

**'Narratives of Blame'**  
**HIV/AIDS and Harmful Cultural Practices in Malawi:**  
**Implications for Policies and Programmes**

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## Abstract

The aim of this research is to examine the *fisi* practice and HIV/AIDS in a high HIV prevalence country and to highlight implications for HIV/AIDS policies and programmes. Five objectives were identified to meet this aim. First, it assesses the extent to which the Malawian elites (educated Malawians working on HIV/AIDS) are reframing the AIDS epidemic to further their goals and self-interests. Second, it investigates whether the debates on HIV prevention in Malawi are facilitated or constrained by international donors (bi and multilateral agencies). Third, it explores whether or not HIV/AIDS is being represented as an exceptional circumstance, justifying policies that would not normally be applied to other public health crises, for example to other Sexually Transmitted Infections. Fourth, it ascertains and examines the extent to which international frameworks, agendas and paradigms are influencing and impacting on traditional cultural practices, resulting in changes to legislation to ban such practices. And finally, it assesses the implications of the findings for the conceptualisation and provision of current and future HIV/AIDS policies and programmes in Malawi.

In-depth interviews (n=60) were carried out to foreground stakeholders' own views and to understand how constructions of narratives linking HIV/AIDS and harmful cultural practices came about. These data are also supported with interview data (n=28) I collected during a consultancy for the Joint United Nations Programme on HIV/AIDS, interviews I conducted in a village in Lunzu (n=45), newspaper articles, policy documents and field notes.

Findings demonstrate that due to the epidemiology of HIV the *fisi* practice does not contribute significantly to the spread of HIV/AIDS in Malawi. Instead, I argue that the way that harmful cultural practices have been linked to the spread of HIV/AIDS is a distortion of the reality and what becomes lost is a critical understanding of how harmful cultural practices impact negatively on women's lives and feed into patriarchal values.

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**Author's declaration**

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

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## Acronyms and Glossary

AIDS	Acquired Immune Deficiency Syndrome
Akunja	An outsider to the grace of the Christian God
Anankungwi	The traditional female initiation counsellor
Angaliba	The traditional male initiation counsellor among the Yao
Ankhoswe	The traditional marriage counsellor
ATR	African Traditional Religion
Bwalo	Ground or open space in a village for meetings and <i>nyau</i> dances
CABS	Common Approach to Budgetary Support
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CHAT	Country Harmonization and Alignment Tool
CBO	Community Based Organisation
Chiharo	The practice of widow inheritance: marrying the wife of a deceased brother
Chikule	The initial instruction given to a girl by her aunt or grandmother on her first menstruation
Chimwanamaye	Exchanging of husbands or wives
Chinamwali	Traditional initiation rite
Chisuweni	Female and male cousins are socially allowed to have sexual relationships
Chitayo	An illness believed to be caused by having sex during menstruation, soon after delivery or just after an abortion; also described as a hydrocele that develops in the scrotum of a man who has been in contact with a woman who is more than five months pregnant
Chokolo	The name of the widow herself in the practice of widow inheritance
DFID	Department of International Development
EU	European Union
FBO	Faith-based Organisation
Fisi	A man organised to have first sexual intercourse with a girl after commencement of menstruation or following initiation rite as symbol of maturity
GBV	Gender Based Violence
GFTAM	Global Fund to fight AIDS, Tuberculosis and Malaria
GTZ	German Technical Development Agency
Gwamula	Boys from different households sleep in one hut and invade a girls' hut; sometimes girls are forced to have sex with the boys
HADG	HIV/AIDS Development Group
HCP	Harmful Cultural Practice
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IAWP	Integrated Annual Work Plan
INGO	International Non-Governmental Organisation
Jando/Mdulidwe	A male initiation ceremony that involves circumcision
Khundabwi	Herbal mixture given to a girl upon her first menstruation
Kuchotsa fumbi	Chichewa kulowa kufa (cleasing after death)
Kuchotsa milaza	Among the Chewa and Mang'anja, a widow may resume sexual intercourse without the disturbance of the spouse's spirit in her after experiencing sexual cleasing with the deceased's relative, thereby re-entering the life cycle
Kulowa kufa	Cleaving after death

Kupita kufa	Sexual cleansing involving the surviving spouse with a relative from the other side of the family; it can take place for men or women
Kusasa fumbi	Sexual intercourse done soon after undergoing initiation rituals
Kutenga mwana	Newborn cleansing
M&E	Monitoring and Evaluation
MANASO	Malawi Network of AIDS Service Organisations
MANET+	Malawi Network for People Living with HIV/AIDS
Matrilocal	Upon marriage, the husband relocates to the local group of the wife, generally to her mother's household compound
Matripotestal	Authority over the members of the family is in the hands of the mother or relatives
MBCA	Malawi Business Coalition on AIDS
Mbulo	Temporary husband replacement
M'bvade	Where an unmarried female's post-natal abstinence is concluded by surrogate sex
MDHS	Malawi Demographic and Health Survey
MDICP	Malawi Diffusion and Ideational Change Project
Mdulo	Mysterious disease caused by the transgression of a sexual taboo
MIAA	Malawi Interfaith AIDS Association
MGDS	Malawi Growth and Development Strategy
Mitala	Polygamy
Mkangali	The last stage of a chief's initiation rite
MoE	Ministry of Education
MoH	Ministry of Health
MOWCD	Ministry of Women and Child Development
Mphini	Ear piercing and tattooing
Mwambo	Custom
NAC	National AIDS Commission
NAF	National Action Framework
NAPHAM	National Association for People Living with HIV in Malawi
NGO	Non-Governmental Organisation
Nkhoswe	A go-between to handle marriage negotiations and marriage affairs
NSF	National Strategic Framework
NSO	National Statistical Office
Nthena	Widow cleansing: in the Northern region, where a widower is given a wife's younger sister
Nyau cult	The Chewa secret male society
OPC	Office of the President's Cabinet
Patrilocal	Upon marriage, the wife relocates to the local group of the husband, generally to her father-in-law's household compound
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother To Child Transmission
Polygyny	Having multiple wives
SAFAIDS	Southern Africa HIV/AIDS Information Dissemination Service
STIs	Sexually Transmitted Infections
SWAp	Sector Wide Approach
Tsempho	An illness that appears like AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
USG	United States Group
WHO	World Health Organisation

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## **Dedication**

For my grandparents

## **Dissemination**

### **Conference papers and presentations**

'Narratives of Blame': HIV and AIDS and Sexual cultural practices and in Malawi: Implications for Policies and Programmes', ENRGHI14 Conference, Portsmouth, UK, 19<sup>th</sup> June 2014.

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'Sexual Cultural Practices and Narratives of Blame: HIV/AIDS in Malawi': Centre for European and International Studies Research Seminar, Portsmouth, UK, 4<sup>th</sup> December 2012.

'Discourses on HIV/AIDS and sexual cultural practices in Malawi: Knowledge, Policy and Practice' Anthropology in the World conference, London, UK 8<sup>th</sup>-10<sup>th</sup> June 2012.

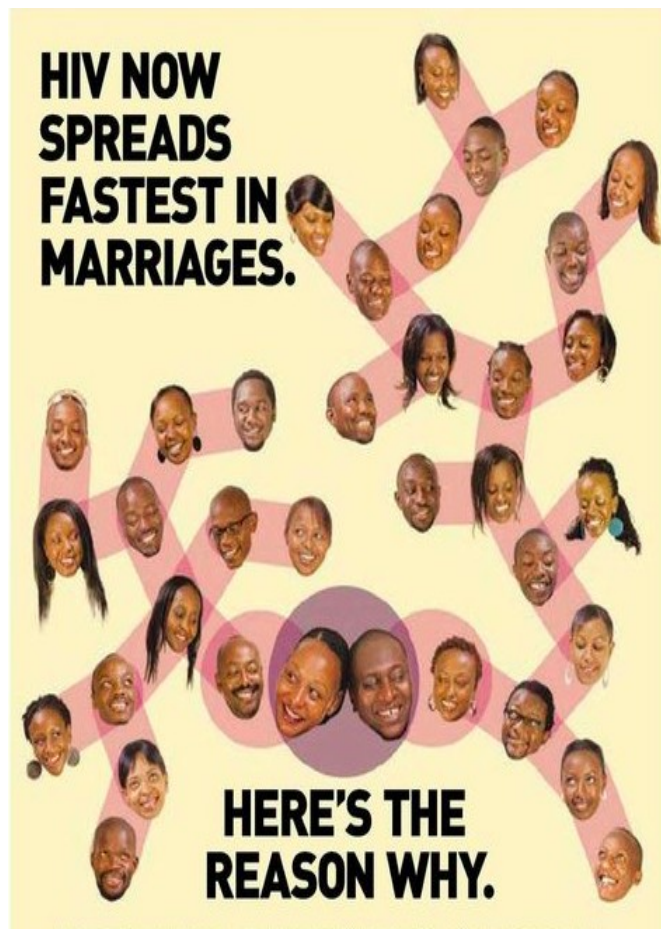


## CHAPTER 1 Introduction

Man has a wife. By the time she is 30 she is too old. So he starts looking for another woman. He finds his secretary and gives her money whilst also finding a woman in the village and he gives her some money. But the secretary starts getting concerned that the man is not giving her enough money so she starts looking for another man.

Quote from a speaker at 'The Role of Culture in Influencing Multiple and Concurrent Partnerships' MANET + and SAFAIDS conference, Blantyre 2009 (Journal entry 04/03/2009)

Figure 1.1 – Advert illustrating how HIV is spread in marriages



### Situating the thesis

One particular event stimulated my interest for this study. In 2008 I carried out a field trip to Malawi to monitor a community-based AIDS prevention programme funded by the Department for International Development (DFID) whilst working as Programme Manager for a sexual and reproductive health Non-Governmental Organisation (NGO) based in London. While speaking to women in Blantyre (Malawi's second largest city, located in the South of the country) who worked for a Community Based Organisation (CBO), and who had contracted HIV, I was informed about

certain cultural practices which are said to be risky for the spread of HIV. One particular practice grabbed my attention. It is called *fisi*, which means 'hyena' in Chichewa. The story recounted to me was about a hyena, which is a man who is brought in to have sex with young women during initiation ceremonies.

I then became aware of a widespread misconception that exists in the NGO sector and beyond into the world of international donors that so-called 'harmful cultural practices' were the main driver of the AIDS epidemic in Malawi. Colleagues described these practices at length, expounding on the risks they presented and efforts to stamp them out, while at the same time weaving into the discourse other fashionable interests of international agencies. Yet the link between harmful cultural practices and the epidemic was never supported by evidence. For example, while it is known that the prevalence of AIDS among widows is higher than among married women, no evidence was presented that this was due to widow inheritance rather than to years of marriage to a man who had died of AIDS – and from a biomedical perspective the latter is more likely. Consequently, when I returned to the UK I applied to study for a PhD in order to critically analyse the development process of which I was part.

This study interrogates the policy-making process surrounding HIV/AIDS eradication. It draws attention to the ways that the elite in Malawi - people who stand out from the average Malawian as educated with an at least secondary education and occasionally more advanced study either in Malawi or, especially desirable, abroad - dominate the policy arena and influence perspectives of international donors who buy into the distorted accounts provided by them. The elite to whom I refer throughout are middle class people in government positions or working in INGOs or bi and multilateral agencies; see page 36 for a list of national actors and chapter 4 in the section on the Malawian elite. Malawians who work in the development field can be described as elites (Watkins & Swidler, 2009; Myroniuk, 2011). This distorted reality presented by the Malawian elite makes progress on women's rights even more difficult because of the ways in which cultural practices support the oppression of women, and so issues of violence towards them are missed.

