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Women in Chinsapo, Malawi: vulnerability and risk to HIV/AIDS



J Ghosh, E Kalipeni

ABSTRACT

Malawi, a very poor country located in southern Africa, is no exception to the growing trend and severity in HIV prevalence. By the end of 2003 there were 900 000 adults and children in Malawi living with HIV/AIDS. Adult prevalence was estimated to be 15%, which is higher than the 7.1% average rate for sub-Saharan Africa. In order to understand the spread of HIV/AIDS it is imperative to address the economic, social, cultural, and political issues that impact on women's contraction and spread of the virus. We do so in this paper by critically examining the gendered context of HIV/AIDS with reference to Malawi. The theoretical framework for this research focuses on poverty, gender relations, regional migration patterns, and global economic changes which place women in highly vulnerable situations. The study was conducted in a low-income area in Lilongwe, the capital city of Malawi. In 2003 and 2004, 60 randomly selected women who lived in a low socioeconomic residential area completed a structured interview on issues concerning individual economic situations, marriage history, fertility, family planning and social networks, gender, sexual partnerships, and HIV/AIDS. Focus group interviews were also conducted with an additional 20 women. The results of our study indicate that the rising epidemic among women in Malawi is firstly driven by poverty which limits their options. Secondly, gender inequality and asymmetrical sexual relations are basic to spreading HIV/AIDS among women. Thirdly, in spite of their awareness through media and health care professionals, women are unable to protect themselves, which further increases their vulnerability.

Keywords: Lilongwe, Malawi, HIV/AIDS, women.

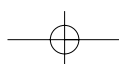
RÉSUMÉ

Le Malawi, un pays très pauvre situé en Afrique Australe, n'est pas exclu de la tendance croissante et la sévérité de la prédominance du VIH. A la fin de 2003, il y avait 900 000 adultes et enfants vivant avec le virus au Malawi. Le taux de prédominance chez les adultes fut prévu d'être à 15%, ce qui est supérieur à la moyenne de 7.1% du taux de l'Afrique sudsaharienne. Pour comprendre la propagation du VIH/SIDA, il faut absolument aborder les sujets économiques, sociaux, culturels et politiques qui ont l'impact sur la contamination des femmes et la propagation du virus. Dans cette présente, nous examinons, de façon critique, le contexte de sexes vis-à-vis le VIH/SIDA dans le cas du Malawi. Le cadre théorique de cette recherche met au point la pauvreté, les relations de sexes, la tendance de la migration régionale et les changements économiques mondiaux qui disposent les femmes à des situations de vulnérabilité élevée. Cet article présente les résultats d'une étude faite dans une partie moins aisée à

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Lilongwe, la capitale du Malawi. En 2003 et 2004, nous avons sélectionné, au hasard, 60 femmes qui vivaient dans un quartier socio-économiquement en bas d'échelle. Elles étaient sélectionnées selon les situations économiques personnelles, l'histoire du mariage, la fertilité, la limitation de naissances et les réseaux sociaux, les sexes, les relations sexuelles et le VIH/SIDA. En plus de ces entretiens bien structurés, des entretiens en groupe de foyer ont eu lieu avec 20 femmes de plus. Les résultats de cette étude montrent que l'accroissement de l'épidémie chez les femmes du Malawi est premièrement dû à la pauvreté qui restreint leurs options. Deuxièmement, l'inégalité de sexes et des relations sexuelles asymétriques sont à la base de la propagation du VIH/SIDA parmi les femmes. Troisièmement, en dépit de leur prise de conscience à travers les médias et le personnel de services de soin, les femmes sont incapables de se protéger. Ceci augmente davantage leur vulnérabilité.

Mots clés: Lilongwe, Malawi, VIH/SIDA, femmes.

Introduction

Two decades after their emergence, the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) continue to create havoc worldwide. In sub-Saharan Africa, HIV/AIDS appears to be one of the worst pandemics that the region has ever encountered. By the end of 2004 there were about 36 – 43 million people living with HIV/AIDS throughout the world, of whom 25.4 million were estimated to be living in sub-Saharan Africa (UNAIDS, 2004a). The region reports an adult prevalence of 7.4%, which is considerably higher than the global rate of 1.1%. In 2004, as one looks at the worldwide distribution of HIV infected cases, women accounted for 47% of HIV cases, while in sub-Saharan Africa women and girls accounted for 57% of all infected cases (UNAIDS, 2004a). In the light of the crisis, over the years various attempts have been made to control the pandemic, which include increased political commitment, spreading information about HIV/AIDS, increased allocation of funding, availability of treatment programmes, and prevention efforts (UNAIDS, 2003). In spite of these efforts, the pandemic continues to adversely affect the 15 – 24-year age group in sub-Saharan Africa. It is further noted that in the 15 – 24 age group, women comprise 76% of those living with the virus (UNAIDS 2004a). These statistics indicate that in order to understand the spread of HIV/AIDS it is imperative to address the economic, social, cultural, and political issues that facilitate the spread of the virus and women's infection by it.

