percent from 620 deaths per 100,000 live births in 1992 to 1,120 deaths in 2000 (NSO/ORC Macro 2001: 181-2). The estimated under-five mortality rate has increased from 159 in 1987 to 189 per 1,000 live births in 2000 (NSO/ORC Macro 2001: 2, 98). Preventable and treatable malnutrition, anaemia, pneumonia and diarrhoeal diseases predominantly cause such deaths. Malnutrition is endemic: fifty percent of under-fives are chronically malnourished (MOHP 2001: 9, NSO/ORC Macro 2001: 137).

### *Gender inequalities*

In addition to widespread socio-economic disparities, gender inequalities in Malawi have led to the situation women find themselves in today: one of dependency on men and increased vulnerability. Formal education and employment are two examples of



the ways in which socio-economic structures exclude women and limit their opportunities to make a living.

Overall, the literacy rate for women in 1992 was nearly half that of men: 42 percent versus 72 percent (NSO/Macro International 1994: 16). In the past, formal education for girls was not important among Chewa, Yao and other matrilineal groups in the Central and Southern Region. Since 1994-1995, the government has introduced tuition waivers for primary education, but structural and cultural factors that take girls out of schools are still inadequately addressed (Semu & Chande-Minauli 1997: 87-8).

The educational environment is unfriendly for girls. Sexual harassment by male teachers and boys make parents reluctant to send their daughters to school. Instead, they encourage them to get married as soon as they reach puberty (Semu & Chande-Minauli 1997: 87). Next, teachers and parents expect less from girls' intellectual capabilities and do not encourage them to stay in school (GOM/UN 1993: 147-8). Last, teen pregnancy interferes with school performance and prevents girls from completing their formal education (Van den Borne 2005a: 87-9).

Women experience difficulties in accessing formal sector employment in general and higher paying jobs in particular. In 1995, only three percent of the people in formal employment were women (SARDC cited in Mkamanga 2000: 75). In 1994, only one percent of women working in the Ministry of Agriculture held a middle management position (Mvula & Kakhongwe 1997: 25-6). Despite the fact that the 1994 Constitution offers equal opportunities for men and women, in 2001, men still dominate key-decision-making areas (CHHR 2001: 16).

Access to land for women has worsened (GOM/UN 1993: 47). Due to the population pressure and the plantation economy, land has become a scarce and valuable asset. Female-headed households are much more likely than male-headed households to cultivate less than 0.5 hectares. The poorest households, therefore, have to depend on off-farm income (Wold Bank 1996: 38, 32).

Women in particular are shifting towards informal sector economic activities because growth in formal sector employment is weak and wages do not keep pace with the cost of living (GOM/UN 1993: 119-30). Their lack of capital and access to credit schemes and influential social networks, however, limit their chances in the informal sector as well. They remain dependent on men for their and their children's survival.

### **Trying to survive**

For over a decade, a host of literature has been published on poverty, social security, and formal and informal safety nets for the poor in Malawi. Yet, until recently, none concentrate on poor single women's coping mechanisms.<sup>9</sup> Poor people rely on a mixture of activities for earning a livelihood and spreading their risks. They can be broadly grouped into two categories: those that reduce their cost of living and those that generate income through the sale of labour, sex or possessions. In each category, people embark on different 196 preferably not related activities, like migrating, splitting up the household, farming and trading.



Most authors acknowledge that poor people usually rely on their social networks for economic support.<sup>10</sup> Traditional support networks, though, are breaking down due to numerous structural and ideational transitions (Weinreb 2002: 114). Time proven safety nets at the family and community level exist, but the 'economy of affection' is increasingly breaking down.<sup>11</sup> As Margaret's story shows: poor people's problems are too many and the resources to address them are too limited (cf. Tsoka & Mvula 1999: 21, 63-4, 71-4). In addition, single women do not have an official network of husbands and in-laws who could support them and their children. Their natal support networks appear to be limited to mothers, uncles, sisters and brothers, thus following matrilineal structures.

How do poor single women then survive in a society that offers few alternatives to kin support networks? Most authors fail to acknowledge the role played by non-family related men in single women's attempt to survive. Roe observes that some women rely on 'prostitution' to make money (Roe 1992a: iix, 134-6, 1992c: 92-9). Also, Khaila et al. (1999: 6) remark that, "some wicked women resort to prostitution together with their girl children to sustain their families". Similar to Margaret, other poor single women in our study do not perceive themselves as 'wicked', or as 'prostitutes'. Nor do they intend to work as bar girls or identify with freelancers. However, these authors look at women's sexual networking predominantly as *an end in itself*, i.e. as an income generating activity.