This study argues that there is no empirical evidence, which shows that any of the commonly mentioned 'harmful cultural practices' contribute significantly to the AIDS epidemic. Instead, it postulates that the epistemic community in Malawi (epistemic community includes international donors working on HIV and AIDS as well as the Malawian elite) are reframing both traditional

cultural practices and women's rights concepts in the context of what is widely considered an emergency, the AIDS epidemic.

**Illustration 1.1 – Visiting women's HIV CBO where I first found out about the *fisi* practice.**

**02/10/2008. Author.**



This epistemic community comprises those working in the field of HIV/AIDS, who frame narratives about AIDS to achieve other goals, both ideal and pragmatic, for example for the purposes of self-preservation and self-interest. Haas' (1992) notion of the 'epistemic community' is particularly useful for conceptualising the HIV/AIDS prevention community in Malawi; Haas describes an epistemic community as 'a network of professionals with recognised expertise and competence in a particular domain or issue-area' (Haas, 1992, p. 3). He posits that epistemic communities are groups of professionals, often from a variety of different disciplines, which produce policy-relevant knowledge about complex technical issues (Haas, 1992, p16). This study makes the case that the Malawian elite are influencing the policy agenda on HIV/AIDS and harmful cultural practices. This study also examines how other 'upward' actors – e.g. International Non-Governmental Organisations (INGOs), bi and multilateral donors –adopt the views provided by the Malawian elite without questioning the evidence.

This thesis then also explores how evidence is produced in the context of HIV/AIDS and how certain cultural practices have been co-opted by the NGO discourse in order to provide an explanation as to why its prevalence is so high in Malawi. My analysis orientates around how

different narratives on HIV/AIDS are framed, and what and how evidence is used to support them. As my thesis shows these narratives are not based on face-to-face encounters with women involved in these practices, nor are they are founded in the biomedical evidence. What is under consideration is the way the Malawian elites have constructed a category of rural people as backward because they continue to observe practices deemed to be 'harmful', which they construct as such because of an imagined link to HIV/AIDS transmission. What my analytical framework (Figure 1.3) elicits is how this constructed and epidemiologically inaccurate narrative has been taken up and endorsed by the international donors.

### **Evidence**

Although this research refers to many specific sexual cultural practices that take place in Malawi that are reported to spread HIV, it goes into particular depth about the practice called *fisi*. *Fisi* means 'hyena' in Chichewa and has two meanings. First, a man (who is referred to as *fisi*) is chosen by a village leader to have sex with young girls after initiation. The young girls involved are those who have either recently incurred their first menstruation and are often virgins, or are soon to be married. The hyena is an unidentifiable male who comes to each woman individually under the cover of night and has sex, often without protection (Malawi Human Rights Commission, 2005). Second, a *fisi* can also be a man hired to have sex with a married woman who cannot conceive, and therefore a secret arrangement is made with the *fisi*. I focus on the practice of *fisi* during initiation.

I argue on epidemiological grounds the risk of contracting HIV by carrying out the practice of *fisi* with young girls is low. Shiboski & Padian, (1996) estimated that infectivity for male to female transmission is low, 0.0009 per contact (p. 355). Further, my argument is supported by findings from studies on HIV epidemiology (see previous section on epidemiology) which argue that HIV is not easily transmitted particularly during a one-off sexual act for the first time. For example, one study carried out by Boily et al. (2009) involved a review and meta-analysis of observational studies of the risk of HIV-1 transmission per heterosexual act. Sexual transmission estimations were mainly divided in two categories: per act transmission probabilities, which quantify the risk of infection per sexual contact and per partner transmission probabilities, which measure the cumulative risk of infection over many sexual acts during a partnership. However, as authors point out per-act transmission probabilities are methodologically challenging to quantify (Shiboski & Padian, 1996; Boily et al., 2009).

This supports my argument as the *fisi* practice occurs as a one-off heterosexual act and therefore it is not statistically significant to the spread of HIV (See previous section on HIV epidemiology). Further, no randomised clinical trials have been carried out in Malawi to provide evidence that the *fisi* practice is contributing to the spread of HIV therefore there is evidence of a lack of evidence. As well as the epidemiological evidence to show that the *fisi* practice is of low risk, there is also a lack of evidence to suggest the *fisi* practice is widespread to the extent that it would significantly increase HIV prevalence rates in Malawi. The practice has only been evidenced in a small number of rural communities in Malawi, namely Mangochi and Nsanje.

Further, there is a lack of anthropological evidence to argue that this practice contributes significantly to the spread of HIV. Although there have been studies carried out looking at initiation rites in Malawi (e.g. see Skinner, 2013; Munthali et al., 2006; Munthali and Zulu, 2007; Kamlongera 2011) and several donor and government funded studies on sexual cultural practices and HIV and AIDS in Malawi (Kornfield & Namate, 1997; Matinga and McConville, 2003; Malawi Human Rights Commission, 2006; Kalipeni et al., 2004; College of Medicine, 2005; National AIDS Commission [NAC], 2005; Kadzandira & Zisiyana, 2006; Chimombo, 2006; Conroy et al., 2006) which have been used to explain how sexual cultural practices are spreading HIV in Malawi, these results have been amplified outside of these studies' findings. There is no empirical evidence to support that the *fisi* practice is significantly contributing to the spread of HIV at a national scale in Malawi.

Why is there then so much focus on something that in numerical terms at best has a minor effect in the increase of AIDS at a national level? This thesis does not aim to argue that these practices cannot have a negative effect or that they are not problematic in terms of gender, sexuality and control. However, as this thesis will show, empirical evidence first reflects there is only patchy knowledge of these practices and their prevalence and, second, that the really problematic space for the spread of AIDS in Malawi is not rural traditional areas but urban non traditional areas.

As HIV prevalence rates in Malawi demonstrate prevalence is greater in the south (20-22 percent) than the north (8 percent) and centre (7 percent); and greater in the urban than rural areas (MDHS, 2004). Data shows that urban residents have a significantly higher risk of HIV infection than rural residents. For example, while 18 percent of urban women are HIV positive, the corresponding proportion for rural women is 13 percent. For men, the urban-rural difference in HIV prevalence is even greater; urban men are nearly twice as likely to be infected as rural men

(16 and 9 percent, respectively) (MDHS, 2004 p.231). This is very significant because harmful cultural practices are reported to be largely rural practices but yet infection rates lower in these contexts. This highlights the inaccuracy in the narrative blaming rural harmful cultural practices for high prevalence rates. HIV prevalence rates are ironically much higher in urban areas where the elites interviewed in this study live.

Further, HIV prevalence rates are higher amongst women age 30-34 (18 percent) compared to 3.7 percent of women age 15-19. In addition, at the time this study took place, no data existed for HIV prevalence rates among girls under the age of 15. The fact that data was not collected and yet this is the demographic that is partaking in initiation ceremonies supports my argument that those blaming the sexual cultural practice for the spread of HIV cannot support their case. In terms of education and wealth, the HIV prevalence rate is highest amongst women with a secondary education and above (15.1 percent) compared to those women with no education (13.6 percent). In terms of income those women with the highest rates of HIV were in the top wealth quintile.

In summary I have demonstrated that the *fisi* practice does not contribute significantly to the spread of HIV for four reasons. First, epidemiological evidence reveals that the probability of infection during one heterosexual act is low. Second, there is a lack of evidence to demonstrate how prevalent the practice is in Malawi. Third, although studies have been carried out on sexual cultural practices in Malawi there is little empirical evidence to demonstrate that the *fisi* practice is contributing to the spread of HIV at a national scale. Fourth, HIV prevalence rates reveal higher rates in urban areas amongst women age 30-34 who are in the highest wealth quintile in Malawi. This group of women is significantly different to girls and young women living in rural areas age 15 and below who are participating in the *fisi* practice.

Narratives linking sexual cultural practices and HIV/AIDS have been constructed which blame the *fisi* practice for the spread of HIV. These narratives are not objective but socially constructed. In terms of these narratives, the *fisi* practice is being used as a scapegoat for three main reasons. First the elites maintain the narrative to attract donor funding to ensure the stability of the policies and programmes directed to reduce transmission and therefore ensuring their jobs remain intact. Second, to project the issue of AIDS as a disease being spread by the rural dweller which detracts attention from urban male and female promiscuous behaviour and third supports a Christian narrative that sees those practising African Traditional Religion as backwards. In summary this narrative has been massively amplified because it reflects the agenda of key elites

in Malawi as opposed to reflecting a proportionate threat to the spread of AIDS. This deflects attention from high-risk sexual practices such as promiscuity in urban areas amongst urban and affluent Malawians. The emphasis of AIDS policies should therefore in fact be attributed more to contemporary patriarchal constructions of gender and power than a one-off highly un-evidenced traditional sexual practice. In sum therefore what I argue is there is evidence of a lack of evidence to support the policy to eradicate the practice of *fisi* because of the link with HIV.

It is important to consider that the underside of this is what gets lost, which is a critical understanding of how harmful cultural practices do impact negatively on women's lives. Whilst the *fisi* practice is not responsible for the spread of HIV in Malawi, the practice does feed into a gender ideology that renders women vulnerable to abuse and oppression. This real impact becomes distorted by the HIV/AIDS narrative, and the problematic and really harmful impact becomes either obscured or rendered invisible by these dominant 'narratives of blame'. For example, the way in which the *fisi* practice acts to oppress and marginalize women is not heard. This thesis makes more visible the reality of HIV/AIDS in Malawi and focuses more squarely on the structural underpinnings that render women vulnerable to it.

HIV/AIDS research has grown in scope and volume since the first case of AIDS was reported in 1981 reflecting that a wide range of disciplines has interest in the field: namely, biomedical and public health, population and development, sociology, human rights and gender. HIV/AIDS, human rights and gender in particular have been internationally recognized as a key component of health and development strategies in developing countries since the International Conference on Population and Development which took place in 1994, and subsequently in numerous international frameworks (see chapter four).

The relatively little attention given to the interface between HIV/AIDS, cultural practices and human rights in academic, policy and programmatic spheres in developing countries provided the motivation for this research. Despite its inclusion in the Beijing Platform for Action in 1995 there remains a gap in the academic literature on this important topic:

Strategic Objective C.3: (a) Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues; (b) To review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it, and implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS (UN, 1996, p. 46).

Initially, the study intended to examine the contribution of traditional cultural practices such as widow inheritance and initiation rites (Munthali & Zulu, 2007) to the transmission of HIV (Coombes, 2001; Chizimba et al., 2004). However, by considering the work of epidemiologists (Gray et al., 2005; Boily et al., 2009) and certain traditional cultural practices in Malawi, it is apparent that some traditional practices are unlikely to contribute significantly to the epidemic. Far more important are everyday practices, such as unprotected sex with multiple sexual partners both before and after marriage (Smith & Watkins, 2005; Chimbiri, 2007). My findings reveal an urgent need to revisit and reframe the HIV/AIDS field in Malawi in relation to wider issues of women's rights, particularly with reference to the Convention on the Elimination of all forms of Discrimination against Women (CEDAW).

### **Situating my theory within academic debates**

In this study I argue that a complex interplay of causes has led to the construction of the narrative that the sexual cultural practice of *fisi* is contributing significantly to the spread of HIV and AIDS. I argue this complex interplay can be best understood through three sets of arguments. In this section I present these along with the theoretical positions that I support or challenge. Although presented in this section as separate theories, across my thesis these theories are interrelated and overlap with one another.

