Balancing men, morals and money: Women’s agency between HIV and security in a Malawi village
Verheijen, J.P.E.

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Safe or unsafe – that’s the question: Sex and HIV

Introduction

The overall question that this book aims to answer is whether economic empowerment of poor women will lead them to make safer sexual choices. This question follows from the increasingly widespread assumption among development professionals that it is poor African women’s dependence on male economic support that keeps them from practicing or demanding abstinence, faithfulness, or condom use, thus putting them at high risk of HIV infection. Whereas the previous chapter dealt with women’s choices concerning the partnerships in which sex takes place, the current chapter zooms in specifically on the choices that Mudzi women make concerning sexual intercourse itself. This chapter explores one component of the overall research question, namely the aspect of safe(r) sexual choices – more precisely, the local conceptualizations of ‘safe’ and ‘unsafe’ sex. In brief, I argue that Mudzi women’s perceptions of what constitutes beneficial or harmful sexual practices diverge from what is branded as ‘safe’ and ‘unsafe’ sex in formal public health messages.

Among social scientists, policy makers, and development practitioners alike the concepts of safe and unsafe sex generally relate to the timing of sexual debut, the consistency of correct condom use, and the number and types of sexual partners (GoM 2010b: 37–9, UNAIDS 2011: 25). Safe and unsafe sex are thus narrowly defined as relating to specific health outcomes, particularly unwanted (e.g. teenage) pregnancies and sexually transmitted infections (STIs). In the daily life experiences of Mudzi women, however, sex is perceived to be much more than a potential source of unwanted pregnancies and STIs. In this chapter I elaborate upon the additional meanings – both positive and negative – that Mudzi villagers attach to sexual activity. Multiple short- and long-term pros and cons are (consciously
and subconsciously) weighed by Mudzi women to make choices concerning their sexual practices. As will be described in this chapter, HIV infection is but one consideration amidst many others. To understand the comparative weight given to the risk of a fatal HIV infection, this chapter will first assess the considerations and negotiations of Mudzi women concerning sexual practice in general, and subsequently those related specifically to HIV and AIDS.

In order to sufficiently grasp the attitudes of contemporary Mudzi villagers towards sex, it is relevant to explore how sexuality has been conceptualized and valued throughout Bantu history. The contemporary understandings of this conceptualization permeate daily life dealings with gender in general and sex in specific. Before turning to my findings from Mudzi, I therefore begin by describing the traditional construction of sexuality as a central aspect of Bantu cosmology. Following, I assess how this ideology of sex shapes (but also is shaped by) the daily life practices of today’s Mudzi villagers. After reviewing the multiple interpretations, valuations, and practices of sex in daily Mudzi life, I turn to HIV and AIDS as relatively new considerations when it comes to engaging in sexual activity. Assessing whether and at what cost HIV is preferably prevented, it appears that while some attempts are made to reduce transmission probabilities, HIV prevention is generally given low priority. The reasons for this low prioritization are assessed in the last section of this chapter.

Notably, by discussing how women weigh the pros and cons of sex I do not mean to insinuate that Mudzi women actually make conscious calculations each time they consider having sex. In this chapter, I try to dissect the various interrelated, overlapping, and at times opposing factors at play in creating and reproducing habitual – in this case sexual – behaviour. Human behaviour is rarely consistent: there are no mathematical rules to be found in which such-and-such choice within such-and-such situation will always lead to such-and-such decision. Mudzi villagers, like people everywhere, have multiple, often divergent, and at times contradictory motivations, which they combine in different ways at different occasions without much thought. A similar argument was made in the previous chapter on women’s tactical use of prevalent gender norms to navigate their daily lives. The intersection of an age-old deferential attitude towards sex with the new biomedical fatality of it, as described in this chapter, offers another interesting case to assess how diverging discourses can coexist and be tactically employed in varying ways within different contexts.

Sex

**Sexual ideology in Bantu history**

Throughout history, Bantu groups have been preoccupied with safeguarding fertility as this was considered the first requisite for clan survival (Saiedi 2010, Wembah-
Rashid 1995: 52). In an attempt to ensure sufficient, healthy, and strong offspring, numerous sexual regulations were put in place, presumably by the ancestral spirits on behalf of the Supreme Being (Van Breugel 2001: 172). Community harmony and continuity were believed to depend on observing the sexual norms and taboos as this appeased the ancestor spirits and assured human reproduction (Bryceson et al. 2004: 20, Lwanda 2004: 30). Thoroughly educating both boys and girls on these sexual regulations was therefore perceived of utmost importance.

Sexual education for youngsters took place primarily during a pre-adolescent initiation ceremony. The terminology used for the female rite de passage is comparable among many of the Bantu-descendant ethnic groups throughout Central Africa, indicating that this practice must date back from before the Bantu’s initial dispersion from the Congo basin several thousands of years ago (Saidi 2010: 101). As the continuation of a matrilineal clan depends particularly on women’s fertility and hence sexuality, more emphasis was placed on girls’ sexual instruction. As a result, the initiation ceremonies for girls were more elaborate than those for boys, and have persevered longer and among wider populations than boys’ rites de passages (Morris 2000: 113, Saidi 2010: 121). The prevalence of female initiation rites has in general been associated with a valued social status for women, as such rites indicate that importance is attached to a solid preparation for girls’ role-to-be (Brown 1963: 849). The various initiation rites during women’s lives in Malawi have been argued to function to strengthen the matrilineal bond between women, who make great fun of men and their sexual drives during the rites, so positioning them as outsiders (Bennesch 2011: 92, Morris 2000: 95).

Over time many Bantu-speaking groups in Malawi and beyond have, under various patriarchal influences, evolved into patrilineal, virilocally. However, as established in earlier chapters, the Yao of southern Malawi have remained largely matrilineally and matrilocally organized. Until this day, initiation ceremonies are performed for both boys and girls. The perseverance of this cultural practice among the Yao may to some extent be related to their adoption of Islam from Arabic trading partners towards the end of the nineteenth century. Within this version of Islam it was common practice to ceremonially initiate boys, which allowed the pre-adolescents’ initiation rites of the Yao to be easily incorporated into the new religious lifestyle, under changed Islamic names but with largely unaltered content (Lwanda 2004: 31, Msiska 1995: 70, Sicard 2000: 296). Lwanda (2004: 31) argues, furthermore, that maintaining cultural practices became a significant means to resist colonialism. The Yao in particular resented the colonial.

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1 It is particularly on historical (ethnographic, linguistic, and archaeological) data on these female initiation rites that Christine Saidi (2010) bases her claim that all Bantu-speaking people share a matrilineal history (see also Amadiume 1997 and Diop 1989 [1963] for such claims about the entire African continent).
regime which had deprived them of their main source of wealth and power by abolishing slavery, whereas other ethnic groups appreciated the protection found at Christian missions against the Yao slave raids (see Chapter 2). Bantu-descendants who converted to Christianity are today less likely than their Islamic counterparts to perform pubertal initiation ceremonies (Munthali & Zulu 2007: 154–5), which were considered heretical by missionaries and therefore strongly discouraged (Bennesch 2011: 40, Richards 1969 [1940]: 27).

Yao girls, as the boys, are communally initiated at an early pre-puberty age, usually before the age of ten (Mair 1951a: 60, Morris 2000: 92, Msiska 1995: 70–1). The female initiates were and are held in seclusion with their fellow girl initiates for a certain period of time (some claim it could last up to years in the far past, and today is usually only between two and four weeks: MHCR 2005: 37, Wembah-Rashid 1995: 49), and instructed about the proper ways to behave as an adult women. The girls are told to be generous, kind, and hardworking (Morris 2000: 96). They are taught how to observe personal hygiene, how to dress and sit properly (MHRC 2005: 36, Munthali & Zulu 2007: 159–60). Furthermore, they are instructed to always respect and obey the elders of the community as well as their future husbands (Mair 1951a: 62, Morris 2000: 96, Msiska 1995: 71–2, Munthali & Zulu 2007: 160, Richards 1969 [1940]: 67).

The central theme of the initiation ceremonies is, however, the act of sex. Uninitiated youth are strongly forbidden to engage in sex, as a pre-initiation pregnancy was considered among the worst of threats to ancestral protection of the community (Morris 2000: 96, Richards 1982 [1956]: 33–4, Wembah-Rashid 1995: 49). During initiation, girls are explicitly and elaborately told and shown, through songs and dances, how to perform coitus so that mutual pleasure and timely offspring can be ensured. Sex, it is stressed to both male and female initiates, is vital for good personal health, a solid marriage, community harmony, and clan reproduction (Morris 2000: 70, Poewe 1981: 66–7). In other words, sexual activity was conceptualized as each woman’s duty towards herself, her husband, and most importantly her community (Chirwa & Chizimbi 2009: 19, Wembah-Rashid 1995: 48). As essential as female procreation was for the community, as important,

2 Munthali & Zulu (2007: 154–5) found a strong link between religion and the likeliness of having been initiated. Among Muslims (all of them Yao) 80 percent of boys and girls had been initiated, while among the studied Christian groups 22 to 28 percent of boys and 32 to 40 percent of girls had undergone initiation.

3 When later these girls start to menstruate, they go through another, less elaborate, individual ceremony (Davison 1997: 46, MHRC 2005: 38-9, Morris 2000: 92).


by extension, it became for an individual. Only after giving birth were women considered full members of society, and permitted to establish their own household, thresh their own grain, partake in initiation and pottery rituals, and eventually be granted a position of power (Saidi 2010: 164). During their initiation, girls were (and still are) instructed to never deny sex to their husband unless they are menstruating (MHRC 2005: 38), just delivered a child, miscarried, or induced an abortion⁷ (Richards 1969 [1940]: 88, Van den Borne 2005a: 51). At the conclusion of these rites de passage, the newly initiated were encouraged to put into (sexual) practice what they had learned so as not to forget⁸ (Forster 2001: 251–2, MHRC 2005: 37, Munthali et al. 2006: 51, Rimal et al. 2004: 30–1) [see also P3 1154].

In an early overview of ethnographic data on Bantu marriages, Torday (1929: 257) notes that most of the studied groups neither expected nor valued a bride’s virginity at marriage (see also Mitchell 1962: 38 for Yao specifically). Smith & Dale (1920: 38) quote a Bantu informant who, when probed for a local translation of the word ‘virgin’, jokingly answers that a woman who never had sex would be in his language called ‘a fool’ (in Saidi 2010: 148). Writing about Bantu descendants in Zambia, Richards (1969 [1940]: 15) accounts that women who reject men are criticized for having ‘arrogance of the womb’. As matrilineal and thus female procreation is so highly valued, women’s sexuality seems to have been stimulated rather than restricted (Horne 2001: 307, Saidi 2010: 151).

This is not to say, however, that sexual activity in general was unrestricted, which Caldwell et al. (1989) suggest in their much cited (and critiqued) theory of a distinct and internally coherent African system of sexuality (discussed in Chapter 1). The Bantu considered sexual intercourse to be not only a biological undertaking, but also a spiritual one through which mystical powers were released.⁹ This made it necessary sometimes to refrain from sex while at other times to engage in it in strictly prescribed ways.¹⁰ During the process of pottery and iron making, for example, all involved had to abstain from sex (Saidi 2010: 133, 137), as must close

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⁶ It may be in this light that Niehaus (2007: 852) has argued that for both men and women in rural South Africa “celibacy and singleness were deemed to be more dishonourable than promiscuity.”