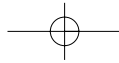
Gender dimensions of HIV/AIDS

Gender inequalities play a role in the spread of HIV, as women are both physiologically and socially more vulnerable to HIV infection than men (Tallis, 1998,

2000). Women often have less access to education, training and productive resources like land and credit (Weiss, Quigley, Hayes, 2000). In situations where women live in poverty and have limited resources, sex is often used as a means of survival. If a husband abandons his family or is gone for an extended period of time due to migrant labour, women are left in charge of providing economic stability. Many women need to turn to commercial sex work, where condom use is seldom an option (Susser & Stein, 2000). If a woman requires that her client use a condom he may simply visit another commercial sex worker (CSW). The dilemma becomes a question of providing for one's family or protecting oneself from infection (Walden, Mwangulube & Makhumula-Nkhoma, 1999).

Gender inequalities also exist within casual and committed relationships. Men are often dominant within the relationship, making women dependent on their financial support. Husbands who visit commercial sex workers put their wives at risk by not taking measures to prevent HIV. However, requesting condom use within a marriage implies infidelity, leaving women at risk of abandonment or abuse. Studies in sub-Saharan Africa including Malawi, South Africa, Kenya and Uganda have found that men are in control of condom use (Bühler & Kohler, 2003; Camlin & Chimbwete, 2003; Kishindo, 1995; Maharaj & Cleland, 2004). For many women it is part of their upbringing to view one's husband as dominant regarding sexual relations (Lawson, 1999). Women in long-term relationships claim that boyfriends provide them with financial support and therefore need to be respected and trusted (Walden *et al.*, 1999).

Both married women and young girls are at risk of infection when married men seek significantly younger



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partners. Many men believe that young girls are free of HIV infection because they are sexually inexperienced (Weiss, Quigley & Hayes, 2000). A similar study in Kenya found that young girls often seek out these relationships to improve their status among peers and to obtain gifts. The girls often live in poverty and their families benefit from the income and gifts they obtain from these relationships. This provides the older men with a position of control, and once again the girls do not request the use of condoms for fear of losing their source of income (Longfield, 2004; Longfield, Glick, Waithaka & Berman, 2004).

It is against this background that the theoretical framework for this paper focuses on poverty, gender inequalities, and regional migration patterns that place individuals, particularly women, in highly vulnerable situations. It should be noted that HIV infection in Malawi is not confined to the poorest of the society. There is evidence suggesting that HIV prevalence is high among doctors, lawyers, teachers, and other skilled individuals (Malawi Government and UNDP Malawi, 2002). This may suggest that this group has adopted a lifestyle that makes them vulnerable to HIV. On the other hand, the poverty theoretical framework suggests that the poor lack education and thus have limited marketable skills, poor health, and low labour productivity. As a result they are trapped in poverty. In 2002, 65% of the population of Malawi was reported to be living below the poverty line (World Bank, 2003). Rural poverty and lack of sustainable livelihoods compel individuals to migrate to the city and these migrants ultimately end up in the low socioeconomic income areas of Lilongwe, which creates conditions that facilitate HIV transmission (Government of Malawi, 2003).

In Malawi, migration from rural areas reflects the high incidence of rural poverty. Migration is in response to lack of sustainable economic conditions in the rural areas. According to Englund (2002), many view migration as a means to improve their economic well-being. Many of these migrants have limited education and training and thus have few marketable skills. Similarly, as one considers rural to urban migration, in the vast majority of cases these tend to be age- and gender-selective and tend to draw the younger age group. The argument is that migrant populations comprising both men and women, without the traditional social networks of rural society and also

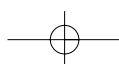
living under abject poverty, often find themselves engaging in high-risk situations which in turn render them vulnerable to HIV infection. Furthermore, when many poor women head a household they may not be able to provide adequately for their families whether they are working in the formal or informal sectors of the economy. In such circumstances they are forced to engage in commercial sex work to supplement their incomes.

It is also important to note that an individual's vulnerability not only depends on economic conditions but also social position. Women in Malawi tend to have limited entitlements, they generally earn low wages, are less likely to own land, do not receive any government assistance, and do not benefit from international aid programmes (Lele, 1990). Furthermore, women in general have less access to education beyond the primary levels, which restricts them in their choices of occupation, formal sector employment, and sustainable wages. The inequality between men and women influences power structures and vulnerability to HIV. In Malawian society men are viewed as responsible for the family and income generation. On the other hand, women are valued as mothers with limited economic responsibility.