The first and main argument is that a narrative of blame is maintained by the national elites in Malawi to ensure that HIV is kept on the development policy agenda within the institutions in which they work thus attracting donor funding and retaining elites' professional status. Furthermore, the narrative of blame ensures that the target group for intervention are rural communities rather than the elites themselves. This argument complements the theoretical work of Mosse (2011) who has pioneered the use of what he terms the ethnography of aid, using this methodology to unravel the complex layers and actors that combine in the production of development policy and practice. Mosse (2011) highlights the importance of actor relationships in constructing policy ideas as well as emphasising the importance of policy ideas themselves in mediating social and professional relationships (2011, p10). Mosse builds on the work of Harper (1998) and Wood (1998) and describes actor relationships as "complex relationships including negotiations over status, access, disciplinary points of view, team leadership struggles, conflict management or compliance with client frameworks defining what counts as knowledge" (2011, p10). In terms of policy ideas, Mosse argues that "policy ideas gain currency because they are socially appropriate....they can submerge ideological differences, allowing compromise, room for



manoeuvre or multiple criteria of success, thus winning supporters by mediating different understandings of development” (2011, p11). Like Mosse, my study also places emphasis on understanding policy construction as a process mediated by those involved in the policy process as well as highlighting the importance of the policy idea itself. In my research those mediating the process were the people I interviewed working on HIV prevention. The policy idea that these actors are mediating is that sexual cultural practices should be eradicated because they argue these practices are the main driver of the HIV pandemic in Malawi.

Additionally, Mosse argues that:

“The interests of national elites and the electoral concerns of those in power affect the state’s policy choices, sector priorities, and programs, with important consequences for the poor. Equally, well-intentioned sector reform programs can run aground where they challenge vested interests, and democratic reforms often have limited or unpredictable effect on power relations. (Mosse 2004, p51).

This is also relevant to my study as I argue that one reason why national elites are able to influence the policy agenda on HIV is related to the desire of donors to be given a simple and rational explanation for high transmission that they can easily focus implementation around. Mosse (2011) also makes reference to international professionals who have to secure their positions within institutional and social contexts, which he says are hugely complex. Although Mosse in this context mainly refers to international professionals I argue that the same is true for national professionals working in development in Malawi, which means that groups of specialists and professionals need to sustain certain agendas to maintain their own status and positions. This argument is also linked to the work of Gibson et al (2005) who argue that the structure of foreign aid can produce perverse outcomes that impede effectiveness and how the aid system is based on a set of power relations between actors ultimately driven by money.

These points are relevant to my argument as I point out on p111 that organisations and agencies working on HIV/AIDS are major employers in Malawi. Although these development organisations are unlikely to disappear they are also unstable as they rely on external funding. Thus successive themes come and go (e.g HIV/AIDS, governance, gender) and with them jobs appear and disappear. Therefore, by maintaining the narrative that the sexual cultural practice of *fisi* is spreading HIV can ensure policy and programmes directed to reduce HIV transmission continue.

A second point linked to the argument above is that focusing on cultural narratives takes attention away from problematic sexual practices and gendered relationships, which are universal

across Malawian society as supported by my data and by HIV prevalence rates, that demonstrate higher rates within urbanised communities than within rural groups. This is in line with Gibson's theory that power relations within developing contexts confuse or obscure the focus of development policies (Gibson et al, 2005). Thus the focus of AIDS prevention policy needs to be constructed around gendered issues and women's inferiority to men. It is in relation to this argument that I use feminist theory, arguing that the practice must be eradicated not because of its link to HIV/AIDS but because this feeds into and helps support women's inferiority to men and vulnerability to violence. (Kistner 2003, Anderson, 2012, Susser and Stein 2004).

The second argument identified in this study is that AIDS is being presented by national, urban elites as a rural disease, which is being spread by people living in rural areas who are mainly illiterate and do not speak English. This narrative distances the urban elite from the disease as well as detracting attention from urban male and female promiscuity. This argument is situated within and supported by the literature on the underdeveloped other. (Gramsci, 1971; Escobar, 1988; Hobart, 1993; Quarles van Ufford & Salemink, 2006). As I highlight in my study, this 'othering' is a result of those elites working in HIV prevention providing explanations to 'problems' that satisfy donors and therefore ensure continued funding. Therefore, the urban elites who are perceived as civilised distance themselves from rural people who they perceive as uncivilised. As Escobar (1995) asserts "rather than being eliminated by development, many 'traditional cultures' survive through their transformative engagement with modernity" (1995, p. 219). This point supports my findings as I argue that elites in Malawi maintain their positions through their engagement with western discourses on modernity and distance themselves from Malawians living in rural areas who they perceive as backwards. Thus, the Malawian elites are making themselves look like the modern, unproblematic group that donors should work with in Malawian society.

The third argument identified in this study is that the Malawian elites see those practising African Traditional Religion as backwards, thus by having converted to Christianity the elites perceive themselves as modern and progressive. This argument has been guided by postcolonial theorists including Bassey, (1999); Kitching (1982); wa Thiong'o, (1986); Lloyd, (1967). They describe the elite in sub Saharan Africa as the postcolonial elite as they have converted to Christianity. Postcolonial theory is thus relevant to my study as it follows on from the imperialist idea of westernising the backward. What it demonstrates is that the elites in Malawi are perpetuating an imperialist narrative by blaming people who practice African Traditional Religion as backwards,

thereby establishing their modernity. Further, Christianity allows them to be seen as consistent with western discourses on modernity.

As I have demonstrated in this section, although there are three sets of arguments to explain why this narrative of blame is prevalent in Malawi, these are interlocking. Several theories have therefore influenced my argument, which are anthropology of development theory, postcolonial theory, theories on the policy process, elite theory, feminist theory and epidemiology. The following section provides an overview of the literature relevant to my three sets of arguments.

My theory has been influenced by scholars within the anthropology of development as this study provides a critique of a specific policy field in development. It exposes current misconceptions among development practitioners and policy makers in Malawi concerning HIV/AIDS: that sexual cultural practices are fuelling the HIV pandemic. I argue that this is an example of a development policy and programme that has failed. Thus, literature within the field of anthropology of development, especially the work of Mosse (2011) and Crewe and Harrison (1998) is highly relevant to my study because their research demonstrates how many different actors are involved in influencing policies and programmes. They critically analyse the complex relationships of power between global multilateral organisations, donors, governments of resource-poor countries, and local communities, and their impact on development projects. I also criticise the impact multilateral agencies have on development. I criticise the neoliberal economic ideology that has been used by agencies such as the World Bank and the International Monetary Fund (IMF) to offer financial assistance to poor countries. I critique this model of development and agree with Sadasivam (1997) and Macleans, Geo-Jaja & Mangum (2001) who argue that neoliberalism required poor countries to reduce spending on social issues including health, education and development, while debt repayment and other economic policies were prioritised. I also agree with Stiglitz (2000) who argues that institutions such as the IMF undermine democratic processes by imposing policies onto national governments.

Mosse and Crewe also demonstrate how to critically engage with development practice by combining academic development work with academic writing and reflection, which is the praxis through which my research was produced. I have done this by working as a development practitioner whilst at the same time conducting my doctorate research. Their approaches have been instrumental in developing my own analytical framework, as my research looks at how different agents working within the field of HIV are able to construct policies based on their own

agendas whilst at the same time I problematize my own position as a researcher. See methodology chapter.

One area that is also particularly significant to the central argument of my thesis is that public policy making, particularly in terms of HIV and AIDS prevention is being set by the agendas of a group of elites in Malawi. (see section on elites in chapter 6). This section therefore looks at the literature surrounding elite theory and policy that has informed my own research. This is relevant as my own research shows how the elite in Malawi have constructed a narrative concerning HIV and AIDS around the sexual cultural practice of *fisi* which has led to the formation of policies and programmes to eradicate it.

### **Elite Theory**

Elite theory has its roots in the work of Pareto (1935) and Mosca (1896 1939). These classic theorists argued that society is governed and controlled by the interests of a group of powerful elites as opposed to the electorate. Such theorists reject an idealized notion of democracy as a reflection of the will of the people instead arguing that a group of powerful elites own the decision making power in government, corporations, and institutions that shape policy, and in doing so they act in accordance to their own self interest. Pareto argued that there is a group of elites who control wealth and power until they are removed by a new aristocratic class (1935).

Later C Wright Mills (1956) used elite theory to understand the nature of power in 1950's America. Mills (1956) argues that the structure of American society was such that a small hierarchy of groups monopolised power (Mills, 1956) and that power is concentrated in several fields of life, including family, religion, education, professional life, military, politics, etc (Mills 1954, p.3). Mills uses this idea of the power elites in an attempt to overcome the over determinism of Marxism thus for Mills there are a range of elites which may have competing and conflicting interests as opposed to power being centralized by a single group as was the case in Marx's theory where power was controlled by a single group 'the Bourgeoisie' and based on the ownership of the means of production (Marx and Engels, 1950 first published 1848). Whereas Mills argues power is not held simply by one group he also rejects pluralistic theory positing that the majority of these elites are interlocking and self-perpetuating (Mills, 1956). Thus many individuals in such elites are in fact democratically elected and further as Mills points out are not always conscious that they are part of the elite. Further, Lasswell and Kaplan (1950) in *Power and Society* remark that elites can hold more than one powerful position. "Persons who occupy a top position with respect to one value are likely to hold correspondingly favorable positions with

respect to other values; in fact, this possibility is the agglutination hypothesis (Laswell and Kaplan, 1950 p.97)".

This theory has since been used in socio-political theory to describe any small group of people that controls a disproportionate amount of wealth, privileges, and access to decision-making Bottomore (1993). Higley and Burton (2006) build on the elite theory and politics and identify two elite types; united and disunited political elites and their associated political regimes. They define political elites as:

"persons who are able, by virtue of their authoritative positions in powerful organizations and movements of whatever kind, to affect national political outcomes regularly and substantially" (Higley and Burton 1989, p9).

Despite differences between elite theorists all conclude that power in society is monopolised by a small group of individuals or groups who shape or influence decisions that affect national policy outcomes. The next section thus looks at how elites influence policy.

### **Elite theory and policy making**

Elite theory applied to policy making argues that policy making is not simply based on using empirical research to construct the most effective means of dealing with a given social issue. But instead in reality any such policy making process is mediated by a range of powerful elites vying for their own interests many of which may hold agendas that are quite contradictory to the objective aims of such policies. As reflected in the work of Anderson (1994) who argues that the ruling elites create the narratives on which policies are constructed. Scholars such as Herrera (1996) concur with Anderson and posit that elites play a key role in defining problems and setting agendas for public policy making. Thus in many contexts policies are shaped by elites who warp democratic processes. Lasswell (1936) argues political elites are able to do this through occupying key leadership positions, which give them proximity to the power and resources, which they use to determine who gets what, when, and how. He argues that as a result there is a clash between interests of the elite and those of the general public.

Easton (1965) in his major theoretical work *A Framework for Political Analysis* argued that most policy decisions concerning the allocation of scarce resources are made by the political elite in line with their interests. De Waal (1997) argues that the power of the elites working on humanitarian issues has been an obstacle to development. He refers to the 'internal political decay' in Africa, which along with increasing authoritarianism, has impeded the construction of anti-famine

political contracts (1997, p3). He also argues that NGOs tend to conflate their interests with those of 'the poor' and present their interests as identical. He reveals there are many organisational imperatives that drive NGO decisions and these are unrelated to the needs of the people whose lives they are trying to improve. In other words, their interests are not the same.