⁷ Writing about the Bemba, a group of matrilineal Bantu descendants in Zambia, Audrey Richards (1969 [1940]: 15) asserts that married couples were expected to have intercourse every night except during these taboo periods, and normally more than once a night.

⁸ To what extent this still occurs is unclear (e.g. Chirwa and Chizimbi 2009: 15–6). Lwanda (2004: 32) argues that this practice is likely to be kept hidden by rural practitioners as it has been widely condemned by health professionals and urban elites for potentially spreading HIV (for examples of this condemnation see GoM 2010b: 39, Liwewe et al. 2009, MHRC 2005).


¹⁰ This is related to the belief that sexual activity creates a ‘hotness’ that is harmful to those who are sexually inactive, or ‘cold,’ e.g. young and old people. I will not go into this hot-cold dichotomy that underlies many sexual rules as I believe it is not necessary for the main point I seek to make. For an analysis that goes beyond the usual description of this explanatory model, see Drews 1991 (in Dutch).
relatives and counsellors of youngsters during their initiation rites (Mair 1951a: 60), parents during their child’s illness (Van Breugel 2001: 203), and the relatives of a deceased person until the prescribed mourning period ends (MHRC 2005: 61). Such ritual abstinence was assumed to help avert misfortunes as small as cracking pots or as big as lethal epidemics. Extramarital sex, furthermore, was considered a taboo at any time, and thus also subject to supernatural punishment from the ancestral spirits (Saidi 2010: 150, Van Breugel 2001: 170,199–200) [P8 0033–5]. When committed by either spouse during pregnancy, the punishment would entail protracted childbirth and possibly the baby’s and/or mother’s death (Mair 1953: 98, MHRC 2005: 48, Torday 1929: 283, Wembah-Rashid 1995: 54). When committed during other periods, a mystical, potentially lethal illness would be inflicted on those near to the perpetrator, generally his or her spouse or children (Peters et al. 2007: 48, Van Breugel 2001: 169). These ailments, called *mdulo*, *tsempho*, *ndaka*, and *kanyera* – of which the symptoms11 to a great extent resemble those of AIDS – are also risked by a man who transgresses the taboo of having intercourse with a woman who is menstruating, recently gave birth, miscarried, or had an abortion (Forster 2001: 253–4, Kondowe & Mulera 1999: 5, Lwanda 2004: 30, Peters et al. 2007: 48–55, Van Breugel 2001: 192).

While sex was curbed during certain precarious, often transitory, situations (Van den Borne 2005a: 51), it was required at other times – to protect, heal, or cleanse (one of) the sexual partners or someone close to them. For example, one act of ritual intercourse was considered mandatory between new parents soon after childbirth to strengthen their baby and protect it from harm12 (Drews 1991: 90–1, MHRC 2005: 84–5, Richards 1982 [1956]: 30, Saidi 2010: 148, Zulu 2001: 475–6). A new widow or widower too had to have ritual sex, with a specifically designated partner (a relative of the deceased or someone hired to do the job) to cleanse off death (Mair 1953: 97–8, MHRC 2005: 64, Richards 1982 [1956]: 34, Saidi 2010: 152). A chief and his wife needed to perform ritual intercourse in the bushes where they planned to found a new village (Saidi 2010: 148). Traditional healers, furthermore, may prescribe their clients to have (sometimes incestuous) intercourse to accomplish their wishes, which may range from curing infertility to becoming rich (Kondowe & Mulera 1999: iv) [P2 0013, 0662; P3 0506]. Sexual intercourse has thus been attributed with strong – positive and negative – potencies, which must be carefully channelled by observing the regulations laid down by the ancestors, to avert illness and other misfortunes, preserve social stability, and, most essentially, assure community survival.

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11 These symptoms include thin hair, weight loss, diarrhoea, ‘miasmic’ appearance (Kondowe & Mulera 1999: 5), feverishness, and sickliness [P8 0033, 0039].
12 If the father was no longer available, the child’s mother could also have ritual intercourse with any other man (MHRC 2005: 54), in some cases a man especially hired to provide this service (Van Breugel 2001: 184).
To what extent these sexual norms and taboos have ever been scrupulously observed cannot be ascertained. What is handed down from one generation to the next, especially when done through ritual ceremonies, often entails ideology rather than actual practice. One example of how reconstructions of history are often reflections of ideals rather than realities was already discussed in the previous chapter: the claim by many Mudzi elders that marriages were more stable in the past than today, which is unsubstantiated by other data (see also Kaler 2001). It seems that these elders’ memories are coloured by prevailing ideas about proper marital conduct and a moral condemnation of contemporary youths’ failure to conform to these. What is today presented as tradition, as “the ways of our ancestors”, may never have been actual practice. What is communicated during the initiation ceremonies as constituting proper behaviour is just that: a contemporary interpretation of how things used to be and therefore should be. Furthermore, ‘traditional’ messages about ideal behaviour not only inform actual practice (to some extent at least), but are also shaped by it. An example of this, described above, is the fact that Islamic elements, including new Arabic names, were added to initiation rites when Yao chiefs strategically adopted the religion of their thriving trading partners. Another example touched upon earlier is the fact that many ethnic groups have shifted or are shifting from matrilineal to patrilineal ‘traditions’, as a result of slave marriages, contact with patrilineal Zulu descendants from Southern Africa, and with Western, patriarchal missionaries, colonial administrators, and post-colonial development professionals. Traditions are thus not static remnants from one pre-historic day of origin – they evolve over time, are reinterpreted and adapted, abandoned, and (re)created.

Various observers of Malawi have noted a discrepancy between the ideological sexual norms and taboos presented as traditions, and actual practice – generally interpreting this as a weakening of adherence (Bennesch 2011: 18, 72, 83, Bryceson et al. 2004: 20, Drews 1991: 94, Van Breugel 2001: 177, Van den Borne 2005a: 54). It has been suggested that this weakening is related to a waning of the moral authority that was formerly vested in the elders of a community (Undie & Benaya 2008: 134). These community elders were responsible for ensuring that the cultural customs of their ancestors (as perceived by these elders) were honoured and preserved. Ever since young men gained access to paid employment, however, the power balance is said to have increasingly shifted from the elders to the male youth (Lindsay & Meischer 2003 for Africa in general, Mandala 1982: 35 for Malawi). Their contact with other secular and religious worldviews through labour migration, education, urbanization, and modern mass media have likely contributed to a crumbling – though not a vanishing – of the felt need to behave as presumably prescribed by the ancestral spirits. The Zambian Bantu descendants studied by Drews (1991: 94) noted that taboo-violating behaviour is no longer punished as consistently as it used to be in the past – which may well be related, as both cause
and consequence, to a slackening in the observance of traditional rules. Chirwa & Chizimbi (2009: 61) found the same to be said throughout Malawi. In Mudzi, several elderly blamed external development agencies and post-Banda presidents that introduced and promote concepts like ‘freedom’, ‘democracy’, and ‘human rights’ for a progressing disregard from younger generations for the advice of their elders, and so their communities’ traditional guiding principles13 [P3 0435, 0953, 2543, 2586, 4027]. According to them, contemporary boys and girls argue that “this is our time” and “we have rights” to emphasize and justify their sexual freedom.

It is not my intention to resolve whether or to what extent observance of sexual traditions has weakened. I have presented a reconstruction of the Yao ancestors’ norms and taboos concerned with sexuality so as to assess what is impressed upon contemporary men and women as ‘the way it should be’ – irrespective of whether this is representative of the way it actually was in the past. This reconstruction should therefore be taken as an impression of the various issues at play, particularly the strong cultural emphasis on female fertility.

**Sexual practice in Mudzi village**

In rural areas like Mudzi (contemporary versions of) traditional practices are still discernible. Boys are circumcised14 and undergo a one-month initiation program while girls are secluded for two weeks to be initiated into adolescence and adulthood [P3 0214, 1669]. Another custom traceable to early Bantu history (Saidi 2010: 101) and still performed in Mudzi is the ceremony held during a woman’s first pregnancy to prepare her for delivery [P2 1846; P3 1880]. The traditionally prescribed abstinence15 after childbirth and during menstruation too continues to be observed [P2 0144; P3 1951, 1967], as is the taboo on adding salt to food when menstruating [P3 1880].

Other norms and taboos seem to be taken less seriously. Despite clear instructions, during initiation ceremonies and beyond, to always respect and obey elders, many Mudzi youngsters fling to the winds the advice and requests of their (grand) parents [P3 0771, 0953, 2263, 2543]. Another restriction that is not (and may never have been) strictly observed is marital fidelity, as we have seen in Chapter 5. Although

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13 Bennesch (2011: 72–83) and Chirwa & Chizimbi (2009: 79) have also noted this discourse throughout Malawi. Both suggest that it may have rather been the disappearance of Kamuzu Banda’s intensive and brutal disciplinary regime (keeping a close watch on people’s behaviour; scaring them from going out at night; and forbidding, among many other things, women from wearing trousers or skirts above the knee, and men from having long hair or earrings) that triggered ‘loose’ behaviours rather than the introduction of these Western concepts per se.

14 Before the introduction of Islam, Yao boys were partially circumcised. When the initiation rites were Islamized, it became customary to remove the whole foreskin instead of only the outermost skin of the penis (Msiska 1995: 73).

15 As noted earlier, there is no fixed rule about the length of post-partum abstinence in southern Malawi, but on average it is practiced for six and one-half months (GoM 2011a: 84, Zulu 2001: 475–6).
A child’s illness is often (sometimes semi-jokingly) interpreted as a sign of its parents’ promiscuity [P2 1498; P3 1817, 2560; P8 0023, 0035–7] – indicating that the belief in a mystical link between infidelity and disease continues to prevail – numerous Mudzi men and women engage in concurrent (semi-)relationships [P2 1084, 1300, 1345, 1408, 1567, 1636, 1645, 1656, 1695, 1893, 2187; P3 1038, 1186]. A recent study on risk perception during pregnancy among Malawian Yao also suggests that ancestral sanctions against extramarital sex continue to be feared. One major concern was found to be the supernatural harm that can be caused through the infidelity of either partner (Launiala & Honkasalo 2010: 405). But, as further discussed below, and as also found by an in-depth study of multiple and concurrent partnerships throughout Malawi, a number of extenuating circumstances can be called upon by both men and women to justify their involvement in such relationships (Chirwa & Chizimbi 2009). Van Breugel (2001: 200, 208) furthermore writes that Malawians increasingly attempt to circumvent potential punishment from the ancestral spirits for sexual ‘misbehaviour’ through the use of protective medicine. Whether this solution to ancestral restrictions truly is new may be disputed, but in Mudzi such herbal measures were indeed discussed and presumably used – for example by women who wanted to avert their child’s illness after having slept with another man than the child’s father [P3 1208, 1967; P8 0024, 0037].