Such beliefs are embedded in family, schools, religious and political structures. These messages influence the decisions made by men and women, both within and outside marriages, and over sexual exchanges. In addition such assigned roles dictate government policies regarding wage structures and resource allocations. Recent research shows a close relationship between socio-economic status and the spread of HIV/AIDS (Kalipeni, Craddock, & Ghosh, 2004; Oppong & Ghosh, 2004). Urban women who are employed in the formal sector often occupy supporting positions and as a result are subject to sexual exploitation by men. Within marriage they are incapable of protecting themselves, due to their lower status. For rural women, severe poverty and low literacy increases their risk of HIV infection. When many of these women migrate to cities their vulnerability continues and so HIV/AIDS continues to spread rapidly among the general populace.

Women, HIV/AIDS and poverty in Malawi

Based on available estimates by the end of 2003, there were 900 000 adults and children in Malawi living



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with HIV/AIDS (UNAIDS/WHO, 2004). Adult prevalence was estimated to be 14%, which is higher than the 7.1% average rate for sub-Saharan Africa, but much lower than that of other countries in southern Africa such as Zimbabwe, Botswana and Lesotho (UNAIDS, 2004a; 2004b). These estimates, however, should be used with caution because samples are often drawn from specific groups such as from women going to prenatal clinics in a country where most people do not go to hospitals (Kalipeni *et al.*, 2004). Therefore, officially reported cases should be considered a conservative representation of the actual figures (Kalipeni & Ghosh, in press). Urban prevalence is 23%, which is considerably higher than the rural rate of 12.4% (UNAIDS/WHO, 2004). Life expectancy has dropped from 47 to 39 years because of AIDS (UNAIDS 2004b). Some estimates indicate that it may have already dropped to levels of below 30 years (BBC News, 2002; Engender Health, 2002; Haney, 2000).

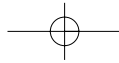
In recent years, the HIV/AIDS crisis in Malawi has been made worse by the additional vulnerability from drought and famine. Severe food shortages since 2002 have affected over 5 million people. The shortages exacerbated living conditions for more than 65% of the population considered 'poor', and for some 14% of the adult population infected with HIV/AIDS. Although some international organisations such as the United States Agency for International Development (USAID) and Save the Children Fund report success stories of Malawi in combating the spread of HIV through widespread condom campaigns, HIV continues to wreak havoc in the lives of many Malawians, particularly those in the economically active age range. Although official records indicate the HIV rate to have stabilised at 14%, other estimates indicate that the rate might actually be much higher at about 20%, and that it is expected to increase to 24% by 2010 (Kalipeni & Zulu, in press).

Furthermore, important national issues such as the worsening food crisis and the plight of HIV/AIDS victims have been sidelined as political instability in Malawi unfolds. Instead of tackling these issues, the government has been distracted and the parliament has lost focus. During the last days of the Muluzi presidency, Western donors froze balance of payments support to Malawi over corruption and governance concerns. However, with the new government of Bingu wa Mutharika, donor confidence and aid have

been restored. Mutharika, the current president, won the elections in May 2004 under Muluzi's United Democratic Front (UDF) ticket. After taking the reins of government, Mutharika soon put in place a strong anti-corruption programme, which displeased Muluzi and his cohorts, who forced Mutharika to resign from the UDF party, plunging Malawi into the current political crisis. This political wrangle has seen the former president (Bakili Muluzi) face a corruption probe from the government's Anti-Corruption Bureau (ACB), and the current incumbent (Bingu wa Mutharika) faces impeachment in parliament advanced by Muluzi's political party, the UDF. This is why observers note that the food crisis and the HIV/AIDS epidemic are likely to escalate as government loses focus in its fight for its own political survival.

Since 1990, the United Nations Development Programme (UNDP) has produced an impressive set of composite indicators of development for each country in the world, which are reported in its annual publication the *Human Development Report* as well as on its website <http://hdr.undp.org/>. The Human Development Index (HDI), the Human Poverty Index (HPI), Gender-Related Development Index (GDI), and the Gender Empowerment Index (GEM) are among the impressive composite measures of development. For each country in the world the Human Development Report offers a rank based on each of these indicators. When we examine these indicators with reference to Malawi, it becomes clear that this country is among the least developed in the world.

According to UNDP (2004) Malawi ranks 165 on the HDI, which focuses on life expectancy, literacy level, and per capita income. Although the HDI helps us to measure the average progress of a country in human development, it fails to address the various aspects of poverty. A more refined measure that focuses on poverty is the HPI. This composite measure focuses on life expectancy, literacy rates and proportion of people living below a certain level of income. Based on this measure, Malawi ranks 83 among 95 countries (UNDP, 2004). Another specialised measure that looks at gender inequality issues is the GDI. This index helps us to understand gender inequalities and their connection to vulnerability, particularly the inequalities that exist between men and women. When this measure is taken into consideration, Malawi ranks 134



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out of 144 countries. A similar index on gender issues is the GEM, which takes into account gender inequality in economic and political spheres. Unfortunately this measure was not available for Malawi in the *Human Development Report*, due to the lack of data concerning women who are in administrative and managerial positions and professional and technical ranks.