Mosse's (2011, p10) and Chin's (2006) work also resonates with my argument. As pointed out in the section situating the thesis on page 8 Mosse (2011) highlights the importance of actor relationships in the shaping and salience of policy ideas and the importance of policy ideas in maintaining professionals' jobs. In the context in which I worked policy ideas are both the policies and legislation drafted to eradicate harmful cultural practices in Malawi. However Mosse does not reduce policy-making processes to this alone. Chin (2006) concludes that policies and programmes on HIV/AIDS are being implemented for social and moral reasons to keep the disease on the political agenda and, by implication, ensure funding and jobs for those working on HIV (Chin 2006 as cited by Whiteside and Smith 2009). Here it is important to note that the elites in Malawi have not manufactured a crisis but instead that they are shaping how this crisis is being interpreted to pursue their own agendas. What I argue is that although policies on HIV and AIDS in Malawi are not produced in national vacuums but are informed by international frameworks and agendas, elites within Malawi have the power to warp such agendas for their own interests.

### **Elite theory in sub Saharan Africa (SSA)**

There is a wealth of literature on SSA that recognises that groups of elites play an important role in controlling power within national contexts (Svanikier 2007 and See Ornett and Hewitt 2006 for a comprehensive literature review on elites and institutions in SSA). SSA is a vast continent and it is perhaps unjust to make generalisations about the elites as countries are diverse. However, Hossain and Moore provide a definition of the elites in a developing country context as:

"the people who make or shape the main political and economic decisions: ministers and legislators; owners and controllers of TV and radio stations and major business enterprises and activities; large property owners; upper-level public servants; senior members of the armed forces, police and intelligence services; editors of major newspapers; publicly prominent intellectuals, lawyers and doctors; and – more variably – influential socialites and heads of large trades unions, religious establishments and movements, universities and development NGOs ... In most developing countries, governing elites tend to be especially powerful. They often command a particularly large slice of the national income, and the influence that goes with it." (Hossain and Moore 2002, p1)

The many different national contexts in SSA imply that elites are not a homogenous group and indeed many scholars differentiate between the elites. Ornett and Hewitt (2006) remark that the elites are divided by ethnicity, functionality, politics and economics. However they do not divide the elites in terms of gender. They also contend that since decolonisation the elites in Africa have developed within or in close proximity to the state as both politics and economics have been almost entirely linked to the state within SSA countries.

In SSA it is important to highlight that the middle class is often absent as Sklar (2000) refers to the lack of an 'autonomous bourgeoisie' in most post-colonial African countries. However, In *Architects of Poverty*, Mbeki (2009) discusses the flawed capitalism in Africa and particularly censures the political elite, who he argues have no capital of their own and who manage to keep their fellow citizens poor whilst enriching themselves.

However Chandra (2006) argues that there is a middle class in Africa. She identifies elites as those who have the capital to launch a political career, who are upwardly mobile middle class individuals, better educated and better off than the voters whom they seek to mobilise. She uses the term 'elite' interchangeably with the terms 'politician', 'candidate', 'incumbent', and 'entrepreneur' (Chandra 2006). Scholars such as Bassey, (1999); Kitching (1982); wa Thiong'o, (1986); Lloyd, (1967) describe the elite in SSA as the postcolonial elite. They sub-divide postcolonial elites into two categories, elites with a Western style of education that enabled them to access employment opportunities with adequate wages to meet their living expenses; and elites associated with chiefs and administrative positions during the colonial period who had already acquired some wealth. They argue that in general both types of elites often shared some common Western behaviour patterns and had often converted to Christianity. The identification of Christianity as a factor in the identity of elites in SAA is particularly relevant in the findings of my study. Further Christianity not only plays a symbolic role of identifying commonality between high status individuals in Malawi but also was a driving force behind the policy construction of harmful cultural practices.

Galtung (1971) in his structural imperialism theory also focuses on the elite in terms of postcolonialism. He described the African elites as having more in common with Western elites than with 'their own people' thus sustaining neocolonialism in their quest for survival. In other words the African elites are legitimizing their existence within western contexts by converting to Christianity and by distancing themselves from the rest of their nation. Although some of these

groups are not inherently political, divides between spheres of power, for example the business, the political, the religious in a developing context are far more porous.

Diop (2012) also refers to the self-interest of the new African modernizing classes during the post-colonial period:

The immediate post-colonial period was one of optimism in which the new African modernising classes had the opportunity to pick and choose the optimal modalities for development. But they failed to deliver, mesmerised as they were by the material dazzle of the products of modern market capitalism. But modern market capitalism needs and wants those products which in their raw forms serve as the basis for the production of those goods coveted by the post-colonial African bourgeoisie. The result of this class egotism is the open face of an Africa plagued by cultural collapse in key areas such as its vaunted communitarianism, only to be replaced by the false consciousness of corrosive self-interest, consumer greed, eruptive xenophobia – as in the cases of South Africa and Ivory Coast – and political corruption (Diop, 2012, p.234).

Further he talks about elites in relation to their traditional cultures:

The reader must have noticed that the word ‘elites’ is in the plural. In so doing I want to express the idea that all elites are concerned here: intellectual, political, cultural, and those of the business world. The reason is that each particular elite group is necessarily imbued with the cultural tokens of tradition. But what creates the cultural antinomies is the fact that – for the most part – they willingly allow themselves to succumb to the temptations and blandishments of neoliberal capitalism. And in spite of the communitarian principles of their traditional cultures, the dictates of neoliberalism force them to satisfy their own individual wants and needs and not extend such privileges beyond their neo-class boundaries (Diop, 2012, p223).

Chabal & Daloz (1999) concur that that power is often exercised in SSA between Big men, or patrons, and their constituent communities (1999, p. 37). As a result, they hold the view that most state institutions in a number of countries have been subordinated to the interests of these elites. Several scholars also use the ‘big man’ model, a term made popular by Sahlins (1963), which in a SSA context describes the leader of a country who uses his networks to maintain power. The big man concept can be seen in Malawi as Cammack (2006) points out there is a continuity in leadership style amongst Malawi’s ‘big men’ and that the former President Mutharika was one of the big men (the President at the time the fieldwork for this study was conducted). Malawi has been considered a neopatrimonial state since its independence in 1964 and the ‘big man syndrome’ has been a perpetual feature of its politics. Cammack (2007) conducted a study on the former president Mutharika and explains:

In ‘hybrid’ states where neopatrimonial politics are the norm there is by definition a weak legal regime. In such states the constitution, rules, laws, and behavioural norms may be well-articulated, even written down, but they are weakly applied. The institutions normally responsible for their application are themselves weak – judiciaries, watch-dog institutions, parliaments, police, media, civic organisations, etc. They are sometimes ‘captured’ by the leader through his control of the appointment (and dismissal) process, or through patronage and clientelist practices. States such as these are invariably poor and unproductive – because the weak regulatory environment makes



them risky environments for investment and corrupt. Also, because they are unproductive, individuals are unlikely to have outside sources of income, or alternative economic prospects, and are therefore reliant on the leader (or one of his subordinates) for employment and income. When he uses the same techniques to get his way, there are few who can rein him in and no institutions to call upon to limit his excesses (Cammack 2007, p1).

Cammack (2007) also makes an important point and remarks that the dynamics of neo-patrimonial politics tend to legitimize and strengthen elite groups that are not necessarily interested in focusing on development and subsequently accelerate the disparities even in states with sufficient capacity to fight poverty. Lange, Wallewik and Kiondo (2000) focus on government elites in Tanzania setting up 'independent' civil society organisations (CSOs). They argue that these CSOs were staffed by civil servants to access funding from donors who, during the 1980s, turned to CSOs to take on the service delivery role that the state often failed to carry out as well as becoming more engaged in the policy process.

Although there is a vast literature on the elites in sub-Saharan Africa there are gaps in the body of knowledge concerning HIV/AIDS and the elites. One of the few scholars that addresses the subject is Van de Walle (2003). He argues that:

The development of the pandemic defects the stability of the governing elite. All countries are run by a relatively small group of people who dominate government, party, army, business and civil society ... One of the challenges facing many African countries is how to ensure a smooth transition from a relatively closed elite ... to a more institutionalized and pluralistic system with wider access. The HIV/AIDS pandemic has several consequences. It erodes the institutionalization of the government and accelerates the need to replenish this elite. As noted, this affects patrimonial structures as well as rational-legal ones. Men and women who have decades of political experience, strong networks and respected judgment, are being lost, and younger cadres are being promoted to fill the posts, but cannot fill the structural gap ... the most probable scenario is that those in power rely more heavily on a smaller circle of loyal comrades, and use more ruthless or corrupt methods to co-opt or buy support." (van de Walle 2003 p, 300).

Van de Walle's comment supports my theory as I also argue that there are a small group of elites in Malawi who dominate government and civil society in the context of policy making on HIV/AIDS.

Ornett and Lewis reaffirm my point above and state that in small countries such as Malawi the total number of elites can be very small. They estimate between 800-1000. (Ornett and Lewis, 2006). Watkins and Swidler (2009) conducted research on the elites in Malawi and identified three types; local elites, interstitial elites and national elites. Matiki (2001) remarks that the English language is used in Malawi to provide a code, which symbolizes modernization and elitism. Miller (1974) also makes the link between education and elitism and describes education

as being the pathway to elite status (1974, p527). Further, he makes the link between education and modernity.

“Education itself tends to set an individual apart, especially in a predominately illiterate society. To acquire an education is also to be re-socialised into a modern western orientation in which achievement, universal, rational, criteria tend to displace ascriptive, particular and traditional norms” (Miller, 1974, p.527)

### **Policy making process**

In terms of the policy making process I present theories on public-policy making in chapter 6 and I argue that policy-making is not a rational process with a beginning, a middle and an end. Instead I argue that it should be understood as a ‘chaos of purposes and accidents’ (Sutton, 1999, p5; see also Clay and Schaffer, 1984). (See chapter 6). I agree with Sutton (1999) who points out that concepts and tools from different disciplines can be deployed to put some order into the chaos, including policy narratives, policy communities, discourse analysis, regime theory, change management, and the role of street-level bureaucrats in implementation. Having given an overview of theories of elites in SSA and the policy making process I will now situate these within my own theory.

### **Situating the Elite theory and policy making in Malawi**

Although there are a range of elites in Malawi that play different roles in different institutions this study focuses on the elites that affect policy concerning HIV/AIDS. Therefore some important elites are not represented here as this study only focuses on the elites that were found to be having a role on HIV and AIDS policy and programmes. My research argues HIV and AIDS policies are being produced not to objectively deal with this issue but instead to further the interests and agenda of a number of national elites (see Anderson 1994). Thus, that the *fisi* practice contributes significantly to the spread of HIV in Malawi is a narrative produced in line with the interests of elite groups. (The elites to which I am referring are presented on p 110).

As demonstrated by the brief review in the last sub-heading a number of studies conducted in SSA have shown a high correlation between higher education and political elite status. What the elites in my study have in common is that they all are English speaking and literate with at least secondary education and all work in some form or other on HIV and AIDS prevention. As observed by Matiki (2001) the English language is used in Malawi to provide a code, which symbolizes modernization and elitism. Elites then are likely to have a common educational background. This is an important point as in order to qualify for jobs related to HIV and development one must

have to speak English and be literate. This suggests that once people use English at work and are literate they are perceived as elites as those who speak English and are literate are a minority in Malawi. However my research also demonstrates that elites in Malawi are stratified with those who have external PhDs at the top with those with degrees below them.

Whereas my research does not focus on the chiefs where my findings are similar to the findings of scholars in the section on elites is that the elites in my study are educated thus enabling them to access employment opportunities they would not have had if they had not been educated. Further, that they have adopted Christianity as their religious faith. My study further demonstrates that the ideology of Christian elites within Malawi is in fact a key catalyst driving the anti harmful cultural practice agenda of HIV/AIDS policies.