Concurrent (semi-)partnerships occurred so frequently in Mudzi that Gertrude considered it key in explaining the high number of weak and ill children [P8 0023, 0036]. The high incidence of concurrent partnerships despite traditional restrictions against it is likely to relate, whether as cause or consequence, to exculpations that have been constructed for both male and female promiscuity (see also Chirwa & Chizimbi 2009, Maganja et al. 2007, Wamoyi et al. 2010). As established in the previous chapter, women’s involvement in multiple relationships can locally be excused on economic grounds. The pretext constructed for male promiscuity is rather of a biological nature, as Malawian men and women alike presume that men are promiscuous by nature16 (Bennesch 2011: 146, Smith & Watkins 2005: 654) and may even die if unable to release their sperm when sexually aroused (Van den Borne 2005a: 308). This is difficult to reconcile with the prescribed months-long abstinence after childbirth, hence justifying many fathers to seek temporary or permanent new sexual affairs. The innate sex drive that is attributed to men, like the need for economic support that is ascribed to women, help to explain the fact that despite strong ancestral discouragement, multi-partner relationships can take place on a large scale. The fact that older generations (including those who turned into ancestor spirits) also involved

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themselves in such sexual ‘misbehaviour’ has been used as justification too [P2 1692] (see also Chirwa & Chizimbi 2009: 32–3, Van Breugel 2001: 260–1). Some other studies have suggested that the Islamic approval of polygyny is at times referred to by Malawian men and women to justify (only) men’s involvement in multiple sexual relationships (Chirwa & Chizimbi 2009: 19,31; MHRC 2005: 20). We have however not heard reference to such religious justification during the many conversations we had with and overheard between Mudzi women.

The fact that males are assumed to be driven by an innate desire for sex does not mean that women are denied feelings of sexual lust. In line with the traditional emphasis on sexual enjoyment for both partners, several comments from Mudzi women show that female sexual desire is explicitly acknowledged. When mentioning reasons for entering into sexual relationships in general, numerous women mentioned lust [chilakolako], or the veiled term ‘human nature’ [chilengedwe], along with the more pragmatic motives discussed in Chapter 5 [P3 0802, 2277, 2798, 3322–3, 3440–1, 3596, 3664]. Although rare, on a few occasions women hinted more openly at their own feelings of sexual desire [see also P3 0790]:

Makuta (32) is financially sufficiently provided for by her husband who migrated to find work in South Africa. When she came to borrow Gertrude’s bicycle to visit her boyfriend in a neighbouring village, she explained about her extramarital relationship: “Imagine, four years of not sleeping with my husband! I cannot manage to stay without sex for so long.” She had complained to her husband about this over the phone, and he had joked back that he would cut off his penis and send it to her. [P2 1539, 1600]

Another Mudzi woman told Gertrude that she could not sleep because of “some feeling in her body”, and that she, lacking a man to satisfy her desire, considered taking a maize cob to help herself. [P2 0158]

Other research in rural Balaka found that women’s extramarital relationships are, among other things, motivated and justified by sexual dissatisfaction with their husbands (Tawfik & Watkins 2007, also Chirwa & Chizimbi 2009). Saidi (2010: 151), in her book on women’s social position in early East-Central Africa, argues that throughout Bantu history women have been “raised to be free agents in their sexual lives.” This is confirmed by statistics that indicate that in Balaka district only 1 percent of men and women feel that a husband would be justified to beat his wife if she refuses to have sex with him (GoM 2011a: 393–4). My data show, however, that whereas some of the miyambo [traditions, cultural values] promote women’s sexual agency, others work to curtail it:

Several young women, at least some of whom had enjoyed sex during the courting stage of their relationship, complained after marriage to us and other women about the unrelenting sex drive of their husbands. Eventually, several of these women decided to divorce because of it, as did Jane (15): “I have run away from my husband [in Balaka town] because he was just sleeping with me often. I hadn’t realized that marriage is different from chibwenzi. Then you see each other sometimes, and then not for some days. But now, this boy wants sex all the time! Sometimes up to five times a day! I can’t manage.” [P2 0414, 1586; P3 0757, 1462, 1569]
The fact that these women chose to divorce so as to elude unpleasant sex demonstrates their perceived right to a satisfying sex life, and their ability to act upon it. This confirms Saidi’s (2010) claim about women’s high degree of sexual autonomy. It also demonstrates, however, the limits to this autonomy. The women felt unable to reduce the frequency of their sexual encounters to better meet their own desires through any other means than complete dissolution of the relationship. They were reluctant to negotiate about their partner’s sexual behaviour, possibly because they had been socialized not to disobey or deny sex to their husband.

Hence, while raised to be active sexual agents and encouraged to make sex enjoyable for themselves, women are restricted in their agency by the other norm: to not obstruct their husband and his sexual desire (see also Bennesch 2011: 83, MHCR 2005: 38). The question that remains is whether this has always been the case, or resulted from the relatively recent strengthening of (young) men’s social position due to their access to financial capital and other earlier described patriarchal forces.

For women, giving in to male sexual lust seems, besides a cultural obligation and personal pleasure, also to be considered an important instrument for harnessing male support. It is a major aspect of women’s obligations within the marital gender contract, and the performance of it in theory obliges men to live up to their side of the contract. According to some Mudzi women chatting at the pump one afternoon, the many children born in their area are a result of the fact that women believe they can only hold on to a partner by giving him the pleasure of sex often [P2 1402]. Other comments indicate that overall, women have no doubt that withholding sex from a man will directly push him into the arms of another woman [P2 1620; P3 1324, 1563, 2251].

Besides satisfying male (and female) lust, women often consider sex necessary to solidify a relationship as it provides their new partner with a child of his own – which is particularly desirable when either partner already has children from a previous partnership [P2 1534; P3 0871, 1268, 1290].

Not long after the youngest of their two children was born did Chikondi (28) decide to divorce her husband – who was a generally fine man but who would beat her severely when drunk. As a divorcée she faced the increasingly offensive suspicion from her fellow village women, who feared that Chikondi would now be hunting for their husbands. Therefore, when a stranger proposed marriage to her one day when walking to the market, Chikondi allowed the man to move into her house that very same evening. Her new husband objected to only feeding the children of another man, and insisted that Chikondi would soon bear him a child too. Chikondi therefore refrained from using birth control measures and indeed found herself pregnant without much delay. Nine months later she gave birth to twins, and six months after that her husband decided to move back to his previous wife. “Men these days are a problem,” Chikondi sighed. “During the first days they say that they love you, that they will take care of you, and stay with you until you die. Then they start saying that they want to have a child. Then you get pregnant, working in the field with a big belly, afterwards running home to cook for him. But soon after, they leave you. Then the next one comes, and the same happens…” [P3 0871, 3817]
Through purposefully conceiving a child with her new husband, Chikondi weaved him into her patchwork household. By doing so she hoped, as she did before and expects to do again, to increase her chances of keeping the new man attached to her household. This attachment, as described in the previous chapters, may last even after the sexual relationship formally ends (see also Guyer 1994, Luke 2003: 74, 77). Conceiving a man’s child creates a bond, with the father himself but also with his relatives, that can be called upon as long as the child must be provided for. It thus forms one of those much-wanted potential sources of support to fall back on in times of need – although, as described in Chapter 4, these potentially supportive bonds do not always materialize [e.g. P2 0924; P3 3821, 3897].

Not only men value offspring, however. As described earlier, procreation is also vitally important for women, whose (self-)identity largely depends on their status as mother. Besides conforming to the cultural ideal of motherhood, and turning a sex partner into a potential provider, conceiving leads to children who will hopefully take care of their mother once grown up. Mudzi women who were encouraged to give up a child, for example to have it taken care of by its father or to kill it as sacrifice to become rich, explicitly argued that they did not want to do so because the child is their future source of support [P3 0784, 1899, 3949, see also P3 2491, 3823]. “He may go to South Africa,” one woman dreamed out loud about her baby boy, “and send me blankets” [P3 1899]. Unsurprisingly, considering the emphasis on procreation and encouragement of sex during initiation rites, over one-third of the Mudzi women who can recall the year in which their first child was born (N71) became mothers before turning 18, and some were as young as 14. Most unsolicited comments from Mudzi women about sex revolved around its reproductive qualities. Generally, sex is directly associated with becoming pregnant [P2 0123, 1527, 1540, 1638, 1832, 1866; P3 1370, 1735]. When sex does not lead to pregnancy, herbal medicines and folk healers are sought to bring about conception [P2 1702; P3 0502, 2895]. When these measures remain ineffective, women may (secretly) turn to another man (who is either paid for this service or not) in an attempt to conceive. If a couple that fails to produce live offspring does not divorce by itself, they are pressured by their parents or community elders to pursue new, hopefully more fruitful matches [P3 3854, 4012].

While pregnancy is desirable in many cases, in several others it is not. The small minority of young women who are serious about finishing school, for example, do not want their ambitions shattered by having to stay home caring for a baby [P2

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17 Local witchdoctors (are believed to) advise clients who request to become rich to kill their child, or have incestuous sex [e.g. P2 1212, 2166-7; P3 0506] in order to accomplish their wish.

18 This number is based on self-reports. The real number is likely to be higher, as we know of at least two women who during the formal interview omitted to mention a child they conceived years before their first marriage [P3 1046, 1099].
Young women who prefer the generally more profitable *chibwenzi* relationship over a marital union would rather not have this lifestyle jeopardized by a baby either [P2 0914, 1845; P3 1249, see also P2 1811, 1940; P3 0860, 2249, 3001–2 about the unlikeliness of men being attracted to women who bore many children]. Conceiving a new baby while still nursing another is culturally disapproved of (Forster 2001: 253, Wembah-Rashid 1995: 55–6), so having a young child is generally felt to be a reason for not wanting a new pregnancy yet [P2 1515, 1736, 1756; P3 1248, 1951, 2059]. Mudzi women with older children, furthermore, regularly expressed their unwillingness to have to care for even more – especially after having been abandoned earlier by several men after conceiving [e.g. P2 1403, 1498, 1534, 1772; P3 1735, 3978–80]. Elderly women may feel ashamed to become pregnant [e.g. P3 0871].

As sex is for Mudzi women so inextricably bound up with conception, this potential consequence is an important consideration when deciding whether or not to become involved with men. Desperately wanting to avoid pregnancy leads some women to temporarily refrain from any sexual relationship – particularly girls who hope to secure a future livelihood through education, and women who are fed up with men leaving them with ever more mouths to feed. Abstinence, however, is not the only, nor the most desirable, means to reduce reproduction risks. Mudzi women who are unwilling or feel unable to completely abstain from sex, yet prefer not to conceive, can use either traditional and modern folk medicine or biomedical contraception.19 Those who find themselves with an unwanted pregnancy can undergo clinical abortion (fairly costly at 3000MK) or can (and at a large scale do) turn to herbal folk healers or self-medication with poisonous substances available at the local shops, such as washing powder [P2 0485, 0643, 0902, 0914, 1500, 1515, 1544, 1702, 1756, 1845].