Still, women not only rely on non-family related men as an end in itself but also as *a means to an end*. Women feel that men have more responsible positions, are better connected to the bigger world, are better informed about what is going on and have more money to spend. Single women, therefore, depend on men to strengthen their social capital, and for assistance to reduce the cost of living and to generate income. They get information from these 'helpers' about where to get a patch of land, or unripe fruits, or 'permission' to receive some items men themselves may obtain through, for example, unlawful practices. When women generate income, predominantly through piece jobs and petty trade, non-family related men again feature to begin and sustain their work: providing connections, sourcing capital and acting as customers. In exchange for this assistance, most men expect that these women are sexually available to them.

In search of male 'helpers', women compete with each other. This makes them sufferers and instigators of unstable unions. Margaret referred to the fathers of her children as 'useless' because they were spending money on drinks and 'other women'. At the time of the study, she had somebody else's husband as provider. These 'single' women use their survival tactics at the expense of other women and, in so doing, destroy relationships among them and obstruct their own progress. In addition, women's reliance on men for help in exchange for sex also reinforces women's dependency-laden femininities and men's sexually laden masculinities.

Women thus often end up having sex with predominantly two different types of men for different reasons. The first type of sexual contact results from a kind of patronage system. Hereby women are expected to have sex with men in positions perceived as more powerful for the purpose of receiving favours. Women may thus be enabled to expand or strengthen their social capital, reduce their cost of living and generate some

income. The second type is the *chibwenzi* (manfriend) relationship, in which women expect some kind of practical and financial assistance from men, as well as emotional and sexual comfort. This second situation is similar to marriage and depending on the situation and context, many women may even call these affairs 'marriages' (Van den Borne 2005a: 83-103).

Both, the patronage system and the manfriend relationships, operate in all layers of Malawian society, not only among the poor. Failing to understand the dynamics of this kind of sexual networking obscures the realities of 'poverty reduction' and those of multiple partner sex, as well as hampers the development of realistic sexual and reproductive health programmes at the community level and at the work place.

Although HIV/AIDS is a big concern and most Malawians are infected or affected by it, many believe that it is not their worst problem. Similar to Margaret and Rose, the majority of women have to struggle on a daily basis to make ends meet. They know that their living conditions expose them to many risks and many ways to die a premature death: through hunger, sickness, cholera, childbirth, physical violence or car accidents. Also, one can become HIV positive in many ways. To them, not only death but also AIDS is almost unavoidable.

As Devereux notes, it is difficult to draw a line between 'adaptive' and 'survival' behaviours with any certainty because people often intensify what they were already doing to cope (Devereux 1999: 8-9). In other words, if people do piece jobs only during the hunger season from January to March, these are adaptive behaviours. But if they have to do these throughout the entire year, even though they are the same activities, these are survival behaviours. They are done with increased intensity and cost and the consequences are irreversible (Devereux 1999: 16). I argue that desperate women do exactly the same. Throughout the year, they rely on 'husbands' to survive. They do so with increased intensity and cost, and with the AIDS epidemic, the consequences are irreversible.

### Revisiting of A-B-C messages

Health messages that promote abstinence (A) and mutual faithfulness (B) are irrelevant to women's lived experiences when they depend on men for their survival and barter sex for assistance from them. Teaching women how to negotiate condom use (C), however, is problematic as well. Such messages are not viable because they are being 'killed' before becoming implemented. This happens for two reasons. First, the socio-economic and gender inequalities in Malawi fuel the AIDS epidemic and limit women's agency to take these messages at heart. This challenges the neo-liberal health communication assumptions that individuals have the agency to protect themselves against the 'deadly disease'. Second, although structural violence may inspire the have-nots and oppressed to resort to direct violence, it may lead people like Margaret and other desperate women and men in Malawi to apathy and passivity regarding HIV prevention.

Lack of knowledge about condom use and disapproval of its use by faith-based communities, however, are not the reasons that the majority of sexually active people

in Malawi do not use them. In addition to the lack of consistent availability and access to condoms at the community level, women are again confronted with the same dependencies on men who control the sexual agenda: men decide when to have sex, with whom, how, how often and under which conditions. This gender inequality weakens women's ability to negotiate safer sex.