### **Elites – political, religious, policy actors?**

It is difficult to sub-divide the Malawian elites as boundaries are fluid and often different individuals fit into multiple elite groups. For example in my research I evidenced that there is a degree of fragmentation within and between the various elites. Individuals may occupy positions within more than one elite group: a journalist may also be a reverend or an MP may also own a private company. See Lasswell and Kaplan (1950). Or a programme officer working for an NGO on HIV/AIDS may also be pushing a religious agenda. However, as we have seen in the section on elite theory in SSA, many scholars do sub-divide elites into groups. Furthermore, although elites who work as district HIV/AIDS officers cannot be perceived as elites in the same way as urban policy makers, I argue that they are all elites as they are all arguing that the sexual cultural practice of *fisi* is spreading HIV. See page 37 where I map the actors involved in my research and Appendix 2 for a list of interviewees.

Whereas the majority of the narratives are produced by the national elites they are often being communicated to the general population by the local elites. For example the Church preaches through services of worship and the media that HIV/AIDS can only be controlled through abstinence and faithfulness in marriage (See Appendices X-Z).

I argue that a narrative of blame for HIV/AIDS is maintained that focuses on harmful cultural practices so that the elite can ensure the stability of the policy and programmes directed to reduced transmission and therefore maintain their professional status. These elites push cultural reasons over others because it makes them seem modern and also distances themselves from the

crisis at a national level. As a result they make their positions safer as they are seen as the group with which multinational agencies should engage with at a national level to solve these problems. These elites produce these narratives so they are seen as part of the solution and not part of the problem.

My argument confirms the work of Chin (2006) who argued that UNAIDS and AIDS activists accept certain myths about HIV epidemiology to keep the disease on the political agenda and, by implication, ensure funding and jobs (Chin 2006 as cited by Whiteside and Smith 2009). As Chin argues “AIDS programmes developed by international agencies and faith based organisations have been and continue to be more socially, politically, and moralistically correct than epidemiologically accurate” (2006, p. vi). He further argues that the myth that HIV is spread easily is done either unintentionally out of genuine ignorance or misunderstanding or intentionally by deliberate exaggeration (2006, p. vi).

This thesis is not focused on understanding the nature of elites in Malawi society per se however it does focus on those elites who play a fundamental role in the production of HIV/AIDS policies. I argue that the policy making process is messy and complex and that the process of HIV/AIDS policy production in Malawi has in fact been manipulated and warped to fit in with the agendas of a small group of elites.

### **Feminist theory**

Feminist theory is central to my argument because my data demonstrates that to deal with the HIV crisis, patriarchal sexual practices need to be addressed at every level of society in Malawi. At present focus is largely being placed on cultural practices in rural areas, for example the practice of *fisi*. Therefore the current way in which these narratives are framed is to present this issue in terms of traditional culture versus modernity where it is seen as tackling cultural practices will reduce HIV prevalence rates. Therefore my theory dovetails with feminists’ research on HIV and AIDS (Campbell, 2003; Schoepf 2004; Susser and Stein 2004) as it emphasises taking a gendered perspective at all levels of society not simply seeing AIDS as a product of traditional culture. Thus this study has shown that HIV is being transmitted in urban areas in Malawi where HIV prevalence rates are higher than in rural areas.

I argue that the concept of culture has been used to support practices that legitimise and perpetuate violence against girls and women; an argument supported by feminist theorists. For

example Coomaraswamy and Kios in their work on traditional practices being harmful to women, they contend that violence against women is inherent in patriarchal traditions and culture (1999, p190). Further, Boyle (2002) argues that the practice of female genital cutting is a form of gender oppression. I agree with Boyle and argue that the *fisi* practice equally oppresses women and that it is a form of gender based violence. Further that the practice is a product of a patriarchal environment and serves to maintain women in a position of vulnerability and subservience, I argue this because the girls and young women who participate in the practice are told that if they do not have sex with the *fisi* they will not become women and will be ostracised from society.

I also examine who has constructed this 'narrative of blame' and whose interests are served by this claim. As Blanc (2001) points out gender based power in sexual relations is frequently unbalanced and that women usually have less power than men. In terms of powerlessness and HIV Reid and Bailey (1992) argue that the inability of young women to protect themselves from infection is a direct function of power relations between men and women and in particular of men's sexual identity. Further, as Anderson points in her research on gendered bodies and HIV in Malawi, women are dependent on men and men are guardians of the female body (Anderson 2012). Ngwira et al. (2001) supports my argument concerning male sexual dominance and highlights how, in Malawi, sexual intercourse is conducted according to the man's terms and for his pleasure.

I do however recognize, as do scholars such as Tawfik and Watkins (2007) and Schatz (2005), that women do have some agency in relation to their own sexuality. However I highlight in my research that gendered social and sexual norms are influenced by cultural beliefs and practices. For example, I found in my research as Cohen and Reid (1996) and Oppenheim-Mason (1992) highlight, that women are expected to keep silent about the sexual behaviour of their male partners. In the context of Malawi, Mkamanga, (2000) remarks that patriarchal traditions and cultural norms in Malawi determine women's behaviour and conduct. The majority of girls who participate in the practice do not have the power to refuse to participate, especially those who lack education and live in the rural areas (Anderson, 2012). Kamlongera (2007) in her study of the *fisi* practice and its effects on young girls in Malawi argues the *fisi* practice does not only exist to serve the man involved in the practice (the *Fisi* himself) but also that of the potential/future groom. She argues the initiation process is based on teaching a girl how to please a man. She remarks that even the initiation processes that do not involve the *Fisi* himself carry the same theme of pleasing the man sexually. This practice is therefore an example of a gendered norm in

that women are being taught during initiation how to have sex and to behave in ways which pleases men. The *fisi* practice thus defers attention from other sexual practices such as having multiple sexual partners and having sex with prostitutes.

### **Epidemiology theory**

The science of epidemiology, which includes biology, clinical medicine, social sciences and ecology, seeks to describe, understand and utilise disease patterns to improve health.

Epidemiology is concerned with disease in a population. Therefore, epidemiological theory has also guided my theory as I examine HIV transmission risk to determine whether the sexual practice of *fisi* contributes significantly to the spread of the disease.

### **Epidemiology of HIV**

Those working on HIV epidemiology have been estimating the probability of transmission per unprotected coital act with an HIV+ partner for more than two decades, using empirical studies of sero-discordant couples (one partner is infected, the other is not) and modelling. Although such estimates cannot give the exact risk of HIV transmission for an individual, they do provide empirically based data on the *average risk of transmission*. Such estimates, according to Gray and Wawer (2012), mainly derive from empirical studies and modelling based on HIV-discordant couples meaning where one partner is HIV infected and the other is not. Pilcher (2004) also notes that probabilities of transmission are only derived from HIV-1–discordant couples and argues that estimates generally reflect transmission by individuals with long-term infection. Thus the data available on this topic are based on HIV discordant couples.

Transmission is much lower than is generally perceived by those living through the AIDS epidemic. In a survey conducted in Malawi, when respondents were asked what the likelihood of infection from a single act of unprotected intercourse with an infected is, over 90% said that it was “certain” or “highly likely.” (Anglewicz, 2009). The scientific literature, however, shows that it is much lower. Powers et al (2008) conducted a comprehensive review and systematic analysis of studies that produced estimates of heterosexual transmission. The analysis found that that HIV-1 transmission was commonly found to be 0.001, or 1 transmission per thousand contacts (p.553). Findings from the classic study by Gray et al (2001), (also see page 62) also show that the overall probability of HIV transmission was 0.0011 per coital act (p1149). In this study, data were collected between 1994 and 1998 in a community-randomised trial of STI control of AIDS prevention in Rakai, a rural district in Uganda. 15,127 individuals aged 15–59 years were originally involved in the study and were followed up in their homes every 10 months. A subsequent study

by the same researchers (Wawer et al 2005) confirmed these results. In this study, they estimated rates of HIV-1 transmission per coital act in HIV discordant couples by stage of HIV-1 infection in the index partner and found that the overall rate of HIV transmission amongst discordant couples, 0.0012/coital act. Another study by Wilson (2008) used the results of the Rakai 2001 study to derive a mathematical relation between viral load and the risk of HIV transmission per unprotected intercourse with an infected partner, based on a model that assumed that each sero-discordant couple had 100 sexual encounters per year. The cumulative probability of transmission to the sero-discordant partner each year was 0.0022.

Chin, a leading epidemiologist of HIV who was involved in the international response to AIDS for 20 years remarked that “all published sex partner studies have shown that the risk of HIV transmission via sexual intercourse is a minuscule fraction of the risk associated with most other sexually transmitted diseases.” (Chin, 2006, p.vi).

Cofactors such as the presence of another sexually transmitted infection can decrease or increase the probability of infection, but most estimates of transmission of HIV do not take these into account (Pilcher et al 2004). Gray et al (2001) highlight factors that increase the probability of infection, such as the HIV-1 viral load of the HIV-1 infected partner, younger age and genital ulceration. Their study found that transmission probabilities per coital act were highest amongst younger people, and increased with HIV-1 viral load. Wawer et al (2005) also found higher rates of transmission during early- and late-stage infection, higher HIV load, genital ulcer disease, and younger age of the index partner. Gray (2001) also found that higher infectivity in younger women could be a result of biological factors such as cervical ectopy, which might facilitate HIV-1 transmission. Assuming that some participants in the studies of HIV transmissibility had cofactors that would raise infectivity, presumably without any cofactors HIV transmission probabilities would be even lower than the average transmission probabilities cited above.

In sum, on average and despite factors that may increase or decrease susceptibility to HIV, transmission probabilities are low. In terms of my study, there is no empirical research on the sexual behaviour of the male *fisi*. There is no evidence that this sexual practice has a higher transmission rate than other sexual practices that are common within Malawi. While a *fisi* may be more likely to be HIV positive than the average male, it is the case that intercourse with a *fisi* is usually a single act of intercourse and is far from an everyday occurrence: since intercourse within marriage is much more frequent and the use of condoms in marriage is infrequent (Chimbiri,

2007), regular marital relations are thus more likely to lead to infection than intercourse with a *fisi*. For HIV prevention purposes, it would be far more useful to focus on more frequent practices, such as transmission within marriages or stable couples.

Overall the point I am making is that during a one of sexual act the probability of HIV-1 transmission is on average 1 in 1000. Although there are factors that can increase or decrease risk of transmission there is no scientific, empirical evidence to suggest that these factors are more prevalent within my sample than within the general population. The emphasis on eliminating the practice is due in part to the fact that accurate knowledge about the low probability of HIV has not been disseminated and, I believe, in part to the ways that policy makers and practitioners view Africans, and, since these practices are considered to be rural, the way they view rural and relatively uneducated Malawians.

The narratives of blame that were discussed earlier in this dissertation are mentioned above therefore are not in accordance with the epidemiological evidence. My research is set in the time period 2008-2009 when the fieldwork was carried out, but there is no reason to believe that there was a subsequent change in the epidemiology of HIV. If anything, the increase in reported use of condoms and the effects of antiretroviral therapy, which was just beginning to be introduced in my study period, on reducing the viral load (and thus infectiousness) of those who are HIV+, are both likely to have reduced the transmission probabilities even further.