In sum, more than with anything else, sex is in Mudzi intrinsically associated with reproduction – which is in line with the age-old emphasis on sex as vital for community survival. Fertility, procreation, motherhood, and children are in general highly valued, and important reasons for women to engage in sexual relationships with men. Nonetheless, there are also numerous circumstances under which individual women may prefer to avert conception or terminate a pregnancy.

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19 The most commonly used (traditional folk) method consists of a string tied around the waist with a knot for each year that one wishes not to conceive [P2 349; P3 0871]. Because of its visibility this measure can, however, only be used when a woman’s sexual partner approves of her birth-controlling intentions [P3 0871]. The same goes, albeit to a lesser extent, for biomedical contraceptive pills as these have to be kept somewhere in the house and be taken in each day, which may be difficult to conceal. The pills can be obtained for free at any of the three health clinics frequented by Mudzi villagers, but I know of no one in Mudzi who used them [P3 0593]. The head nurse of one of these clinics confirmed the general low use of birth control pills, and explained this as resulting from women’s fear to forget a daily dose, and the potential risk of a disagreeing husband finding out [P3 0982]. Mudzi women themselves mentioned
Obviously, then, other reasons to engage in sexual activity play a role too. Similarly, as described in this section on sexual ideology and practices, even though infidelity is traditionally discouraged through threats of ancestral punishments, in day-to-day practice both men and women regularly engage in concurrent sexual relationships. Conformity to the traditional ideals of procreation and faithfulness is thus recurrently compromised by other needs and desires. Our data, as presented in this section and the previous chapter, suggest that women’s other motives to engage in sex besides reproduction include satisfying lust, conforming to the (new?) cultural ideal of female subordination to male sexual desire, and wishing to cultivate a partnership with a man for both social and economic reasons.

Whereas pregnancy as a consequence of sex is considered negative in some situations but positive in many others, the risk of contracting a disease as a result of sexual contact is considered negative at all times. In the next section this consideration of risking a sexual transmittable infection, particularly HIV, when having sex is further elaborated upon.

HIV and AIDS

When mentioning fear of infection as reason for refraining from sexual intercourse with a particular man or at a particular occasion, Mudzi women use the term ‘matenda’ [P3 0505, 0742, 1558, 1599, 2941, 2943–4, 3147, 3475], which is the general word for ‘diseases’ [singular nthenda]. Gertrude, as well as other researchers of ChiChewa-speaking people, however, usually translated this word as specifically meaning ‘AIDS’. Further comments from informants indicate that they indeed often, though not necessarily always, referred particularly to matenda a Edzi (literally ‘the diseases of AIDS’) [P2 0741; P3 1491, 1501, 1572, 2134, 2943–4, 3147, 3868, 3919]. In the past it had been other sexually transmitted infections like gonorrhoea and syphilis that were feared for their potential fatality [P3 3861, 3547] (Lwanda 2004: 33). However, since the introduction of Western medicines these are now easily curable – and thus less frightening – diseases (Watkins 2004: 679). Consequently,

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a widespread fear of permanent infertility being inflicted by these pills [P3 0721]. Alternatively, women can, and more often do, opt for birth control injections that last for three months [P2 1300, 1594, 1756, 1761, 1838; P3 0748, 2734], which are also freely available at the health clinics. These do not depend on daily adherence, and can be kept hidden from a sex partner, if needed. Nonetheless, these are also feared by some to cause sterility, illness, or even death [P3 2867, 3481–2]. Condoms are rarely used [P2 1594; P3 0871, 1186], as will be further explained in the next section on HIV and AIDS. Women who are certain never to want another child can choose to have a surgical operation (but only when having no less than four living children, as prescribed by hospital regulations) or drink a locally brewed sterilizing concoction [P3 0871, 1280, 1290].

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Researchers tend to interpret the word matenda as a euphemism, used to avoid utterance of the stigmatized word ‘AIDS’ (e.g. Bryceson et al. 2004: 13, 29, Peters et al. 2007: 40). However, the widespread and uncomplicated use of references to HIV and AIDS in Mudzi, for example in jokes
HIV is at present the main sexually transmitted virus to be feared. In this second half of the chapter I therefore focus in particular on the extent to and ways in which Mudzi women take into account the risk of HIV infection when considering having sex.

To this end I first establish that Mudzi women (and men) prefer not becoming infected with HIV for a number of reasons (which differ somewhat from the generally assumed reasons). Following, I assess the ways in which HIV transmission is (and is not) avoided, finding that despite a general hope to not become infected, prevention is often not actually a priority. In the last section I assess explanations for this low prioritization of HIV prevention in the daily lives of Mudzi women.

**Fear of infection**

It may seem obvious but should not be taken for granted that a research population, or a group of individuals within it, necessarily feels the need to avoid HIV infection. In this light, the study results of Launiala & Honkasalo (2010) are noteworthy. Assuming that malaria would be perceived as a major risk during pregnancy, as it is life threatening to both an expecting mother and her unborn child, they intended to study how rural Malawians manage this risk. To their surprise they found that this risk was not taken seriously and consequently few measures were taken against it. In Mudzi, women expressed an explicit preference for not contracting HIV. One woman said she dreaded being diagnosed with HIV because she feared that she would then spend all her time “just waiting for death” [P2 1655]. Several other women worried that their children would be left uncared for if they were to die [P3 2943–4, 3147]. Most concerns about HIV infection, however, related to the stigma that continues to surround it:

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[P3 1573, 1598, 1625, 2770], when scrutinizing someone’s unkempt appearance [P3 2770] or sexual behaviour [P2 0741, 1404, 1542, 2187; P3 0435, 2709, 2867, 3868–9], when discussing someone else’s or one’s own sickness [P2 1271, 1524, 1719, 1871; P3 1419, 1730], or the death of relative [P2 1287; P3 1280, 1326, 3868], suggests that the topic is not necessarily hushed up (anymore) (see also Watkins 2004). I have no decisive answer to why the word matenda is generally used to refer to the potential sickening effects of sex (see also Van den Borne 2005a: 54–61 about multiple local readings), but I can make some speculations which seem reasonable within the context of our findings. Firstly, *matenda* may not necessarily refer to AIDS alone, but have been used also before AIDS entered the scene, and refer more generally to the fact that one can get a disease through sexual intercourse – as seems to have been the belief for many centuries. In the last century STIs were especially rampant, after having been introduced by colonial Europeans (Lwanda 2004). Furthermore, AIDS in itself is not a disease, but a syndrome that inhibits the body from fighting against infections and thus causes it to increasingly fall ill. Rather than having a distinctive ‘face’, AIDS expresses itself through a myriad of illnesses. Hence, the phrasing that someone suffers from ‘diseases’ is actually quite accurate for AIDS. Alternatively, or additionally, the word may simply be an abbreviation of the full expression *matenda* a Edzi [disease of AIDS], which is at times used too [P2 1548; P3 1419, 3919]. As educational messages about HIV and AIDS invade daily life in Mudzi on such a scale that they have become inescapable and omnipresent, AIDS needs only to be referred to as “the disease”, and anyone will understand what is meant. Use of the word *matenda* may, however, also be a remnant from earlier times when AIDS was surrounded with greater shame than it is now – by which I do not mean to imply that this shame has entirely disappeared.
“I am afraid to go for blood testing. If I will go and am found positive, definitely everybody in the village will talk about me”, one woman (24) said [P2 2080, see also P3 1523]. Another woman, Evelin (29), justified her reluctance to get tested by referring to a fellow village woman whose positive sero-status had recently become a public secret, and who for some time thereafter had been ignored by everyone other than her close relatives. Women had stopped talking when she approached the water pump, gossiped behind her back, and refused to share food and utensils with her [P2 0359; P3 1598, 2584]. Facing such hardship Evelin considered it impossible to live ‘positively’, which, following campaigns that encourage such an attitude, she understood to be a requirement when infected with HIV. [P3 1523, 2583–4]

Besides instigating loneliness at a time of emotional distress, the exclusion that results from the AIDS stigma bears severe material risks. An HIV-positive woman (34) from one of Mudzi’s neighbouring villages, told me how her fellow villagers had successfully argued to the chief that she should not receive a coupon for subsidized fertilizer “as she would soon die anyway” and therefore would not benefit from increasing yields [P8 0091]. Until recently at least, little reciprocity could be expected from someone headed for the debilitating, lingering death caused by AIDS. He or she would be in increasing need for support rather than be able to give any, making it unappealing for others to invest in the maintenance of a good relationship. The same has been found by Nombo & Niehof (2008: 241) in rural Tanzania, who summarize:

Different from the idealized view that social capital helps households maintain their livelihoods and strengthens their resilience to future shocks and stress, many of the HIV/AIDS-affected households were found unable to cope with HIV/AIDS impacts, because social capital itself is not resilient in a context of high HIV/AIDS prevalence and widespread poverty.

In this light, even arousing suspicion of a positive HIV status can be detrimental for one’s potential access to support, and is thus anxiously avoided.

Comparing data from rural and urban Zambia, Virginia Bond (2006) found that AIDS stigma is most severe where resources are insufficient to help all in need. The intensive care that AIDS patients need, often for a long period of time, makes them an almost unbearable burden for (potential) caretakers who are already limited in money, food, and time. According to Bond, these (potential) care providers tend to frame the painful decisions they must make about the allocation of resources in a language of attribution and blame (2006: 192).

As described, promiscuity and infidelity have throughout Bantu history been classified as sexual taboos. Breaching these taboos was believed to provoke supernatural sanctions, many of which were health and life threatening. For over a century, Christian and Islamic leaders have preached against sexual ‘perversity’ too. Therefore, when public health campaigns introduced HIV and AIDS as resulting

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21 In the next chapter I elaborate upon this important concept, defining it as ‘the ability of individuals and collective actors to mobilize resources through their social network’.
from ‘dangerous’ sexual practices, including infidelity and promiscuity, this must have been fairly easy to grasp for Mudzi villagers and others throughout Central Africa (Watkins 2004: 679). Comments from Mudzi men and women indicate that HIV infection is indeed strongly associated with promiscuous sexual behaviour [P2 0144, 0309, 0741, 1272, 1404, 1524, 1542, 1811, 2187; P3 0602, 1326, 1791, 2527, 2665].

Eveles (88): “One of my daughters died because of AIDS. All her children died before they reached their first year; that is how my daughter realized that she was infected. She had a husband who moved around a lot, sleeping with many women. It was he who infected her.” [P3 1326]

Jasmine (57): “Have you seen Suset? She is just getting thinner and thinner. She used to have a lot of boyfriends, that why she is not looking healthy.” [P2 1271, 1524]. … “Livia likes men too much. She will die of AIDS just like her sister” [P2 1542].