Nevertheless, the poor performance of the country on the above indicators of development testifies to the existence of massive poverty and the high gender disparities in human development. When one carefully examines the position of women in Malawi one cannot help but notice that women in this country increasingly play an important role, especially in the informal sector. In spite of this fact and the efforts made to improve the status of women, they continue to face discrimination in areas of health, nutrition, access to education, employment, and political participation. Based on our research in Malawi, it was clear to us that women in Malawi continue to be in a disadvantageous position. According to a recent report by UNAIDS (2004) on Malawi, it is noted that violence against women, especially wife beating and rape, is widespread in Malawi. Another study points out that a third of Malawi's households are female-headed (Ngwira, Kamchedzera & Semu, 2003).

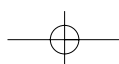
Poverty, according to the World Bank (2003), has many dimensions which include low income, lack of education, environmental degradation, and gender inequality. UNDP (2004) reports that in Malawi between 1990 and 2002, 42% of the population lived on less than \$1 a day and 75% lived on less than \$2. The World Bank (2004) reports that nearly 65% of the Malawian population lived below the poverty line in the mid-1990s. About 66% of the rural population lived below the poverty line, while in the urban areas it was reported to be about 55% (World Bank 2004).

According to Sen (1999, p. 87), 'poverty must be seen as the deprivation of basic capabilities rather than merely as lowness of income which is the standard criterion of identification of poverty'. Sen further argues that poverty is a multifaceted problem and that there are a number of physical, social, and cultural factors, in addition to economic conditions, that can exacerbate the situation. Firstly, as we consider physical conditions, the susceptibility to natural disasters like

droughts can render individuals vulnerable and thus push them towards poverty. Malawi is a country which has witnessed severe environmental degradation that has had the potential to displace many from their land, rural homes, and livelihood (Government of Malawi, 2003). This is a big problem in a country where 84% of the population live in rural areas (UNAIDS/WHO, 2004) and 83% of economically active people derive their livelihood from agriculture. Women in Malawi are overwhelmingly engaged in the agricultural sector, with 97% associated with subsistence farming (Ngwira *et al.*, 2003). The high dependency results in greater shock and vulnerability when lack of rainfall and environmental problems contribute to crop failure and food insecurity, which in some cases compels women to migrate to urban areas as well as to countries such as South Africa in search of jobs.

Secondly, as noted earlier, lack of education and training available to women makes them more vulnerable to poverty and forces them to undertake risky behaviour. There is a close association between illiteracy and poverty. Sen (1999) indicates that if the family income is not enough to cover the education and health care of girls and women, in the long run they face multiple problems such as higher mortality, under-nourishment, and medical neglect, among others. Over the years the Malawian government has allocated funding to education, but in spite of this, there is a pronounced gender gap as one continues to look at retention, attendance, and attainment. The drop-out rate is higher for girls and is highest in the age group 10 - 15 years. The reasons for drop-out include higher cost of schooling, demand for their labour, puberty-related factors, early marriage, pregnancy and sexual harassment by male teachers and students (Ngwira *et al.*, 2003).

Finally, the social structure also influences people's ability to acquire resources and thereby improve their economic situation – their location and position in the social structure determines their ability to acquire and mobilise resources. Since there is a gender gap in access to education (Kalipeni 1997), many girls grow up with limited access to education, which further impedes their capability to earn a living, and thus forces them to seek employment in the informal sector. Also, as women are primarily engaged in farming it is assumed that they will not require education or training. On the other hand, men are engaged in production and



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of Human Subjects at Dominican University of California for ethical clearance for the research in Malawi, since we were going to involve human subjects. The submission of the proposal included consent protocols for both one-on-one interviews and the focus group interviews, which were both in Chichewa, the local language, and English. All the participants knew how to read and write, at least in Chichewa.

The city of Lilongwe is divided into several subdivisions called areas. Some of these areas have number names and others have traditional Malawian names (see Fig. 1). We were interested in interviewing in five areas, namely Chinsapo (peri-urban area with many rural characteristics and low-income people); area 25 and 29 (peri-urban areas for low-income people); areas 10 and 15 (medium-income and high-income residential areas). Each of these areas is further subdivided into several wards with each ward led by a councillor or headman. The study in this paper only analyses the interviews we conducted with women in Chinsapo. Permission to hold the structured and focus group interview was also obtained from the councillor or the headman of the ward in which the participants were selected. The focus group interviews were segregated by gender, which was necessitated by the fact that Malawian society is dominated by men. Women do not ordinarily speak if men are present; however, when it is only a group of women, they often speak their minds openly.