### **Background to the research**

The empirical research for this study took place in Malawi between 2008-2009. Malawi suffers from one of the highest HIV prevalence rates in sub-Saharan Africa, with HIV prevalence among sexually active adults 15-49 years of age estimated at 10 percent (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2013). It is also one of the poorest countries: its ranking on the UN's Human Development Index is 0.385, below the mean for sub-Saharan Africa of 0.389; and its per capita GNI is estimated at \$911, below the mean for sub-Saharan Africa of \$2050 (UN, 2010). The population is predominantly rural (about 85 percent), and contains many ethnic groups with varying traditional cultural practices (Kornfield & Namate, 1997; Matinga & McConville, 2003; Malawi Human Rights Commission, 2006). Particularly relevant for this research is the role of donors (Crewe and Harrison, 1998; Mosse, 2005). International donors (i.e. bi and multilateral agencies) have been quite generous to Malawi (OECD-DAC, 2007, UN 2006), perhaps in part due to its poverty and the severity of its AIDS epidemic, as well as other health issues.



Given its political stability, and the widespread use of English in government and the NGOs, Malawi also makes it a relatively pleasant place for international aid workers to work which in part accounts for the large expatriate aid community.

Figure 1.2 – Map of Malawi



Since the mid-1980s and the movement toward the privatization of foreign aid, donor funding has been channelled to support NGOs. A study showed that the number of registered NGOs increased from a handful in 1964, at the time of Independence, to approximately 120 in 2003 (Morfit, 2008). With the vast number of NGOs and development agencies operating in the country aid becomes tightly clustered resulting in and reinforcing the 'donor-darling'/'donor orphan' divide (Koch, 2007). Registration of NGOs is incomplete, but a proxy measure – the sheer number of advertisements for NGO positions in the newspapers – shows a dramatic increase, as I anecdotally noted during my fieldwork in Malawi.

The NGO positions are filled by the Malawian elites. The international elites (with PhDs from abroad) and national elites (with university degrees) did not grow up in the rural areas and almost invariably did their schooling in Lilongwe or Blantyre (Watkins, 2013). I argue here that the disparagement by the elites of harmful cultural practices is a way of establishing their modernity, ensuring distance from what they call the 'backward' rural areas. It is also relevant for this study that the NGO sector, although unlikely to disappear, is unstable, with successive themes coming and going (e.g. development, food security, gender) – and, with them, jobs appearing and disappearing. Thus, the elite seem aware of the way that their public statements on culture, on women's rights and on AIDS have pragmatic purposes in positioning them for new employment should their current jobs end. In other words, by maintaining a narrative of blame for HIV/AIDS that focuses on harmful cultural practices the elite can ensure the stability of the policy and programmes directed to reduce transmission and their jobs remain intact.

The Government of Malawi has demonstrated political commitment to combating HIV/AIDS and turned to legislation as a potential tool to fight the pandemic. In 2006, the Law Commission received two submissions from the National AIDS Commission (NAC) and the Department of Nutrition, HIV/AIDS, requesting the development of legislative framework governing issues related to HIV/AIDS. A Special Law Commission was established in 2007, representing public and private sectors including representation from organisations of people living with AIDS. The reform process started in 2007, when a decision was made to create new legislation rather than incorporate HIV/AIDS into existing pieces of legislation (P18: 11/01/09).

Objectives of the legislation are to strengthen institutional structures dealing with HIV/AIDS; entrench human rights protection with respect to HIV/AIDS for those affected and infected;

introduce criminal sanctions related to HIV infection, or conduct and actions that promote infection; and consider entrenching the public health concerns relating to HIV/AIDS as a disease (Malawi Law Commission, 2008). Broad areas covered by the legislation include the institutional framework; gender and HIV/AIDS; human rights and HIV/AIDS; education and HIV/AIDS; information and HIV/AIDS; public health and HIV/AIDS; employment and HIV/AIDS; and criminal law and HIV/AIDS (Msowoya, 2008; Malawi Law Commission, 2008).

According to the Law Commission, ‘the vulnerability of women and girls to HIV/AIDS is aggravated by certain cultural and religious practices’ (2009, p. 33). The legislation intends to prohibit or regulate harmful practices that pose a risk of infection with HIV and other Sexually Transmitted Infections (STIs). It also addresses the issue of subjecting others to harmful practices. The Law Commission identified eighteen cultural practices to be proscribed. These include *Chiharo* (marrying the wife of a deceased brother); *Chimwanamaye* (exchanging of husbands or wives); *kulowa kufa* (cleansing after death); *fisi*, which means ‘hyena’ in Chichewa, has two meanings. First, a man (who is referred to as *fisi*) is chosen by the village leader to have sex with young girls at initiation ceremonies. Second, a *fisi* can also be a man hired to have sex with a married woman who cannot conceive, and therefore a secret arrangement is made with the *fisi* (See chapter 4 for more details about the legislation).

These practices are considered to be contributing factors to the spread of HIV/AIDS (Kalipeni et al., 2004; College of Medicine, 2005; National AIDS Commission [NAC], 2005; Munthali et al., 2006; Kadzandira & Zisiyana, 2006; Chimombo, 2006; Conroy et al., 2006). The legislation referring to human rights proposes to prohibit discrimination on the basis of HIV/AIDS – whether perceived or actual – and to provide for rights of persons infected with HIV or suffering from AIDS. Finally, the criminal law legislation aims to create offences on deliberate transmission and to create differentiated categories from deliberate to negligent and reckless acts or omissions (Malawi Law Commission, 2008).

### **Methodological approach**

From the onset of carrying out this research one point became apparent: the exploration of HIV/AIDS, cultural practices and women’s rights does not fit neatly into a single area of study. Instead it combines qualitative social science research techniques with perspectives from public health and gender. It is also positioned within international development studies. Due to the interdisciplinary nature of the study, it was necessary to review selected literature on HIV/AIDS,

cultural practices and gender from feminist, development and epidemiological perspectives. The literature formed an important and significant component in framing this study's research questions, and for its significance to the development of the analytical framework and research methodology. Literature relating to sub-Saharan Africa in particular is emphasized. Fieldwork was undertaken for this study in 2008-2009 in Malawi and this thesis is situated within this time period.

I approached the literature review searching a number of topics, including global HIV/AIDS policies; Harmful Cultural Practices at the global level; and Development in Malawi. This review pursued six main areas of study. First, in order to provide an understanding of cultural practices and HIV/AIDS, culture is defined followed by an analysis of the discourses that shape debates on cultural practices and HIV/AIDS: namely, anthropological approaches, national and local perspectives, religious discourses, feminist theories and development discourses. Second, literature on human rights, and human rights arguments about cultural practices, are examined as well as international and national statements on cultural practices. This section also looks at the role of human rights NGOs and national NGOs in Malawi that address human rights. Third, cultural practices, human rights and gender are examined, analysing literature to identify whether those who talk about harmful cultural practices see them as particularly bad for women, and whether human rights activists are explicitly focused on women's rights. Fourth, literature on contradictions between human rights and cultural practices is analysed; contradictions that exist between those that see human rights as universal and cultural practices that are perceived as region or village specific. Fifth, actors involved in the development of policies and programmes are identified and material on the role of elites within institutions is reviewed. The final area of study in the literature review concerns the epidemiology of HIV infection and the AIDS virus in sub-Saharan Africa. This is an important section, which after reviewing material on the virus and transmission rates, led to the formulation of the Analytical framework and generated the following hypothesis: 'Misconceptions concerning how easily HIV is transmitted through sex have resulted in the development of policies and programmes that are not seen in other public programmes e.g. infant mortality'.

### **Aims and objectives**

The overall aim of this research is to examine how policies surrounding HIV/AIDS and harmful cultural practices have come to be linked. Five objectives were identified to meet this aim. First, it assesses the extent to which the epistemic community in Malawi is reframing the AIDS epidemic

to further their goals and self-interests. Second, it investigates whether the debates within the epistemic community are facilitated or constrained by international donors (bi and multilateral agencies). Third, it explores whether or not HIV/AIDS is being represented as an exceptional circumstance, justifying policies that would not normally be applied to other public health crises, for example, STIs such as *Neisseria gonorrhoeae* (gonorrhoea) or *Treponema pallidum* (syphilis). Fourth, it ascertains and examines the extent to which international frameworks, agendas and paradigms are influencing and impacting on traditional cultural practices and women's rights, resulting in changes to legislation to ban such practices. And finally, it assesses the implications of the findings for the conceptualisation and provision of future and current HIV/AIDS policies and programmes in Malawi. The overall rationale for these research questions is that future HIV prevention programmes will be more effective and based on rigorous scientific evidence.

The research aim specified above seeks to test my hypothesis through five research questions, corresponding to the objectives, which were formulated to substantiate or disprove the hypothesis: (i) how are epistemic communities framing and/or reframing the AIDS epidemic to further their goals and self-interests (such as keeping themselves in jobs?); (ii) how are the debates within the epistemic community facilitated or constrained by international donors (bi and multilateral agencies?); (iii) to what extent are HIV/AIDS being represented as exceptional circumstances, justifying policies that would not normally be applied to different public health crises?; (iv) how are international frameworks, agendas and paradigms influencing and impacting on traditional cultural practices and women's rights, resulting in changes to legislation to ban such practices?; and (v) what are the implications for HIV/AIDS policies and programmes in Malawi?

### **Analytical framework**

When I started my fieldwork my dissertation planned to look at women's vulnerability to HIV/AIDS; but when I tried to unravel the different layers of activity and the different ways people talked about women's lives and about HIV/AIDS at that time in Malawi I found the story I was seeing was much broader, and so I took in the whole policy context at all levels, district, national and global. In order to help me theorize this context I developed an analytical frame which enabled me to piece together the different actors (international, national, bilateral and multilateral and the government) involved. I conducted my fieldwork first and then built on my theory retrospectively. This is referred to as inductive analysis and is consistent with Strauss and Corbin's interpretation: 'The researcher begins with an area of study and allows the theory to emerge from the data (1998, p. 12) (see the section on data analysis in chapter two).

Returning from my fieldwork I stepped back and looked over what I had, realizing I had collected a far wider range of data, perceptions and narratives than I ever imagined or needed, and it was a challenge to develop a way of bringing it altogether in one piece of work. Not least because what I wanted to understand was the relationships between different actors engaged in HIV/AIDS issues in Malawi and in turn their perceptions of the communities in which they work. So in the first instance, I did this visually as attempts to write it out became confused as the picture I needed to unravel was not a simple hierarchy of power relations from a global donor level downwards, but a web of interlocking relationships with different spheres of influence.

Scholars that have critiqued development state how fundamentally negative and unhelpful the concept of the underdeveloped other is (Gramsci, 1971; Escobar, 1988; Hobart, 1993; Quarles van Ufford & Saleminck, 2006). But my analytical framework highlights that this 'othering' has come out of the necessity for government officials to provide explanations for 'problems' that satisfy donors and thus ensure continued funding. Cultural practices are not the reason why HIV prevalence rates are high in Malawi; but the use of them as part of the explanation provided to donors by national actors reveals the extent to which the system of aid is based on a set of power relations between actors ultimately driven by money (Gibson et al., 2005). In other words, without providing a satisfactory explanation for high transmission rates the Malawian elites would not hold the positions they do largely funded by and through international aid.

The analytical framework (Figure 1.3) maps out the thought process regarding the interpretation and analysis of data. The scheme is a broadly cyclical representation of how knowledge (evidence) is used and constructed with regard to HIV/AIDS in Malawi. HIV/AIDS is at the centre of the framework. Harmful cultural practices are blamed for HIV/AIDS and this narrative is being reproduced at different levels of the aid system (district, national and global), but there is little biomedical evidence to support this link. The actors complicit in maintaining this 'narrative of blame' are multilateral and bilateral agencies, international organisations and national actors (See chapters 3-5).

Policies are being developed on so-called risky cultural practices (chapter five), which in turn become projects as aid flows directed by the policies. My analytical framework critiques this process. Policies and projects are constructed by donors and by the Government of Malawi on so-called harmful cultural practices. Both groups of actors have vested interests and pursue their



See Table 1.1 below, which presents the six research questions and corresponding chapters in which the questions are addressed.