Ada (18) was left by her husband just after bearing her first child. He had simply disappeared one day without a word. Her anger about his deceit was still fresh and bitter. “I think that he did not come back home because we were not able to sleep together [have sex] as our child is still young. He has now moved in with another woman, but soon she will also be pregnant and give birth to a child, and then he will leave her too and move to another wife. Later on he will have many wives, and die before he reaches 30 years!” she smiled grimly. [P2 0144]

Sofia (25): “I met my ex-husband on the way back from Balaka, and he gave me a cabbage. But he does not look good, very thin. He likes women too much. … He travels a lot, so maybe he is having girlfriends everywhere” [P3 2527]. Jasmine, the man’s mother, on another occasion listed that at that moment her son had a pregnant wife, a pregnant girlfriend, and two ex-wives with two and four children respectively, of whom Sofia is one. Worried, his mother added: “He is just getting married everywhere without fearing matenda.” [P2 2187]

It appears that HIV prevention messages fit in well with a local, age-old, and over-time-reconfirmed adage against sexual licentiousness. This adage, however, happens to be one that is widely accepted as a command that, despite its veracity, cannot always be lived up to. In other words, the new threat of AIDS has been merged into the realm of an existing and still-upheld norm against sexual transgression that is (accepted to be) at odds with lived experience. Notably, the norm itself is not challenged: it continues to be subscribed to by virtually all, just like the need to protect oneself against HIV infection is widely subscribed to. Yet in practice, below the surface of genuine agreement, failure to comply is considered normal.

In line with this, Isak Niehaus (2007) has argued that it seems unlikely that AIDS stigma is related to the apparent transgression of sexual normative behaviour, as is usually assumed. He argues that if this were the case, then the other sorts of inflictions caused by such behaviour should generate the same degree of discrimination, which they do not. Instead, he suggests that it is the horrendous physical decay and deadly end caused by AIDS, and the resultant status of HIV-infected persons as ‘dead while living’ that trigger fear and stigmatization. My findings, like those of Bond (2006) and Nombo & Niehof (2008), suggest that it may indeed be the terminal nature of AIDS that explains the differential attitudes towards this and other STIs. However, rather than stigma stemming from a fear of
the zombie-like look of patients, it may be their prospective inability to provide future support and the drain they pose on caretakers’ resources. Furthermore, it seems too farfetched to completely dismiss the thesis that an association of HIV and AIDS with sexual immorality causes stigma, because the discourse on this association is widely practiced at village level.

This analysis suggests that a double standard prevails in Mudzi. On the one hand, sexual transgression is widespread and clandestinely justifiable on many grounds. On the other hand, however, when the threat arises that a community member may become a severe burden due to AIDS-inflicted diseases, accounts of sexual culpability (and with this ‘stigma’) quickly surface. Possibly, as argued by Bond (2006), this sexual culpability discourse serves, whether consciously or subconsciously, to cover up and cope with one’s inability to offer the communal solidarity that is traditionally prescribed.

It appears that Mudzi villagers have good reason to dread HIV infection – because of its inherent death sentence, but even more so because of the (emotional and material) exclusion that it triggers. Suspicion of being HIV-positive is therefore preferably avoided – which, notably, is not the same as avoidance of infection itself.

**Efforts to prevent**

- Formal public health efforts

The knowledge that public health experts deem necessary for individual avoidance of HIV is widely at hand in Mudzi, as it is found to be elsewhere in Malawi and many other parts of sub-Saharan Africa (see Chapter 2). Until recently, formal HIV-prevention efforts in sub-Saharan Africa focused almost exclusively on informing the public about the existence of a new fatal virus, and ways to protect themselves against infection (Barden-O’Fallon et al. 2004: 131, Hardee et al. 2008, Kalipeni et al. 2007: 1015–6, Nguyen & Stovel 2004). Policymakers seemed to assume that, firstly, lack of knowledge about HIV and AIDS was the main contributor to the continued spreading of the virus, and, secondly, that people automatically stop having unsafe sex once they understand the risks involved (Barden-O’Fallon et al. 2004: 132, Hardee et al. 2008: 6). As a result of the widespread awareness campaigns, by the end of last century virtually all Malawians had at least heard of AIDS (see Chapter 2). When my Mudzi informants were subjected to an unexpected test on their knowledge of HIV and AIDS – during an event that was announced

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22 I doubted whether to use the word ‘unwillingness’ instead of ‘inability’ here. As noted in this chapter and further elaborated in the next, the few resources (including time) that Mudzi villagers can dispose of are often strategically invested, particularly in relationships that are potentially reciprocal. Villagers could choose to allocate their resources to help community members suffering from AIDS, but tend to choose not to – hence my inclination to use the word ‘unwillingness’. However, as I hope to be making clear, such decisions tend to be instigated by a lack of sufficient resources and a need to survive – hence my final choice of the word ‘inability’.
as a workshop about growing trees – they could all flawlessly recite the awareness and prevention messages that reach them via radio broadcasts; posters decorating the walls of each health facility, restaurant, grocery and liquor store; and external development interventions, like the ‘tree workshop’ [P3 0600, 0602, see also P3 0435, 1280, 3540-1]. Their formulations largely followed the exact wording used in the educational materials, e.g. “HIV ndi kachirombo kamene kayambitse matenda a Edzi” [HIV is a virus23 that causes AIDS].

Despite the fact that knowledge of HIV and AIDS seems to be impressively accurate in Mudzi as it is found to be throughout Malawi (and beyond), the number of new infections per year in the region continues to increase24 (GoM 2010b: 71). Of all pregnant women who attended antenatal services at the health clinic near Mudzi over the past year, 12 percent were found to be HIV positive.25 Among those who came for voluntary counselling and testing (VCT), infection rates were much higher – almost 24 percent of men, and nearly 22 percent of women [P3 0982]. Mudzi women’s life histories attest to these high figures with frequent references to close relatives dying in prime-age, some of their deaths explicitly attributed to AIDS [P2 2187; P3 1280, 1326, 2063, 3868].

As also noted in Chapter 2, the extensive awareness and behaviour-change campaigns have led to high levels of knowledge of HIV and AIDS, but not stopped the virus from spreading. The messages transmitted through these campaigns often stress one or several facets of the so-called ‘ABC’ recommendation, which stands for Abstain, Be faithful, or use a Condom (Barden-O’Fallon et al. 2004: 131, GoM 2010b: 64, Mbugua 2009). Abstinence is, however, difficult to reconcile with the great value that Yao men and women, as many others, traditionally attach to procreation and the act of sex itself. Furthermore, as assessed in the previous chapter, (prime-age) Mudzi women for a number of reasons want to attach a male partner to them and their household, and sex is an essential means to achieve this. For many within and outside Malawi, therefore, abstinence is not a realistic option.

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23 The ChiChewa word kachirombo literally translates as ‘small wild beast’ and is also used to denote insects, germs, parasites, bacilli, and bacteria (Steven Paas ChiChewa/ChiNyanja-English dictionary 2004). One young Mudzi man (23) told us that men are not supposed to fear wild beasts, so neither should they show any fear for the ‘small wild beast’ of HIV [P3 2134]. Reducing the number of sexual partners or using condoms would be considered as exhibiting such fear.

24 In absolute terms, the number of new infections in Malawi is estimated to have been almost 70,500 in 2010, and prospected to be almost 80,500 in 2012 (GoM 2010b: 71). The HIV incidence rate has been and continues to be highest in Malawi’s Southern Region (ibid: 19).

25 HIV testing has become a standardized component of antenatal care in Malawi, and is found to be experienced as mandatory by pregnant women and their partners (Angotti et al. 2010). It has furthermore been found that fear of stigma and discrimination when found HIV-positive keeps large numbers of women from accessing antenatal care, or their husbands from letting them (Chikonde et al. 2009, Turan et al. 2008). It seems probable that especially women (or partners) who have reason to believe they are infected forego antenatal care to avoid being tested. If this is the case, then the HIV prevalence of 12 percent is likely to underrepresent the actual percentage of pregnant women living with the virus.
Fidelity as a preventive strategy is difficult too, as it is only effective when both partners are faithful, and can thus only be applied when partners sufficiently trust each other – which in Mudzi is often not the case [P2 1370, 1405, 1440, 1600, 1605; P3 0806, 1572, 1639, 1776, 1888, 1998, 3860]. As described in Chapter 5, despite many women’s expressed desire to form a team with their husbands (“helping each other to develop our household”), most partnerships are ad hoc, unstable, and short-lived. Rather than forming a team with a shared goal and future, Mudzi couples in general seem to expect and accept that, in the end, each fends for him- or herself. Throughout Malawi studies have pointed out that distrust is a common feature of relationships between men and women, and husbands and wife in particular (Bryceson et al. 2004: 27, Forster 2001: 247, Smith & Watkins 2004: 649). Forster (2001: 247) suggests that this has long been the case, referring to old songs that women sing when pounding maize together, which are highly critical of male laziness, drunkenness, and womanizing habits. The risk of AIDS, he argues, has compounded the mutual distrust. Bryceson et al. (2004: 27) indeed found that women blame men for bringing HIV to the family, more specifically for their drinking habits and their tendency to go after other women when drunk. Men, on the other hand, blame women for coming home with the virus after having been looking for food or money, insinuating they often find it by providing sex. Findings from the MLSFH project confirm a discourse of distrust and blame among rural Malawian women and men. Women are particularly worried about their own husbands infecting them, as men are considered promiscuous by nature. Men, in turn, are most worried about contracting HIV from their extramarital partners (Smith & Watkins 2004: 649). When distrusting one’s partner, fidelity is an illogical and possibly risky strategy to protect oneself against infection.

The last option offered by formal HIV-prevention campaigns is condom use. However, in Mudzi, as found elsewhere in Malawi26 and sub-Saharan Africa,27 condoms seem to be rarely used during sex,28 despite their free availability at the nearest health clinics. On numerous occasions Gertrude or the village women themselves brought up the topic during casual conversations, and each time women were clear about their non-use of condoms, including with extramarital boyfriends [P2 1084, 1585, 1594, 1697, 1736, 1757, 1831; P3 0871, 1263, 1558, 2253]. Whenever they further elaborated upon this, they explained that they do not use a condom during sex because their partner does not like it, or he at least did not bring it up [P2 1585, 1697; P3 1263, 1280]. Responsibility for condom use (and especially non-use) was thus by-and-large placed on men. A common argument heard throughout

28 Condoms in Mudzi seem to be used mainly by young boys who make footballs out of them [P2 1831; P3 0624, 1371].
Malawi and beyond, and reiterated by Mudzi men too, is that “one does not eat a sweet in its wrapper either” [P3 1263; P8 0081]. Condoms are believed to take away the ‘sweet taste’ of (skin-to-skin) sex, and a woman who suggests using them would therefore be perceived as wanting to deprive her partner of his sexual pleasure. “If you ask about condoms,” Livia (21) explained, “boys say you don’t love them” [P3 1263]. In the literature on condom use in Malawi more elaboration can be found on the general aversion to it. Condoms are so strongly associated with AIDS, promiscuity, and distrust that neither men nor women seem even tentatively willing to use them. For women it seems most stigmatizing to possess condoms or even suggest using one (e.g. Van den Borne 2005a: 135) [see also P3 1294, 1665]. Associated with prostitution and promiscuity, Agnes Chimbori (2007) writes, condoms are considered appropriate only in risky extramarital relationships, not within marriage. Condom use signals the inferior status given to a sexual relationship: not safe, not serious, not intimate (Chimbori 2007: 1104, Tavory & Swidler 2009: 181, Van den Borne 2005a: 135–8). The suggestion to use a condom within a steady relationship is considered by both men and women a reason for break-up, as it is either taken as proof that the suggesting partner has been unfaithful, or accuses the other of infidelity. In order to turn casual sexual encounters at least into the form of a relationship, disassociate oneself from disrespectful prostitution, and increase one’s chances for the relationship to last, condom use is not brought up or even rejected. For a woman, as discussed, the wish for pregnancy may not only be at play within but also outside marriage, as it increases her chances for lasting support from the child’s father. Furthermore, the religious objection that condom use would be against God’s will prevails in

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30 Interestingly, a study comparing sexual attitudes among “Whites, Blacks and Indians” in South Africa found that only Indian males felt a strong incentive to forego the pleasure of skin-to-skin sex and use a condom because they are forced to marry a girl in case of pregnancy (Kaufman & Stavrou 2004: 388).