Field work and study limitations

During 2003 we carried out fieldwork in this area to examine the perceptions of women about their risks regarding HIV. We hired two female interviewers to conduct interviews with the selected 60 women. The reason for choosing female interviewers was based on the premise that the questions in the questionnaire were sensitive and private issues, and that women would be more open to discuss these issues with female rather than male interviewers. Indeed, the results of the interviews confirmed our fears. For example, a number of the respondents were not comfortable to give the requested information on their knowledge and practices regarding AIDS, and whether they had talked with friends about family planning and AIDS. Other women were afraid or shy to give information on extramarital affairs, due to fears that we

might report the information to their husband, in spite of the fact that the consent form emphasised confidentiality. Some women refused to be interviewed because they said the questionnaire had too many questions and that they were afraid that their husbands might find them being interviewed because of the length of the interviews (about an hour and half). A few women refused to hear mention of certain words such as condoms because of their religious beliefs which forbade them to say such words. Women who objected to be interviewed or to continue the interview after it had started were dropped from the sample.

The two female interviewers were familiar with the area as they also lived here and spoke the local language, Chichewa, understood by all the residents. Questions were asked about religion, family background, economic conditions of the individuals, marriage history, family planning and social networks, fertility, sexual partnerships and HIV/AIDS. As noted above, we also conducted two focus group interviews with 20 additional women. Such discussions were informal in nature. We asked about people's perceptions and understanding of HIV, what people thought about prevention of infections, and changing social and cultural practices. Surprisingly, the focus group discussions were a great success as women were more open to discuss issues than in the structured one-on-one interviews. In future studies, we will carry out more focus group interviews and streamline the structured questionnaire. In this light, we wish to acknowledge that the subset sample of 60 women is on the small side and therefore may not be a true representation of the general populace in the city of Lilongwe. Nevertheless insights can be gleaned from this sample when coupled with data from the focus groups.

We used the questionnaire developed by the Malawi Diffusion and Ideational Change Project (MDICP) at the Population Center of the University of Pennsylvania (Watkins, Zulu & Behrman, 2003). The MDICP has conducted similar surveys in rural areas of Kenya and Malawi, which meant the questionnaire had already been amply tested in other localities of Malawi. We therefore did not conduct a pilot study, but had we done so, given the reluctance of some women to answer the questions, we might have decided to use a different method, to minimise some of the concerns highlighted above.

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Results and discussion of structured interviews

Several questions in the structured questionnaire examined issues surrounding vulnerability of women and their perceptions of risks regarding HIV/AIDS. The descriptive results of these questions are summarised in Tables 1 – 5 and discussed below.

Gender and reproductive issues

On gender issues we asked two central questions: when would it be proper for a wife to leave her husband, and what could a woman do without informing her husband. As shown in Table 1, the majority of women (about 53%) noted that it was proper to leave her husband if he beat her frequently. This was followed by sexual infidelity (33%) and if the woman thought he might be infected with AIDS (about 19%). Financial support for her and the children from the husband was not considered to be a reason for leaving the husband, nor was the denial by the husband of her using family planning. Lilongwe is in the heart of the matrilineal system of descent in which the father is not obligated to support his own children but those of his sisters. Also in a high fertility rate society, begetting children is central to marriage, hence the low percentage scores on these two issues. When we asked women whether they could go to the local market or to the local health centre without informing their husbands, the majority (over 63%) said they could not simply do so without informing their husband. It is clear from these rather low percentages that a woman cannot leave a husband even when he does not provide economic support, is unfaithful, and has AIDS; nor can she do certain simple things on her own without informing her husband, for fear of being accused of being unfaithful to the husband.

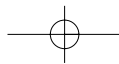
Regarding reproductive rights, we asked women several questions on whether they could take certain actions without informing their husband (Table 2). It is clear from this table that the majority of women were dependent on their husbands for deciding whether to use contraceptive techniques or not and how large the family was to be. For example, 81% of women agreed that there was nothing much they could do to change the mind of their partner when he refused the use of modern methods of child spacing. Similarly, 58% of women disagreed that if they wanted to delay their next pregnancy, they would be able to have their way. However, it was interesting to note that 54% of the women agreed that even if their husbands did not want them to use family planning, if they wanted to, they would go ahead without the husband's knowledge. This is largely due to the fact that the family planning clinics in Malawi and elsewhere in Africa target only women and that the women themselves are the ones who go to the clinics to obtain the techniques, which can easily be hidden from husbands. However, should the husband find out, the consequences could be tragic for the woman.