<b>Table 1. 1 – Research questions</b>	<b>Chapter</b>
RQ1. To what extent is HIV/AIDS being represented as an exceptional circumstance, justifying policies that would not normally be applied to different public health crises?	3
RQ2. How are the elite reframing the AIDS epidemic to further their goals and self-interests?	4 and 5
RQ3. How are the debates amongst the elite facilitated or constrained by international donors (bi and multilateral agencies)?	6
RQ4. How are international frameworks, agendas and paradigms influencing and impacting on harmful cultural practices, i.e. changing legislation to ban such practices?	6
RQ5. What are the implications for HIV/AIDS policies and programmes?	7

### **Structure of the thesis**

Including the opening chapter of this *Introduction*, this thesis comprises seven chapters.

Chapter 2 *Methodology and Research Design* provides an overview of both the field of study and the methods used during fieldwork. By presenting the stages of the study and methods used and the different locations in which research was conducted, I set the scene for the following chapters while discussing why I used qualitative and specifically ethnographic techniques, and the choices made during specific periods of fieldwork.

After setting the methodological scene in the following four chapters (Chapters 3-6) I present the central substantive contribution of the thesis based on data collected during fourteen months of fieldwork. I argue that harmful cultural practices do not contribute significantly to the spread of HIV but I do argue that these practices are harmful towards women as they render women vulnerable to gender-based violence and wider systematic oppression.

Chapter 3 *The Situation in Malawi: Development Aid, HIV/AIDS and Cultural Practices* provides a brief history of the development aid situation, which is given to highlight the reliance of the National Government on external aid to address high prevalence rates. I then demonstrate how the HIV pandemic is widely considered an emergency and I highlight how HIV/AIDS has been represented as an exceptional circumstance, justifying policies that are unique to this country's context. I analyse HIV and harmful cultural practices in Malawi and explain how, given the epidemiology of HIV, the *fisi* practice cannot account for the spread of the epidemic. Finally, the section on gender norms demonstrates how gender plays an important role in structuring



perceptions of risk and how women's powerlessness in sexual decision-making places them at great risk.

Chapter 4 *Policies on Harmful Cultural Practices and HIV/AIDS* shows how harmful cultural practices have emerged as a development issue in global conventions and policies over the past ten years. I then analyse the shift from the global to level to the national level and demonstrate how international policy has influenced national policy on harmful cultural practices and HIV/AIDS in Malawi. I then use data collected in Malawi to show how the Malawian elite have constructed narratives of blame concerning HIV/AIDS and cultural practices which reflect their own narrow and biased view that the backwardness of village people is to blame for high HIV prevalence rates.

Chapter 5 *The Role of the Church in Framing HIV/AIDS Policies* explores the role of religion in the fight against HIV/AIDS and analyses the influence of the church in shaping the views of the Malawian elite. In my interviews with members of NGOs, INGOs and civil servants it is apparent that those working for religious institutions hold the same view as Malawian elites. In fact, the church is so influential in shaping the perspective of the elite that the two are barely indistinguishable. I demonstrate in my interviews how the attendance of Malawian elites at church has influenced the way they think about HIV/AIDS, cultural practices and rural people. First, I provide the religious context in Malawi. I then illustrate how religious elites perceive cultural practices as negative and backward, positioned against their Christian beliefs they perceive as enlightened. The argument I present in this chapter is evidenced by my critical analysis of interviews, newspaper articles and policy documents as well as secondary academic sources.

Chapter 6 *The Construction of Policy: Donors, HIV/AIDS and Cultural Practices* analyses the policy construction process and reviews literature on policymaking processes, concluding that the policymaking process in Malawi is messy and complex. I argue that stakeholders try to influence HIV policy by using narratives and discourses to pursue their own vested interests, which are presented as knowledge. Additionally, I look at the aid game in Malawi. I then consider how these narratives have been passed on through education. I also reviews donors' perceptions of harmful cultural practices and argue that donors have absorbed narratives of blame linking harmful cultural practices and HIV/AIDS because it feeds into and supports the still dominant neo-colonialist view of the African other as primitive and backward.

Chapter 7 *Conclusion* argues that my ethnographic approach has enabled me to highlight why the legislation on HIV/AIDS discussed in chapter 4 has not been enacted and how ‘narratives of blame’ are used as a smokescreen to pursue government and donors’ interests. It also presents policy recommendations and suggestions for future research.

While these chapters may appear to be focused on specific content, in the course of writing the thesis, the boundaries between data sources became less rigid, and many topics were addressed in more than one chapter. Each chapter contains a literature review with examples from the data (interviews, policy documents, newspaper articles) used throughout the dissertation to support the hypothesis.

### **Significant contribution of the thesis**

My thesis is not just contributing to the HIV/AIDS debate but it is also a methodological contribution, enabling an understanding of how policy and practice translate into practice across levels from the global arena down to the community level. In particular, I focus on what I have coined different ‘narratives of blame’, constructed through the development process itself, and not grounded through actual experiences, that act to marginalize women further and fail to get to the root causes of disempowerment and violence. In other words, conflating the HIV/AIDS debate with that of harmful cultural practices fails to appreciate the ways in which women are disempowered by culture.

## CHAPTER 2                      Methodology and Research Design

In anthropology, or anyway social anthropology, what the practitioners do is ethnography. And it is understanding what ethnography is, or more exactly *what doing ethnography is*, that a start can be made toward grasping what anthropological analysis amounts to as a form of knowledge (Geertz, 1973, p. 6)

The purpose of this chapter is to provide an overview of the field of study, methods used and data collected during fieldwork, and my analysis strategy. By presenting the stages of the study and methods used and the different locations in which research was conducted, I set the scene for the following chapters while discussing why I used ethnographic methods and why I made the choices I did during specific periods of fieldwork. Then I describe my role as an actor in the research process and how I came to have an insider's view by positioning myself as a consultant in the NAC and by living with development professionals. Finally, I describe the methodology used, data I collected and my analysis strategy.

### **Interpretivist or positivist methodology**

I aligned my research with the interpretivist paradigm to include ontological, epistemological and methodological assumptions as acknowledged by Guba and Lincoln (1994, pp. 107-108).

According to Mertens, 'a researcher's theoretical orientation has implications for every decision made in the research process, including the choice of method' (2005, pp. 3-4). The interpretivist approach is founded on the theoretical belief that reality is socially constructed therefore what is taken to be valid or true is negotiated as there can be multiple valid claims to knowledge. Methods traditionally associated with the interpretivist approach are mainly qualitative and can include participant observation, focus group discussions, action research, ethnography, phenomenology and discourse analysis. A qualitative rather than a quantitative approach was therefore undertaken for this research as I investigate the opinions, interpretations, beliefs, values and attitudes of agencies rather than the collection of statistical data. This approach also enabled the collection of rich data to critique the response to HIV/AIDS prevention in Malawi at the time the fieldwork took place (2008-2009).

Qualitative research methods were the main methods used in this study. Qualitative research methods were developed in the social sciences to enable researchers to study social and cultural phenomena and to capture human behaviour. I decided to use this type of methodology because I conducted research on people's views on HIV/AIDS therefore it was necessary to look at the social, political and cultural factors which may influence a person's view. The best way to obtain

data to analyse the impact of such factors is the use of methods such as participant observation or ethnographic research. This type of approach allows the researcher to get inside the skin of his or her research subjects. The researcher is then taking on more of a learning role as opposed to a scientific testing role (Silverman, 1993) as s/he is observing the situation in context. This approach also allowed me to obtain data that cannot be retrieved by using methods typically associated with positivism (e.g. statistical modelling or fixed choice questions to random samples). Such quantitative methods have been rejected by interpretivists for their failure to understand and capture people's experiences.

Supporters of qualitative research argue that what is extremely contextual information should not be subject to the standardizing techniques of quantitative methods (Holland & Campbell, 2005). Methodological debates regarding the understanding and elucidation of meanings, how they are shared and how they affect individuals and groups belong to the interpretivist account (Whimster, 2007). As Bourdieu expresses the view: 'in the eyes of the objectivist or "hard social scientist" it [qualitative research] represents the quintessential expression of "fuzzy-wuzzy" sociology. Ironically, though, this academically derogated manner of looking at the social world is generally closer to reality' (1988, p. 781). He also postulated:

When you want to escape from the world as it is, you can be a musician, or a philosopher, or a mathematician. But how can you escape it as a sociologist? Some people manage to. You just have to write some mathematical formulae, go through a few game-theory exercises, a bit of computer simulation. To be able to see and describe the world as it is, you have to be ready to be always dealing with things that are complicated, confused, impure, uncertain, all of which runs counter to the usual idea of intellectual rigour (Bourdieu, 1991, p. 259).

The advantages with using an interpretivist paradigm to achieve the aims of this research can be juxtaposed with the limitations of employing a positivist one. Research focusing on HIV/AIDS that adopts the positivist approach, for example, is the use of the survey that enables the researcher to analyse patterns of high-risk sexual behaviour. HIV/AIDS statistics reveal the effects of high-risk behaviour yet explain nothing about how social, economic, and political structures create high-risk conditions.

A further example of the inadequacy of quantitative methods is the Gross Domestic Product (GDP) measurement, a data collection technique which measures the size of the economy in terms of income; however, it is a poor yardstick of well-being. As an alternative, the Human Development Index (HDI) was created – now used by the United Nations Development Programme – which takes account of national indicators such as life expectancy, infant mortality and literacy rates as well as GDP. In many countries in Africa, HIV/AIDS has been seen as the

biggest threat to gains made in the HDIs because they do not give space for a social analysis of such indicators. A social analysis should include estimates of the impact of HIV/AIDS on HDIs that would provide a clearer picture. A final example is research conducted by Semu and Binauli on inequalities in Malawi. They contend that the Gender Development Index and the Gender Empowerment Measure 'do not present complete pictures of specific country situations, being more concerned with just the figures and not the dynamics that lead to such inequalities' (1997, p. 86). This is not to say that quantitative data are not useful – indeed, quantitative data have been used in this thesis – however, it is not the main method. Statistical data have been used, taken from the Demographic Health Survey and the NAC to present HIV incidence and prevalence rates and statistics on HIV within Malawi.

### **Ethical considerations**

Ethical issues are considered and addressed. Ethical approval was sought for the study entitled at the time 'Cultural practices and vulnerability to HIV/AIDS in Malawi: What are the implications for HIV/AIDS policies and programmes?' and approved by the National Health Sciences Research Committee, Ministry of Health (MoH), Malawi in February 2009. Ethical clearance was also given by the University of Portsmouth (See Appendix 1).

Ethical issues arose concerning anonymity and confidentiality. I agreed all those involved in the in-depth interviews would remain anonymous; therefore all people's names have been omitted. Data have been identified by a specific coding, e.g. P1 to the information provided by Person 1. I have as far as possible maintained the anonymity of my informants and consent was secured for all interviews (see Appendix 2 for the list of interviewees). I have removed their names but listed the job title, organisation, place the interview took place and the date.

### **Conduct of the field study**

I went to Malawi initially to carry out ethnographic research using a participatory qualitative research method designed by Options Consultancy Ltd, in collaboration with academics at Swansea University, called the Participatory Ethnographic Evaluation and Research (PEER). It is a rapid approach to programme design, monitoring, evaluation and research, designed to generate rich narrative data to provide insight into how people view their world, and how they make decisions on key issues. The close partnerships developed with peer researchers represent entry points for future work with marginalized social groups. It has been used in a range of sectoral and cultural contexts and is also an approach to building dialogue for social change. In

the PEER method researchers are from the peer group that is being researched. These peer researchers act as key informants because of their recognized status as community members and their knowledge of the local context. They do not require any specialist skills, besides basic communication skills and motivation to be involved in the research. It entails training peer researchers to develop the research questions and tools, and then to conduct interviews with their peer group or members of their social network with whom they already have an established rapport. They are interviewed periodically by the lead researcher, where they recount the different conversations they have had. At the end of the process, a workshop is held where Peer Researchers conduct and share their own analysis of their findings, which also becomes an important aspect of the research, used by the lead researcher in an overall analysis (See Chapter 2 where I present the findings of peer researchers).