Female condoms are not only extremely expensive but also unavailable in the market. PSI, a social marketing organization, took female condoms off the market in Malawi in 2002. The marketing officer in Lilongwe told me that the women did not use new ones after each sexual encounter. In this way female condoms became a source of infection for their sex partners. Instead of drastically reducing the price to make female condoms more affordable and accessible to women, PSI removed them from the market.

Also various socio-cultural and political factors discourage male condom use, including the notions people have about condoms, male-female relationships, respect, sex, semen and AIDS (Van den Borne 2005a: 135-9). Having said that, bar girls and freelancers have a higher awareness of STIs and HIV/AIDS than do the poor single women.

To initiate sex or to tell a man to use condoms is perceived as disrespectful. Poor single women reported, "We can't convince men because we are afraid of them. We aren't used to instructing them in what to do and what not to do". "You don't instruct your boss. Do you? It's disrespectful." Especially with 'manfriends' and other 'regulars' women find it difficult to insist on condom use. Joyce from Lilongwe, 29 years and 'single', shares her experiences with a female field assistant:

You know that they have been supporting you. They have been faithful to you and have been helping you. And you have been assisting them as well. Familiarity comes in. Even when you know that he 196 behind your back 196 has been with other women, you can't tell him to use condoms because you are desperate for his assistance. And a beggar can't be choosy, you know. If you refuse, he will go to an other and your assistance has gone. So by insisting, you aren't helping yourself. You are losing out. So, you just give in ... Iiiiih, life, it's difficult!

Women like Joyce consider such manfriends as faithful when they keep on coming back to them and assist them. To them these types of 'mutual faithfulness' are important aspects of strengthening their social capital, reducing their cost of living and generating income.

Despite the cultural norm that a self-respecting woman is not supposed to propose condom use to her manfriend, a few women said that they had tried to do so. Tide is 27 and a mother of three. She divorced the children's father whom she labelled a 'brute'. Once she had the courage to tell her current manfriend 196 a married man 196 to use condoms. During one of the in-depth conversations with a female field assistant, Tide narrated her story:

I told him that I don't want him to play around with me. I told him my problems. I really told him my fears.... I don't want to let him get into my house. I told him that if he wants

to continue to be with me in a friendship, he should use condoms. But he refused. He told me that he didn't doubt himself [that he was HIV negative]. But I told him that I was afraid to become pregnant and get infected with the famous disease. He insisted and really refused [to use them]. He told me that he had a wife at home and that he didn't visit prostitutes. He also said that he was well protected by traditional medicine, so he couldn't be infected with AIDS. He encouraged me to use family planning pills so that we would have sex without condoms, because he wouldn't feel good to use them. He only wanted plain sex. But I know that these days are risky. If he would use condoms, I would feel well protected because nowadays there are too many things like syphilis, gonorrhoea, AIDS and pregnancies. But what can I do? He is the man and I need support (in-depth conversation with female field assistant, Blantyre).

One would expect that condom use among bar girls and freelancers would be common since there is a strong societal association with condom use and promiscuity, hit-and-run affairs, and prostitution. Over half of all freelancers and more than three-quarters of bar girls contacted by mystery clients insisted on condom use the first time they met. Several changed their mind and accepted plain sex during the initial negotiations. The others agreed to plain sex from the onset.

Condom possession among bar girls and freelancers did not guarantee that they successfully negotiated condom use. Their condom negotiation was neither universal nor consistent. Successful negotiation for the first 'round' was no assurance that condoms were used for the next 'rounds' or during subsequent encounters. And when condoms were used, they were not always used correctly.

Although we used a covert research method to increase the face validity of information on condom negotiation skills, we discovered that a successful condom negotiation in the bar, might be revisited 196 and changed 196 by the man when both are on bed. Some women reported never having used a condom. It was if they could not care less about AIDS, "We are all going to die."

### **Condoms and fatalism**

Individual behaviour takes place in social contexts where structural violence limits health-promoting behaviour (cf. Lane et al. 2004: 331). Women who feel overwhelmed by their financial problems, who lack family support and future perspectives, and who think that they cannot improve their living situation, tend to be less concerned about contracting HIV/AIDS: it is just one of the many problems with which they have to deal. Like Margaret, quite a few women had fatalistic attitudes towards AIDS, saying that, "everybody has to die some time". Therefore, Catherine, a 24 year old bar girl from Zomba, did not believe that condoms could postpone her death:

We will go according to when it's our time, not earlier, not later. That's it! But if men want it with condoms, then they use them. I am not going to argue with them about that. But if they want it natural, then there's no hassle: we just can be free and be floating. I

like it that way. I want to be a free woman. Yes, that's what I want. . . . My parents are tired of me [because of her two pregnancies from men who did not marry her]. But I don't care. I don't care about death. I take every day as it comes. I can't change much anyhow. So, if I get that disease, then I know that my time has come and I will go (in-depth conversation with female field assistant, Zomba).