31 One young, educated, urban, Malawian woman that I know well had long protected herself against HIV infection by completely refraining from sexual relationships – although her purpose had been particularly to avoid pregnancy so as to be able to finish her studies. When she allowed herself to have her first boyfriend, already in her twenties by then, she prepared herself well and bought condoms. This was not at all appreciated by her boyfriend, who did not know how to interpret this shocking fact. The young woman had to do a lot of explaining but failed to restore her boyfriend’s trust.

32 In line with this, Schoepf (2001: 344) mentions studies finding that women who self-identify as commercial sex workers are more likely than others to use condoms, albeit only with men they consider clients.


34 Trinitapoli (2009), however, found no overall correlation between religious affiliation and sexual behaviour in Malawi (although characteristics of a particular local congregation may impact the sexual behaviour of its members). In general, Muslim authorities in Malawi have been found to be more pragmatic towards ‘human weakness’ and therefore less averse to condom use than Christian religious leaders (Forster 1998: 538).
Malawi as in much of the rest of the world (Kaler 2004b: 106, Chimbiri 2007: 1104). Lastly, Kaler (2004b) points to the often-overlooked ‘long shadow’ of past family planning efforts, which were widely interpreted as hostile attempts of the Malawian government and international organizations to trim down the country’s or continent’s (poor) population. Persistent rumours hold that condoms are part of this conspiracy, possibly purposefully infected with AIDS or at least containing an ill-making oil [see indeed P3 1280].

Besides the ABC behaviour-change recommendations, testing and treatment services are increasingly offered by the government and international organizations as a means to contain the AIDS epidemic. According to the head nurse of the small hospital nearest to Mudzi, most men do not come for testing until they are very ill, at which point it is often too late for treatment (see also Parrott et al. 2011). She added that those few who are voluntarily tested while still feeling healthy are almost exclusively young men [P3 2725]. Women are in principle routinely tested for HIV when attending a health clinic for antenatal care. Those who test positive and do not qualify for anti-retroviral treatment (ART, further discussed in the next session) are offered drugs to reduce the risk of mother-to-child transmission at birth. They are told to return to the clinic at least within 72 hours after delivery so as to receive the same drug for their newborn as well. According to the head nurse of the hospital nearest to Mudzi, however, many of the pregnant women who are tested positive do not return for that follow up: “You will only see them come back after a year or two, when they are pregnant again. Then after having their second child, that is when most of them die” [P3 2725–7]. It must be noted here that a 2009 study found that the drugs needed to prevent mother-to-child HIV transmission were out of stock in over 50 percent of health care centres in Malawi (GoM 2010b: 63). The study did not speculate whether this may be a cause or consequence of pregnant women’s overall low adoption of the prevention strategy.

The fact that they had been tested at pregnancy, for some of my informants, served as a justification to not undergo another HIV test [P3 0765]. Other women argued that they were not married at the moment and would go for a test when finding a proper husband – disregarding the fact that they were involved in non-formalized yet sexually active (semi-)relationships [P2 1697; P3 0752, 0765]. Not only unmarried women themselves left unacknowledged their (informal) sexual activity in the face of HIV risk. Even the health officer running the Voluntary Counselling and Testing (VCT) centre35 nearest to Mudzi did so, at least when

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35 This is a different facility from the hospital referred to in the previous paragraph. The former is a tiny child and maternal health care facility where VCT services are offered, while the latter is a small hospital attending to all health problems (although referring many of the slightly more complicated cases to the larger hospital in Balaka town).
Gertrude, Livia (21), and I had ourselves tested there [P3 0807–22]. Right after I had told the counsellor that I was married, he asked me if I wanted to have any condoms. Gertrude and Livia told him they were unmarried, and did not receive an offer of free condoms. The counsellor’s differential response may suggest that only my involvement in sex could be openly and legitimately recognized, and thus built upon. Livia was meanwhile denied a chance to access free condoms to protect herself against HIV transmission from one of her many (potentially infected) casual lovers. Possibly, the man acted out of respect, because offering condoms to an unmarried woman would have meant insinuating that she might be involved in clandestine relationships. Or maybe he followed donor instructions not to offer condoms to unmarried youngsters as this might encourage illicit sexual activity (see also Ahlberg 1994: 234). Whatever the case, trying to match safe-sex promotion with the norm that (women’s) sexual activity only takes place within a formalized relationship seems very contra-effective, especially considering the fact that condoms are locally considered inappropriate within the marital context.

Despite a general reluctance to get tested, some men and women, like Livia, do muster courage to go for voluntary counselling and testing. For some women, as we will see below, testing (and thus accessing treatment when necessary) serves as a means to lower their risk of dying from AIDS as a result of their profitable sexual relationship with a unfaithful partner. However, these and other Mudzi women who, amongst each other or to Gertrude, said they would soon go for a test, usually kept postponing it. On a day-to-day basis other matters took precedence over the potentially life-saving but at the same time status-threatening trip to the testing centre.

- Locally developed efforts
It appears, as found by other researchers in the region, that the HIV-prevention measures insisted upon by external development agencies are largely incompatible with the daily life realities of Mudzi women. Measuring behaviour change in line with the conventional ABC recommendations gives the impression that these women do little to protect themselves and others against HIV infection. This should, however, not be interpreted as complete paralysis or denial, as is sometimes assumed (e.g. Bryceson et al. 2004: 29). As Schatz (2005), Watkins

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36 When I told Gertrude that I wanted to have myself tested, she decided on her own to be tested too. I did not request this from her, or even suggest it to her.
37 I have not been able to figure out what exactly motivated Livia to join us when we went to be tested. Possibly, she had wanted to know her status, and had disliked both options of going alone or going with someone from within her close network. Maybe our example made it easier for her to actually go too. Maybe she just liked the prospect of spending some time alone with us, as walking to and from the clinic took over two hours. Maybe a combination of these factors triggered her (quite unusual) decision.
38 At a national level it is estimated that in 2009 4.5 percent of Malawian men and women aged 15–49 underwent an HIV test (GoM 2010b: 19).
found elsewhere in rural Malawi, Mudzi men and women have developed strategies to reduce their risk of contracting HIV that are more feasible and contextually appropriate than the strict ABC instructions. These strategies reveal, however, that avoiding HIV transmission is often outweighed by other considerations:

At 13, Lovely (now 29) worked in the fields of one of the farm estates near Mudzi to help her mother provide for their household. At the estate Lovely met a young man, aged 18, who was kind enough to share some of his salary with her each time they were paid. Soon, Lovely found herself pregnant and the two decided to marry. The couple struggled to make ends meet and in the following years often went without sufficient food. Lovely gave birth to six children, three of whom did not survive. When her brother-in-law migrated to South Africa and found waged labour, her husband decided to join him. The couple sold their maize stores to buy a passport and pay for the man’s journey. Luckily, it did not take long for him to find employment – although he has never told Lovely what exactly it is that he does for a living. Since then, he has regularly sent her money, with which she can buy enough food and hire labourers to help her in her field. He even sent her a mobile phone that hangs on her chest like a necklace, on which he calls her every few days. Despite this overt commitment towards her, she fears that he will not be able to resist sexual temptations, following the general belief that men cannot go without sex for extended periods of time. “Those women in South Africa all want to have a Malawian man,” Lovely furthermore believes, “because they know that Malawians are hard workers.” Fearing that he will come back with ‘diseases’, Lovely spends part of the money that her husband sends to buy herbal medicines that keep him from cheating on her. [P2 1405, 1484; P3 0609]

Married Mudzi men who have migrated to South Africa are commonly assumed to have extramarital affairs, if not polygamous marriages, at their new homes [P2 1370, 1600; P3 0609]. Although these men’s promiscuity in South Africa cannot be ascertained, upon return to Mudzi for a brief vacation many – finally able to attract women because of their newly gained financial power – prove their infidelity with temporary sexual affairs within and around the village [P2 1561, 2166, 1636] (see also Chirwa 1997). The wives (and other sex partners) of migrant men are thus well aware of the HIV risks that they expose themselves to. However, despite the great HIV risk involved, and the high awareness of this risk, none of the migrants’ wives considered divorcing her husband. Instead, they encouraged him over the phone to stay faithful [P3 3860, 4006, 4019]. Several underwent or planned to undergo a HIV test after their husband had come home for a brief visit, arguing that they cannot know how he behaves ‘out there’ [P2 1370; P3 0752, 1371]. By finding out in time whether they had been infected, and accessing treatment if necessary, they hoped to contain the risk of becoming (too) ill. Furthermore some, like Lovely, paid folk healers for the service of safeguarding their husbands’ fidelity.


Nine Mudzi women have a husband in South Africa, three others are married to a man working elsewhere in Malawi.
Apparently, the benefits of these women’s marriages outweighed the disadvantages, of which HIV risk is one (another sometimes being their residence at their husband’s natal village instead of their own, as described in Chapter 5). The benefits not only entail the direct material support that these women receive from their husbands, or can ask for in times of need. Their long-distance marriage combines a relatively secure livelihood and the respectability of being married, with a high degree of personal freedom. Contrary to women with a live-in husband, migrants’ wives do not have to stay at home to cater to a man. Furthermore, women whose husbands are present often complain that they never give money to be spent freely, only providing basic items that are needed in the household [P2 1618, 1643]. Women with absent husbands can spend the money that is sent to them as they please [P2 0118; P3 0996, 1858, 4019, 4105], although sometimes they are advised on this by their husbands (who are however not around to check whether their advice is indeed followed) [P2 1569; P3 0998, 1421, 1673, 3968, 4091].

Women consider themselves (and others) particularly at risk of HIV infection when “exchanging husbands too often” and when staying with a promiscuous husband [P3 2939–41, 2943–4, 3475]. As a result, fear of infection can be (and was) brought up by some women to justify their choice to remain with an unsatisfying husband [P3 2929, 2939–41, 3265, 3475], and by others to justify their decision to divorce an unsatisfactory husband [P2 1548; P3 1448, 2943–4, 3909]. Considering, however, the fact that none of the migrants’ wives actually eliminated this risk by ending the relationship with their – most likely unfaithful – husband, suggests that avoidance of HIV infection only becomes a decisive consideration when other factors valued in a marriage are unmet.