Knowledge, attitudes and worry about AIDS

Tables 3 and 4 offer the results on questions concerning general knowledge, attitudes, and worry about AIDS and condoms. The results are revealing about the general knowledge among women in this area regarding HIV/AIDS. Over 93% of the women had heard a talk at the clinic, hospital or on the radio about how people could protect themselves against AIDS, and 78% mentioned that someone from the health surveillance system came to their home to give them information on how to protect themselves from contracting the virus. When asked if they could get

TABLE 1. QUESTIONS ON GENDER ISSUES: LEAVING HUSBAND OR DOING THINGS WITHOUT HUSBAND'S KNOWLEDGE (N = 60)

	Yes (%)	No (%)	Don't know (%)
In your opinion, is it proper for a wife to leave her husband if:			
• He does not support her and the children financially?	6.5	88.3	5.2
• He beats her frequently?	53.2	40.6	6.2
• He is sexually unfaithful?	33.3	65.2	1.5
• She thinks he might be infected with AIDS?	18.7	75.9	3.4
• He does not allow her to use family planning?	11.0	86.4	2.6
Can you do the following without informing your husband:			
• Go to the local market	33.5	66.5	0.0
• Go the local health centre	36.3	63.7	0.0



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TABLE 2. QUESTIONS ON GENDER ISSUES: CERTAIN ACTIONS THAT CAN OR CANNOT BE TAKEN BY A WOMAN (N = 60)

Action (state whether you agree, disagree, or have no opinion about the following statements)	Agree (%)	Disagree (%)	No opinion (%)
If your partner does not want to use modern methods of child spacing/ family planning, there is nothing you can do to change his mind	81.3	16.6	2.1
If you decide that you want to delay the next pregnancy, you will be able to have your way	35.6	57.8	6.6
If you decide that you want no more children, you will be able to have your way	44.0	54.1	1.9
Even if your husband does not want you to use family planning, if you want to you will use without his knowledge	57.3	38.6	4.1

AIDS through sex with someone who looked perfectly healthy, 100% of the women answered yes.

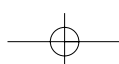
Knowledge about HIV/AIDS among the women was high, but practices and attitudes were not congruent with this knowledge. As shown in Table 3, when asked if it was acceptable to use a condom with a spouse to protect against AIDS, 86% of the women said no. When asked if they had ever talked to their husbands about the chances of infection with the virus, only 44% of the women said they had. However, 70% noted that they suspected that their husbands had had sexual relations with other women, and that their fellow-women had also cheated with men other than their

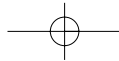
husbands. But when asked if they themselves had engaged in such activities, almost 100% of them said no. It is clear from these results that women, probably due to their vulnerable position, are afraid to raise issues concerning HIV/AIDS with their husbands. While they know that their husbands are cheating, they will not raise a voice concerning AIDS nor how to protect themselves from the virus. They simply accept the status quo.

The results in Table 4 confirm this. We asked the respondents to highlight the ways in which women could get infected with AIDS that they were most worried about. About 70% indicated that they were

TABLE 3. GENERAL KNOWLEDGE AND ATTITUDES ABOUT AIDS AND CONDOMS (N = 60)

Question	Yes (%)	No (%)	Don't know (%)
Do you think it is acceptable to use a condom with a spouse to protect against AIDS?	12.7	86.3	1.0
Can you get AIDS if you have sex with someone who looks perfectly healthy?	98.8	1.2	0.0
Has your best friend slept with anyone other than her husband in the last 12 months?	70.6	19.1	10.3
Have you ever talked to your husband about the chances that you or he might get infected with AIDS?	44.1	53.8	2.1
Do you suspect or know that your husband has had sexual relations with other women apart from you since you were married?	69.9	27.3	2.8
Have you yourself slept with anyone other than your husband in the last 12 months?	0.1	99.9	0.0
Have you ever heard a talk at the clinic/hospital about how people can protect themselves against AIDS?	94.2	5.8	0.0
Have you ever heard a radio programme about how people can protect themselves against AIDS?	93.1	6.9	0.0
Has someone like a Community Based Distribution agent or a Health Surveillance Assistant ever come to your home to give you information about how people can protect themselves against AIDS?	78.2	21.8	0.0





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TABLE 4. WHICH OF THE FOLLOWING WAYS IN WHICH WOMEN MIGHT GET INFECTED WITH THE AIDS VIRUS ARE YOU MOST WORRIED ABOUT FOR YOURSELF? AND HOW WORRIED ARE YOU THAT YOU MIGHT CATCH AIDS? (N= 60)

	%
Most worried about getting infected with the AIDS virus from:	
• Husband	82.1
• Other partner	4.1
• Needle injections	11.8
• Transfusions	2.0
Worry that you might catch AIDS	
• Not worried at all	6.5
• Worried a little	9.2
• Worried a lot	84.3

worried of getting the virus from their husbands. A handful (about 12%) were worried about needle injections at hospitals or clinics. Other partners and transfusions were not significant at all as possible methods of infection. We further asked the respondents how worried they were that they might catch AIDS: 84% said they were very worried, 9% were worried a little and only 7% were not worried. In short, the results in Tables 3 and 4 indicate that women have the requisite knowledge about AIDS and the ways in which people can protect themselves from getting infected with the virus. However, women generally see themselves as helpless and at the mercy of their husbands, boyfriends or other men.