As Margaret did, Martha felt that death would be an acceptable solution to her problems. Martha was 28 and had been a bar girl for the past seven years. She lacked MK1000.00 capital to begin a small business of buying and selling second-hand clothes. She believed the money generated by the business would take care of her, her child and her younger sister. "But I don't have the money and only God knows whether I will ever get it." Most men who slept with her used condoms, she told Humphrey, a mystery client. "Maybe they fear AIDS. I don't care if I die. After all, what am I doing on this earth?" When he reminded her that she took care of her child and her sister, she responded, "Troubles all over. It's better for me to die".

### **False assumptions and hopes for improved HIV prevention**

HIV prevention assumes that sexually active people want to preserve their health and prevent HIV infection in the future. Their socio-economic position, however, makes women dependent on male 'helpers' for their immediate survival: men who control the sexual agenda and tend to seek their immediate interests.<sup>12</sup> Further, health education assumes that women are willing to teach each other how to negotiate condom use and that they perceive sexual relations as business-like transactions. Most women, however, compete with each other for the same men and their money. Furthermore, they want to avoid the impression that they are 'in business'. Therefore, in their negotiations with men, women rely on cultural values like helping, trusting and respecting one another, instead of insisting on correct and consistent condom use.

For women, HIV prevention can only become a priority when they are self-efficacious, no longer depend on men for their immediate survival, have better future perspectives, control their bodies and have the means to protect themselves. Female condoms, provided they are easily accessible and affordable, could increase women's agency. Also, since men still control the sexual agenda, HIV interventions should rather focus on men and emphasize their responsibility: everywhere they live, work and relax. Alternatives for men's drinking and sexual activities should be created, especially in the area of sports and culture.

In their efforts to mitigate the AIDS impact, the UNAIDS claims that Malawi's HIV/AIDS Policy and Strategic Framework are "home grown", that they emphasize the "public health approach" and "respect human rights" (UNAIDS 2004: 1-2). If all this is truly the case, to address structural violence in Malawi should obtain their highest priority and public and private sectors should support the implementation of these promising documents: with immediate effect.

## Notes

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- 1 Women's customary and statutory rights to land have weakened since the amount of unallocated customary land has decreased. In both patrilineal and matrilineal family systems, men usually exercise control over land and its use (Nankumba and Machika 1988).
- 2 At the time of the study in 1996, the exchange rate for US\$1.00 was about 15 Malawian Kwacha (MK15.00).
- 3 See also Van den Borne 2003.
- 4 For more information on the peer education method as employed by the EC AIDS Project, see van den Borne 2005a: 9-10.
- 5 The Project felt that the bar-based peer education methods were no longer cost-effective and followed again two trends in international public health: developing community based interventions and working with 'commercial sex workers'. In 1998, the Project changed the name of the 'bar girl component' into 'commercial sex workers component' (Van den Borne 2005a: 273).
- 6 This index ranks 141 countries in the International Human Suffering Index. It differentiates between extreme, high, moderate and minimal level of human suffering, based on ten measures. These are life expectancy, daily caloric intake, access to clean drinking water, infant immunization, secondary school enrolment, gross national product per capita, rate of inflation, communication technology, political freedom and civil rights. Each indicator can range from zero to ten, with ten indicating the highest human suffering. The Netherlands has an HSI of 1 (Philippine Legislators' Committee on Population and Development Foundation 1992).
- 7 UNDP's Human Development Index measures the progress of both rich and poor nations on key social and economic indicators (Tsoka & Zoani 1997: 9).
- 8 At the end of 2002, the GNP was about US \$ 160 per capita (USAID 2004: 2).
- 9 See, for example, Roe 1992a, 1992b, 1992c, GOM/UN 1993, GOM 1995, Actionaid 1998, Care International 1998, Tsoka 1998, Poppinga 1998, Mueller-Glodde 1998, Devereux 1999, Khaila et al. 1999, NEC 1999, Tsoka & Mvula 1999 and Orr & Mwale 2001. Van den Borne (2005a) focuses on poor single women's coping.
- 10 See previous note.
- 11 Hyden, in his seminal work (1983), has introduced the concept of 'economy of affection'.
- 12 With all respect to those men who do care about their wife's and children's welfare.

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