Women who prefer to stay married to their (suspected) promiscuous husbands rather opt for less radical measures to avert the unwanted consequences of his behaviour, as Lovely did by buying herbal medicines [see also P2 1910]. Many women, as described in the previous chapter, try to advise and encourage their husband to be faithful, or request their ankhoswe (marriage guardians) to do so. Some move on to more violent measures, generally directed at their husband’s lover [P2 1208, 1940]. However, as also described in the previous chapter, promiscuity is disliked by women primarily because it reduces the resources available to them (as these will be shared among multiple women), rather than because of a fear for HIV infection [P2 1561, 1893; P3 0841, 2329, 2340, 2468].

Several studies found rural Malawian men claiming to have become more selective in choosing sex partners, by turning to their social network for inquiries about the sexual history of their prospective sex partners to assess the risk involved (Kaler 2004a: 292–4, Peters et al. 2007: 43, Watkins 2004: 688–9), and preferring the less attractive, married, or very young – assuming such women are less likely to have had many sexual partners and be infected (Forster 2001: 251, Kaler 2004a: 292–4, Smith & Watkins 2005: 655). As discussed in the previous chapter, some
Mudzi women too take time before accepting or declining a proposal so as to inquire about their proposer’s personal background and characteristics. If it is found that he proposes to many women, this is generally considered a drawback – although not necessarily or solely because of the HIV risk that is involved, but rather or also because it is taken to indicate a bleak prospect concerning relationship stability and profitability. Many girls and women, however, accept sexual proposals without lingering to gather such information, glad that someone has shown an interest in them and afraid that a delay would put off their proposer. Only when men seemed desperate to marry – which runs counter to the generally expected male behaviour – did women become so suspicious of ulterior motives that they decided to decline, taking it, not without reason, as a possible indication that he was HIV-positive and in urgent need of a future caretaker:

Wisikesi (30) received a marriage proposal from a man who had come to Mudzi to look for a wife. The man told her that he was cultivating so much cotton that he would be able to buy 100 bags of maize with the revenue, which he planned to resell once prices went up during the hunger season. Wisikesi did not trust his story, which sounded too good to be true, and refused to marry him. Recalling this incident, she and the other knitting women at our veranda commented that the man had afterwards continued to a neighbouring village, where another woman did accept his proposal. Instead of bringing her maize and money, however, the man became very ill and his wife is now just busy taking care of him. [P3 0538]

On her way to the nearest health clinic with a sick child, Sofia was proposed marriage by a passerby. The man said he had money and could take her child to the private hospital at Balaka, where services are much better than the free government clinics. Taking his hands out his pockets he showed her that they were full of money. Sofia had recently been abandoned by the father of her four children, and could certainly use some of that money. Nonetheless she refused his offer, because she found his eagerness suspicious. “Mwina ali ndi matenda” (Maybe he has diseases/HIV), she reasoned, “and therefore showed me all that money in advance” [instead of giving some after she accepted, which is more common]. [P2 1445]

These women, it seemed, did not in the first place fear becoming infected themselves, but rather having to take care of an ill, and thus non-supporting, husband.

My data thus confirm the often-unacknowledged finding that, despite apparent low levels of ABC adoption, rural Malawians do act upon the HIV risks that they face, albeit in locally adapted ways. Some resort to protective herbal medicines, try to persuade their husbands to be faithful, or have become more selective in their partner choice. This is not to say, as seems insinuated by some scholars, that women, within contextually defined limits, do their utmost best to avoid infection. The fact remains, in Mudzi at least, that avoiding HIV infection is generally not considered a priority (see also Dionne 2012).

Low priority of HIV prevention
Three factors seem to contribute to the low prioritization of HIV prevention in Mudzi. The first relates to the fact that there are many other, often more direct,
threats to life and livelihood besides HIV and AIDS. The second concerns the fatalistic perception of AIDS as an inevitable fact of life, and the third – a new factor – results from the free availability of an effective treatment. These factors add up to the relatively low weight given to preventing HIV transmission compared to the highly valued beneficial aspects of (unprotected) sexual activity. I will elaborate on each of the three factors in more detail here.

Firstly, in the experience of Mudzi villagers, AIDS is but one of many possible causes of death, or, put more broadly, one of the many potential problems of life [P3 1503, 2134]. Malaria, tuberculosis, and cholera frequently strike in Mudzi, in some cases with fatal results. In the year prior to our fieldwork, seven villagers had died of cholera. In 2001, a larger cholera outbreak killed many more in and around Mudzi. In the same year food shortages had been severe too, it is vividly recalled, and were the death blow to several old, young, and weak villagers. Childbirth still takes many mothers’ lives, leading one informant to explain that the expression ali ndi pakati [she is in the middle/in between], commonly used to describe a pregnant woman, refers to the fact that she is in a twilight zone between life and death, as she will soon either die or give life. It can be speculated that these various deaths resulted from a prior HIV infection, which affected the victims’ immune system and general health status. But as far as Mudzi villagers can see, they died from cholera, starvation, or delivery complications. The always-present threat of bewitchment, furthermore, haunts all villagers regardless of sex, age, or social status. Other, non-life-threatening difficulties faced on a daily basis have been described in Chapter 4, and are often of such an urgent nature that the possibility of dying from AIDS in some distant future becomes less relevant [e.g. P3 1501] (also Van den Borne 2005b).

A second factor contributing to the low priority given to HIV prevention stems from one of the initial interpretations of AIDS. Because the first victims were from among the better-off elites from town and migrants returning home with cash earned abroad, it made sense to classify their cruel death as bewitchment by someone less endowed and jealous (Lwanda 2004: 32). While villagers now basically understand the medical side of HIV infection, this traditional explanatory model is still called upon to explain why only some individuals become infected after unsafe sexual intercourse while others do not. This seeming randomness is taken to indicate that HIV infection ultimately is a result of witchcraft [P2 1018, 1332; P3 0610, 1491] (see also Niehof & Price 2008: 148–9). Bryceson et al. (2004: 31) found that 60 percent

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41 On average, Malawian women have an estimated 1-in-36 chance of dying as a result of pregnancy-related complications (UNICEF 2008). The risk for rural women is likely to be higher.
42 The Steven Paas ChiChewa-English dictionary gives a different explanation, stating that the expression refers to the growing belly at the mid-point of a pregnant woman’s body.
of rural Malawian households they studied that experienced an AIDS death cited bewitchment as the cause of the deceased’s infection. Making sure not to arouse jealousy or otherwise offend fellow villagers helps to avoid bewitchment – but such offenses can also occur unwittingly or unwillingly, thus placing witchcraft beyond one’s personal sphere of control. Logically then, whether and when HIV or AIDS may strike is by many also considered beyond their personal control.

Women in Mudzi, moreover, believe that they can be unconsciously infected by men who come to have sex with them in their dreams. On several occasions women told Gertrude that they had dreamt of having sex with a certain Mudzi man. One had subsequently scolded the man in real life, warning him to never do this again [P3 0592]. Another woman expressed her worry about a potential HIV infection now that she had dreamt of having sex with a certain fellow villager [P2 0741, see also P8 0025]. The possibility of being subjected to intercourse while asleep and unaware must add to the feeling that avoidance of HIV infection is not just a matter of making the right choices, but of fate as well.

This anticipative attitude may be reinforced by the disproportionate attention that development agencies devote to HIV and AIDS compared to other health risks (GoM 2010b: 49). The massive scale on which educational messages invade daily life in Mudzi may well give the impression that AIDS is an omnipresent and inescapable threat. Campaigns that aim to alert the public and reduce stigma by emphasizing that anyone can become infected, further feed the perception of HIV as unavoidable and beyond one’s power to control (Bryceson et al. 2004: 70, Kaler 2003: 358) [P3 2080]. The longitudinal MDICP survey found a severe overestimation of the probability of HIV transmission after one act of sexual intercourse (Dionne 2008: 3, Kaler 2003: 356–8). Sixty-one percent of respondents were certain that one act of coitus with an infected partner leads to HIV transmission, and 38 percent believed the risk to be high. It is not unlikely that this overestimation results from the ‘bombardment’ of educational messages (Bryceson et al. 2004: 24) stressing the risk of infection but neglecting to inform about realistic chances of contracting HIV. In reality, HIV is one of the least contagious viruses around, with infection probability estimated to be as low as 1 in 1000.43 Several studies indicate that the overestimation of risk has led many Malawians to presume that they must surely be infected already, nullifying their need to change any high-risk behaviour (Arrehag et al. 2006: 107, Kaler 2003: 364).

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43 Under normal circumstances (meaning here heterosexual vaginal intercourse, vagina sufficiently lubricated, and the partners free of genital ulcers) the probability of contracting HIV during unprotected sex with an infected partner is estimated to be as low as 1 in 1000 (Gray et al. 2001). Only in the early and late stages of infection, when the viral load peaks, is the likelihood of transmission relatively high (Pilcher et al. 2004). Genital ulcers and unlubricated sex may create opportunities for the virus to enter the body and therefore increase transmission risk by two- to tenfold (Geubbels & Bowie 2006: 116).
In Mudzi, men and women alike expressed their acceptance of AIDS as a fact of life [P3 0435, 1280, 1367, 1503, 1989, 2134, 3549] (see also Bryceson et al. 2004, Kaler 2004a). Various villagers argued that “AIDS has come for us human beings, not for animals or trees,” indicating that they consider AIDS to simply be a part of the human fate [P3 1503, 1989, 2134, 3549]. “It is our time,” others said acquiescently [P3 0435, 1367]. Kaler (2004a: 289), also writing about rural Balaka, notes that depending on the situation, individuals may switch between this inevitability perspective and an agency perspective, which holds that AIDS risk can be purposefully reduced, as also described in the previous subsection. I will return to this switching between perspectives and discourses shortly.

The (partly) fatalistic attitude radiated by Mudzi villagers is not unique to HIV and AIDS, but cuts across many spheres of daily life. Comments from Mudzi villagers indicate that investing is often condemned as presumptuous, as it is taken to reveal an (unjustified) expectation of a positive outcome:

Whilst pregnant, Chikondi (28) did not dare to join the other Mudzi women in learning from Gertrude how to knit baby shoes and suits, because then “people will say that I know already that my baby will live, while it may be born and leave again after a few days” [P3 0869]. Another woman, who had no children yet but hoped to become pregnant soon because her husband was about to come home from South Africa, did knit baby clothes and was indeed ridiculed for her anticipation of a successful pregnancy: “What are you doing that for?? Maybe you will fail to give birth, and then you will have to sell all the baby items that you knitted!” the women around her laughed. [P3 1816]

The few young women who had set their minds on finishing school also faced discouraging comments, such as “You just wait, we will not see you become a nurse. Somebody will cheat you [get you pregnant]! [P3 0619], and “Why don’t you just get married? Don’t you know that it’s useless? There are no jobs anyway.” [P3 1636]

It seems that Mudzi villagers are conditioned, by both tangible setbacks and social pressure, not to expect much good to come and consequentially to refrain from making investments in a (potentially) better future. The many uncertainties that they face on a daily basis, and constantly changing contexts in which they try to make a living require flexibility and anticipation, as well as a high level of acceptance.44 Anticipating HIV infection as a likely possibility and refraining from efforts to avoid it, fits well into the general compliant attitude.