TABLE 5. WHAT DO YOU THINK IS THE BEST WAY TO PROTECT YOURSELF FROM GETTING AIDS? (N = 60)

	Yes (%)	No (%)	Don't know (%)
Advise spouse to take care	61.2	38.8	0.0
Use condoms with:			
• All other partners except spouse	16.1	83.9	0.0
• Prostitutes / bar girls	38.2	61.8	0.0
• People from town	12.2	87.8	0.0
• Other people you think might be infected	10.7	89.3	0.0
Avoid having sex with:			
• Any partners except spouse	40.1	59.9	0.0
• Prostitutes /bar girls	40.3	59.7	0.0
• Many partners	30.5	69.5	0.0
• People from town	35.0	65.0	0.0
• Other people you think might be infected	29.3	70.7	0.0
Avoid:			
Transfusions/ injections/ sharing razor blades	20.8	79.2	0.0

The respondents were further asked to indicate the best ways to protect themselves from contracting HIV/AIDS (Table 5). About 61% indicated that advising their partners was one of the best ways of avoiding the virus. This is in contrast to the number of women who had actually spoken to their husbands about HIV (only 44% had done so, as shown in Table 3). While women do wish to speak to their husbands, they are constrained by their inferior position in society to submit to the dictates of men. From the answers in Table 5 it is quite clear that the majority of women do not know the best ways of avoiding contracting HIV. Only 38% and 40% respectively pointed out that using a condom with prostitutes and/or bar girls and avoiding sexual contact with this group would protect oneself from getting infected. In spite of their awareness about the disease they are unable to protect themselves, which increases their vulnerability.

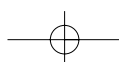
Results and discussion of focus group interviews

We conducted two focus group interviews with 20 women, 10 women per focus group. The focus group interviews were centered on poverty, position and status of women in society, their income-generating activities, and knowledge and attitudes towards HIV/AIDS. The participants in focus group interviews were more open to discuss issues than those in the one-on-one structured interviews. It was clear from these interviews that poverty puts women in very vulnerable positions as far as the spread of HIV/AIDS is concerned.

In response to the questions ‘What is AIDS?’ and ‘What is HIV?’, two of the women offered the following answers:

Respondent 1: AIDS has always been with us, my grandmother told me that in the past they used to call it *kanyera* or *tsempho* but it was not as bad as these days. Today it is extremely bad, people are dying of simple things such as flu, this AIDS is something else, nobody knows what it is!

Respondent 2: You are not answering the question! AIDS is a disease that causes one to get very thin, have lesions on the face, lose hair, and die of TB. Just go to Likuni hospital to see for yourself. I know we all have AIDS and we are going to die of it. See all these little kids running around, they have no parents and they just smoke *chamba* (marijuana).



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There was agreement in both focus groups as to the nature of AIDS and its destructive impact on society throughout Malawi. Everybody knew what it was, including a detailed description of its symptoms. A few women noted that AIDS has always been with us but somehow it had woken up to wreak havoc on society. When asked if AIDS was curable many of them said no. A few said they had heard that there are effective medications called ARVs which might end the symptoms. One woman said she knew a friend who had developed lesions and rashes throughout her body, one of the early symptoms of AIDS. When she began taking the ARVs the lesions disappeared and she gained a lot of weight. We further probed as to where these medications could be obtained, and the respondent indicated that the woman in question was working for one of the well-known hotels in Lilongwe and that she got the medication through a programme at her place of work. Knowledge about the disease and its incurability was quite high. We were surprised to hear that some of the women knew that medication could be obtained to end the symptoms, but these medications were restricted to a select few on a pilot basis.

One of the questions dealt with poverty and income-generating activities in the area for men and women. There was total agreement among the women in the focus groups that the area was socioeconomically deprived and there were very few opportunities for men and women:

Respondent 13: I am sure you have seen for yourself that there is nothing much. The area is poor, there is no water, a few people can afford electricity for lighting, we have to walk a distance to the standing pipe to draw water, there are no schools here for our children to go to, crime and thievery are on the increase.

Respondent 15: Many of our husbands are self-employed, selling second-hand clothing or fixing *kanyenya* (grilled meat) and selling *zibolibori* (curios) at city centre in Lilongwe, or selling goods by the roadside. You see the minibuses passing by, the drivers and conductors are likely to be our husbands in there. The income they bring home is too little to support the whole family. Many of us are lucky to have two meals a day. Just look at the kids running around, they are all malnourished.

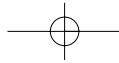
Respondent 19: Don't forget that those who have school papers work in good positions in the government as messengers or clerks, some even work in banks and they own and drive good cars but they stay here in Chinsapo.

Many of the women simply spoke about their husbands' and boyfriend's employment. When asked about their income-generating activities, the majority indicated that they had no employment. One woman noted that there are some enterprising women who go to the lake to buy dried fish and bring it to the area and ask their children to sell it by the roadside. Some women go to the surrounding villages to buy peanuts or maize and sell them to others in the area, thereby supplementing their husbands' income. At this point we asked a question about other activities such as women sleeping with men for monetary gain. There was laughter from the women, an indication that this was a common practice, as suggested below:

Respondent 15: What else can we do! Many of us never went to school, so no jobs for us. When the kids are starving at home and your husband has no income, well one has to do what one has to do to feed the children. So, yes, it happens and I know a few women who do that.

Respondent 11: Take the case of Jennifer (not actual name). She works at Likuni Hospital as an AIDS surveillance clerk and I think she gets about K3,500 a month (about US\$30.00) but she still moves around with other men. Actually it was the husband who started it first, he was moving with this woman. Then she found out that the husband was spending all his money on this woman; she also began moving around with the driver who drives her to various clinics. The husband found out and beat her savagely. She was treated in hospital for two weeks after the beating. We hear she has now left her husband and moved in with the driver and the driver has left his wife, who is now suffering with four small children.

The above quotes are a sample of the spirited discussions we had with women in the two focus groups. The findings in this study confirm that poverty in low socioeconomic income areas puts women at risk of infection from HIV. The vulnerable position of women in society was clearly illustrated in both the structured



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interviews and the focus group discussions. The results in our study are similar to the results of other studies being conducted in Malawi. For example, Barden-O'Fallon, de Graft-Johnson, Bisiha, Sulzbach, Benson & Tsui (2004) found that knowledge of HIV/AIDS does not necessarily translate into perceived risk. As discussed earlier in this study, although we found that many women know about AIDS, risky behaviours were quite common due to the circumstances in which women found themselves. In a very interesting study, Kaler (2004) noted that: 'While Malawians share many ideas about AIDS, where it comes from and how one contracts it, there is evidently a lack of consensus about whether it is worthwhile to change behavior in order to avoid it.' In another recent study, Smith and Watkins (2005) note that in spite of poly-partner sexual activities among men, quite a substantial number of men have begun to change their behaviour in ways that may reduce the spread of HIV/AIDS, e.g. reducing the number of partners and/or careful partner selection. Nevertheless, the inferior position of women, poverty and other economic circumstances force women to engage in sexual activities that put them at risk of acquiring HIV. Many of the women, even if they were faithful to their husbands, pointed out that they would still get the virus from their unfaithful husbands.

Conclusion

It is quite clear from the analysis in this paper that the rising epidemic among women in low socioeconomic income areas such as Chinsapo is driven in part by the cultural context and poverty which restrict their options. Gender inequality and asymmetrical sexual relations result in the rapid spread of HIV/AIDS among women, as evidenced in the structured interviews and focus group discussions in our study. Women are bound by culture not to leave or divorce their husbands even when the husband does not provide economic support, is unfaithful, and has AIDS. It is only when the man becomes extremely violent that a woman might decide to leave the husband for fear of losing her life. Women can do very little to increase the use of condoms, to space or stop having more children, and to protect themselves from HIV. As shown in this study, women are very worried about being infected and agree that they will be infected by their husbands because they know that their husbands have sexual relationships with other women. Due to economic

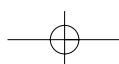
circumstances some women also engage in sexual relationships with partners other than their husband to supplement their meagre incomes. This, though, is done without the husband's knowledge or consent. Although awareness of AIDS was very high among the women in the sample they were unable to protect themselves, which increases their vulnerability to HIV.

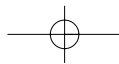
Acknowledgments

We are grateful for the financial support received from the Research Board and the Department of Geography at the University of Illinois at Urbana-Champaign, The Compton Foundation Grant (# 03-1162) and Dominican University of California. Many thanks go to the men and women in the areas of our study in the city of Lilongwe for agreeing to participate in the surveys and focus group interviews that resulted in the collection of the data which form the basis for this paper. However, the views expressed in this paper are the responsibility of the authors.

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