The third factor contributing to the low priority of HIV prevention results from the recently introduced free access to treatment (see Chapter 2). Just like other

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44 The come-what-may outlook on life corresponds to the general experience of life as circular or seasonal rather than linear, as described in Chapter 4. Having witnessed two annual cycles, in Mudzi and two pilot sites, I got the impression that villagers were simply used to the fact that scarcity and abundance alternate. As much as hunger recurs practically each year, it is always followed by a period in which food is excessively available. How long this period of abundance lasts depends on external factors and personal investments, but it (usually) comes anyhow – making the season of scarcity easier to bear and accept.
fatal diseases in the past have become curable with Western medicine, HIV and AIDS now seem to have been made containable too. Once diagnosed with HIV at one of the local health clinics near Mudzi, patients are referred to Balaka hospital. If they are found to be in an advanced stage of infection, they are entitled to receive free antiretroviral (ARV) treatment as well as counselling about living with the virus. Mudzi men and women see fellow villagers fall ill, become weak and thin, bearing down on death. When starting treatment, however, most of the patients recover amazingly quickly, begin looking healthy and strong again, and taking part in community life as usual [P2 1536, 1871, 1884; P3 2583, 2665]. “As if she is not HIV positive,” one women approvingly commented about a fellow Mudzi woman who had recently started treatment [P2 1536]. Another woman chatting at our veranda once explained that “People are not afraid [of AIDS], because of ARV medication. They make you live for a long time.” [P3 1503, see also P2 1411, P3 3549]. When government health staff had instructed Mudzi’s Group Village Headwoman to address her people on various health issues including HIV and AIDS, she organized a meeting and duly urged her public to practice safe sex. Attempting to add weight to these words, she then warned that they must do so “because the hospital does not have enough ARV medication!” [P2 1336, see also P3 1572]. The existence of an obviously effective treatment that is available at no cost calms the senses, and counters the uncomfortable, externally demanded preoccupation with avoiding infection.

As discussed earlier in this section, rather than avoiding HIV infection per se, Mudzi villagers wish to avoid the impression of being HIV positive, as this would directly jeopardize their day-to-day survival (or at least their quality of life). Changing sexual behaviour in accordance with the ABC promotions may arouse suspicion because it associates one with the virus (UNAIDS 2003: 3), and may thus also for this reason be omitted. Fear of being identified with HIV furthermore keeps many from testing their blood, because once known it is difficult to conceal one’s positive status. Suset (23), for example, stopped breastfeeding her baby before it had reached the usual age for weaning – which was in line with the then-current health instructions for mothers living with HIV. Fellow village women quickly noticed this, and interpreted it as indicating an HIV-positive status [P2 1757; P3 2302]. To receive treatment, furthermore, patients must go to Balaka hospital every few

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45 Many hospitals in Malawi are not equipped to measure the viral load and number of CD4 molecules in a patient’s blood, which is the most accurate way to determine the stage of HIV infection or AIDS. Instead, doctors are advised to use a WHO checklist based on symptomatic criteria like unexplainable persisting fever, weight loss, anaemia, and tuberculosis (MoH 2008: 16–7).

46 Costs may be made for transport to the hospital, which is located 15 kilometres from Mudzi. A bicycle taxi costs 150 to 200 MK for one way, approximately 0.75 to 1 Euro at the time of the research. Alternatively the journey can, and often is, undertaken by foot, or on a privately owned or borrowed bicycle at no cost.
weeks for check-ups and new rations of AIDS inhibitors. When Jeneti (37) began to regularly travel to Balaka, under various pretences, it was soon speculated that she did so because of an HIV infection [P3 2583, see also P3 2302]. The regulation that patients only receive free ARVs if they bring with them a “witness” (as Mudzi villagers call it) or “buddy” (as development professionals call it), which is intended to stimulate openness, makes testing and treatment even less appealing. The chief of Mudzi A had been ill frequently ever since we arrived in his village. His wife told us that he once went to the health clinic because of this sickliness, but upon return he had torn up a referral letter to Balaka hospital as well as his complete health records book [P2 1332, see also P3 2727]. He died shortly after our fieldwork had finished. In line with the chief’s choice to deny his (apparent) HIV infection, several Mudzi women were explicit and resolute about their preference to remain oblivious of their HIV status as long as they feel fine, only facing the problems when they may arise [P2 1655; P3 0773].

Thus, on the one hand Mudzi villagers state that their fear of AIDS has diminished as a result of the availability of effective and free-of-charge treatment. On the other hand, however, few actually get tested so as to potentially access this treatment. Furthermore, while employing a discourse of accepting AIDS as part of the human fate and of HIV infection as beyond one’s personal sphere of control, sero-positive others are blamed for having brought upon themselves the curse of AIDS, and active attempts are made to reduce transmission probabilities when infection risk is considered high. The seemingly inconsistent ways in which Mudzi men and women try to deal with the many uncomfortable realities that they face on a daily basis reveal their necessarily pragmatic agency. These seeming inconsistencies fit within the notion of ‘judicious opportunism’, a concept that was coined by Johnson-Hanks (2005), discussed in Chapter 1, and will be further elaborated upon in this chapter’s conclusion.

**Conclusion**

In light of this study’s core question of whether female economic empowerment will lead women to make safer sexual choices, this chapter delved into the sub-question of emic perceptions of safe and unsafe sex. For women to make ‘safer’ sexual choices, they must firstly perceive of their current practices as unsafe, secondly feel incentives to change these, and lastly feel capable of changing them. Proponents of female economic empowerment as a means to halt the AIDS pandemic locate the main problem at this third requirement. They presuppose that women like those in Mudzi experience their sexual practices as ‘unsafe’ and would prefer to change this risky behaviour, but lack the means to do so. However, the data presented in this chapter, like that of the previous chapter, suggest that it is rather the first two requirements that remain unfulfilled, making the third of no consequence.
As concerns the first requirement I argue that what is understood to be safe and unsafe sexual practice differs between Mudzi villagers and the official public health view. In the latter, the criteria ‘safe’ and ‘unsafe’ purely concern the risk of HIV transmission, in a distilled and condensed form. In real-life experience, however, HIV and AIDS manifest themselves within a myriad of interrelated factors from which these cannot sensibly be disengaged. For Mudzi women, the unsafeness of a sexual practice may relate to the risk of contracting diseases, but also (and often more prominently so) to the risk of losing a partner, for example by denying him sex or demanding condom use. Safe sexual practice from a Mudzi point of view may include, for example, conceiving a child to create a lasting relationship of support. Playing it ‘safe’ in Mudzi terms thus refers to broader livelihood concerns, which may be negatively affected by what formal health experts recommend as ‘safe’ sexual practices.

An important aspect of playing it ‘safe’ – in Mudzi terms – is conforming to the community’s expectations for proper female sexual behaviour. As has been the case for many centuries throughout Central Africa, in Mudzi the vital importance of procreation and sex is drummed (quite literally so, as most instructing is done through the medium of songs) into the minds of youngsters during elaborate initiation rites, and repetitively brought back to memory throughout the rest of their life course. The miyambo [traditions, cultural values] that the youngsters are taught stress that sex is vital for personal wellbeing, the relationship between a husband and wife, as well as the community at large. Essentially, sexual intercourse is encouraged, provided that certain rules are observed.

To some extent, public health HIV-prevention messages coincide with these pre-existing rules that prescribe under which circumstances sex should be refrained from, especially where extramarital sex is concerned. Encouraging as this may seem, there are three (discouraging) remarks to be made about it. Firstly, the exclusively negative approach to sex in these public health messages may make them too far removed from the overall positive emic perception of sex to be taken seriously. Furthermore, the traditional norms prohibiting extramarital sex are formally subscribed to by all, yet informally accepted as not always achievable. This gives ample opportunity to sidestep formal HIV-prevention recommendations too. The third remark relates to the fluidity of the marriage concept that I have described in the previous chapter. This vagueness makes it difficult to discern when a certain sexual encounter would be categorized as extramarital, or, put differently, makes it easy to categorize a sexual relationship as marital (and thus legitimate and harmless) at any given time.

As concerns the second requirement, on incentives, I argue that on Mudzi women’s scale of the pros and cons of sex, HIV risk is a con with relatively little weight that is often outweighed by the many pros. Mudzi women certainly do acknowledge the risk of HIV infection as a disadvantage of sex. The practices that they consider to be
particularly risky in relation to HIV are a large number of subsequent partners, and marriage with a promiscuous husband. In neither case, however, does the perceived HIV risk necessarily trigger women to end the practice so as to protect themselves against infection – although some measures (often others than those advised by health professionals) may be taken to reduce transmission risk. Sometimes women do assert fear of infection as reason for refusing a sexual proposal, for reducing the number of sex partners, or for divorcing a promiscuous husband. This, however, seems to be the case only when few advantages of a relationship can be discerned. My data thus suggest that most women feel no urgent need to act upon the threat of HIV infection – in other words, only a minor weight is given to this consideration. As explained in this chapter there are various reasons underlying the little weight given to HIV prevention, including 1) the fact that AIDS is but one of the many threats that Mudzi villagers face, 2) a communally upheld claim that HIV cannot be effectively avoided anyway, and 3) the availability of effective treatment at low or no cost.

Besides the minor weight given to risk of HIV infection as a con of sex, there are, as mentioned, often multiple stimulators at play that encourage women to engage in sex. These stimulators include the high ideological value attached to sex as procreative, pleasurable, and mystically powerful. Sex, furthermore, has certain important practical advantages too, especially for achieving the valued status of motherhood. Furthermore, as explained in the previous chapter, women and girls can through sex access the various benefits attached to having a male partner – some of these for as long as the relationship lasts, or even beyond if pregnancies occur, as (relatives of) ex-partners may be pressured or feel inclined to provide occasional support for their children. Sex thus fits within both short- and long-term survival strategies.

Throughout this chapter, as in previous chapters, several inconsistencies or ‘double standards’ were revealed in Mudzi villagers’ dealings with the world in which they find themselves. The concept of judicious opportunism helps to understand their swaying attitudes towards sexual practices in general, and HIV risk in specific. Tactics are decided upon as opportunities – or problems – arise, and are adjusted or abandoned when perceived necessary or advantageous, as the context changes. In the case of dealing with HIV risk, it is sometimes preferred to downplay the severity of this risk, both towards others and towards oneself, while at other times there may be good reasons to acknowledge the risk and attempt to diminish it (or no good reasons not to do so). The choices that Mudzi men and women make are necessarily adaptive and constantly renegotiated to best fit a certain situation without blocking too many future options. These choices would therefore be difficult, if not impossible, to structurally transform into one static set of behaviours, such as that promoted by the professional health sector.
Overall, the data presented in this chapter show that sex is understood as much more than a potential source of HIV infection. The ABC prevention measures recommended by public health campaigns run counter to what Mudzi women have been socialized to consider proper female behaviour, as well as their perceived need to attach a man to them and the indispensable role of sex in that endeavour. Changing their sexual practices to be in line with what officials have branded as ‘safe’ often would do little good to women’s general livelihood security, and may even be detrimental to it.