As a trained social scientist I also deployed a range of sociological research techniques. Upon my return and after reflecting on my experiences and the data I had collected, I applied an ethnographic methodology retrospectively to design my analysis concerning how knowledge is produced and reported. I did not realise the depth of my data whilst I was in Malawi and I discovered that it had a far more rich, ethnographic side than I formerly realised. Utilizing ethnographic methods has therefore enabled me to highlight how what I describe as 'narratives of blame' are used as a smokescreen to pursue actors' interests.

### **Anthropology in development approach**

In articulating my experiences I have found the work of David Mosse, and Emma Crewe and Elizabeth Harrison, to be particularly useful. In *Adventures in Aidland*, Mosse states that:

Insights [that] do not arise from conventional research projects, but are the result of reflection on the experience of living and working as part of the interconnected expert world of international development. This is 'insider ethnography' or auto-ethnography, offering the fruits of anthropological reflexive capability from those who might describe themselves as observant participants as much as participant observers (Mosse, 2011, p. vii).

What my study does is it takes 'insider ethnography' to apply an 'actor-focused approach'; to look at how different actors come together to produce policy. It is an original contribution to research as it focuses on narratives told by actors working in organisations which focus on HIV/AIDS whilst also tracing the impact of these narratives on the production of policies and programmes, rather than geographically bounded local communities. It can therefore be labelled as multi-sited in that it focuses on the different scales, levels, sites and actors that together comprise the international field of HIV/AIDS. Mosse does not include the local, he looks at how policy is put together at

national and international levels as opposed to the local. However, my study looks at the local all the way through to policy at international level therefore completing the circle outlined in my analytical frame. This thesis thus presents how an ethnographic lens can be used to help understand the construction of policy and practice, which responds to the complexity of people's lives.

In the book *Whose Development? An Ethnography of Aid* Crewe and Harrison (1998) recount their own experiences of development projects in Africa and Asia through ethnographic case studies. The authors explore how one's own position in the aid industry influences moral and political assumptions and how different actors influence policies and practices of development. As they point out:

We aim to look constructively at the complicated interactions involved in the processes of development aid to see how different people and groups are constrained by, yet able to subvert, the objectives of others – and why they are motivated to do so (Crewe & Harrison, 1998, p. 1).

This approach has been useful in developing my analytical framework, as I also look at how different actors involved in development projects are able to influence policy whilst at the same time questioning my own position as a researcher. Indeed, this self-questioning is a common dilemma when aligning with the interpretivist paradigm, where the researcher is part of what is being researched and cannot be separated so subjectivity comes in to play (Wahyuni, 2012).

**Illustration 2.1 – Photo taken on 10/07/09 Malawi: Author**



My analytical framework shows that narratives on HIV/AIDS and cultural practices are an obstacle

to development, as in development we constantly find that these narratives dominate and we do not get to the bottom of what are the actual issues: gender-based violence.

This research therefore does not just concern HIV/AIDS and harmful cultural practices. What I also do is position my argument in the debate concerning gender-based violence. Cultural practices and HIV/AIDS are talked about but the real issue concerns gender-based violence. Since the 1993 World Conference on Human Rights and CEDAW, international debates about gender-based violence reveal that it is widely recognized as a major global human rights, public health and social policy problem and is increasingly cited as an important determinant of HIV risk (Abramsky et al. 2012). However the narratives in my research reveal that it is the cultural practice that is cited as the problem, not men's violent behaviour.

The narrative linking the *fisi* practice to HIV/AIDS blocks detailed analysis into the ways in which girls and women involved in the practice are rendered inferior to men and vulnerable to abuse, often violent, as emphasis is put on the practice itself spreading HIV not the effect the practice has on women. Data on rates of violence against women in Malawi are high as Malawi's culture has condoned most forms of domestic violence as it is perceived as a private issue (Malawi Demographic and Health Survey [MDHS], 2010). Data taken from the MDHS 2010 reveal that 25 percent of all women age 15-49 have ever experienced sexual violence.

Table 2.1 shows the distribution percentage of women aged 15-49 who have ever had sexual intercourse by whether their first sexual experience was forced against their will, according to age at first sexual intercourse and whether their first sexual intercourse was at or before the time of their first marriage. The data show that, overall, 15 percent of women who have ever had sex report that their first sexual experience was forced against their will. By age at first intercourse, women who first had sex between the ages of 25 and 29 are more likely than other women to report that their first intercourse was forced (20 percent), followed by women who first had sex before age 15 (18 percent). Women whose first sexual intercourse was before their first marriage are more likely than women who first had sex when they got married (or started living with a man as if married) to report that their first sex was forced (20 percent versus 12 percent).



**Table 2.1 Forced at sexual initiation**

<b>Table 2.1 – Forced at sexual initiation</b>		
Percentage of women age 15-49 who have ever had sexual intercourse who say that their first experience of sexual intercourse was forced against their will, by age at first sexual intercourse and whether the first sexual intercourse was at the time of first marriage or before:		
	Percentage whose first sexual intercourse was forced against their will	Number of women who have ever had sex
<b>Age at first sexual intercourse</b>		
<15	17.7	1,082
15-19	14.3	3,419
20-24	13.0	551
25-29	20.3	36
30-49	0.0	7
Missing	11.1	340
<b>First sexual intercourse was:</b>		
At the time of first marriage/first cohabitation	12.0	3,101
Before first marriage/first cohabitation (includes never married women)	19.5	1,993
Missing	10.7	339
Total	14.7	5,434

(MDHS, 2010)

The obsessive links between HCPs and HIV/AIDS prevents policymakers from debating and seeking understanding of why these statistics are so high as well as preventing clear focused agreement on why HIV/AIDS is also so high. Mosse refers to the ethnographic approach I have adopted above as the ‘ambiguous processes of actual knowledge production, to actor worlds and the social life of ideas revealed through the still rare fine-grained anthropology of policy’ (Mosse 2011: 10) and highlights two important points the ‘importance of actor relationships in the shaping and salience of policy ideas; the other is importance of policy ideas in mediating professional relationships’ (Mosse, 2011, p. 10). It is also necessary to highlight the importance of policy ideas in maintaining professionals’ jobs. In other words, it is not just how these narratives construct policy but the motivations behind the narratives: why do particular actors buy into a perception of the problem?

This is an important question revealed in my research at the national level. At this level actors I interviewed sustained the myth that harmful cultural practices contribute to the spread of HIV. I argue throughout this thesis that one of the reasons they did this was to keep the issue on the political agenda thus ensuring a constant flow of aid money. As part of my data collection I interviewed an academic who worked at the College of Nursing who described in length about

cultural practices and the studies she was carrying out. When I told another informant, a former academic who had conducted research on sexual cultural practices and HIV/AIDS about meeting the academic from the College of Nursing, she said 'well if cultural practices were to be eradicated she would be out of a job' (P44: 14/10/2008); also see p146. This suggests that global donors were presented with the most convincing story in order to cement continued support. See p143 where I provide an analysis of 43 funding proposals submitted by CBOs to Balaka District Council for projects on harmful cultural practices and HIV/AIDS. I found that although the project proposal stipulated that work would be carried out on harmful cultural practices and HIV/AIDS when I looked at the budget I saw that the activities they wanted to fund had no relation to these sexual cultural practices but were related to income generation activities such as pig rearing, which suggests funds were being obtained and then re-diverted for other projects which were seen as a priority.

My argument resonates with the work of Chin who argues that UNAIDS and AIDS activists accept certain myths about HIV epidemiology to keep the disease on the political agenda and, by implication, ensure funding and jobs. As Chin says: 'AIDS programmes developed by international agencies and faith based organisations have been and continue to be more socially, politically, and moralistically correct than epidemiologically accurate' (2006, p. vi). This resulted in calls for a 'major over-haul of the international AIDS response' (Lewis & Donovan, 2007, p. 532) and defensive responses from UNAIDS and the World Health Organisation (WHO) (De Lay & De Cock, 2007; De Lay et al., 2007). Green's work is also particularly relevant to my study. She demonstrates how development categories are created by policy communities, and how and what impact they have for the formation of policy and then the projects that arise from them. Green uses policy directed at children with HIV/AIDS in Tanzania as her case study, as she argues: 'reflecting on development practice from the perspective of anthropology permits a double reflexivity which acknowledges the nature of knowledge practices in anthropology and international development' (Green, 2009 cited by Mosse, 2011, pp. 34-35).

As Mosse points out (and as was the case with my own experiences), one's positioning as an insider offers a unique insight into the development process:

As in any anthropological practice, insight comes from combining the experience of insider participation with the detachment of an outsider; the ability to stand outside the taken-for-granted frameworks and to see the arena of international development as a foreign country (Mosse, 2011, p. viii).

It is important here to recount one story about an experience in Malawi which in retrospect I realized I was carrying out 'insider ethnography'. In July 2009 I secured a four-week consultancy working for the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the National AIDS Commission (NAC). I applied for the consultancy because of its relevance to my study (and because I was low on finances).

Objectives of the consultancy were: to review the available 'tools' utilized by various government departments; assess aid processes of 'harmonization' and 'alignment' as well as the Country Harmonization and Alignment Tool (CHAT) and adopt a survey to the Malawi environment; conduct data collection with key informants identified; compile the information collected and conduct a detailed analysis to extract key trends, gaps and findings, and present these in a final report. CHAT was developed by UNAIDS and the World Bank in response to recommendation 4.1 of the *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors* to develop a tool to assist national AIDS coordinating authorities (in collaboration with international partner agencies) to assess: (i) the participation and degree of engagement of country-based partners in the national response; and (ii) the degree of harmonization and alignment among international partners. It assesses the performance of implementing and donor and development partners in relation to the 'Three Ones' principles and the national HIV/AIDS response in Malawi, 2009. The 'Three Ones' principles focus on greater national ownership, harmonization and alignment (CHAT Report, 2009). See chapter 3.

This consultancy was invaluable for three reasons. First, I was required to design a survey tool and I slotted a question into the survey, which, whilst relevant for the consultancy, was particularly relevant for this study. The question was 'Does your organisation use evidence to inform policy and programmatic decisions on HIV/AIDS?' Responses to this question are reviewed in chapter six. Also see Appendix 3. Second, it enabled me to meet key stakeholders in the country working on HIV/AIDS. I travelled to the three regions in Malawi meeting Directors of NGOs, heads of Bilateral and Multilateral Agencies (I gained access to people with whom I had not been able to secure interviews for my own research. This gave me the opportunity to interview a key cabinet minister about this study once I had carried out my official business as a consultant). And third, I seized the opportunity to speak with NAC staff members. I gained their trust, which enabled me to have conversations with them related to my research, which I would not have had without securing this work. (See Box 2.2 which presents extracts from my journal notes concerning conversations with NAC staff). These data fit with my argument for three reasons. First, the

respondent talks about male promiscuity. This supports my argument that many women in Malawi are put in vulnerable positions regarding contracting HIV due to male promiscuity (see also section on gender norms in chapter three); Second, the same respondent says how the HIV prevalence rate is higher amongst women with a secondary education or above than amongst women with education lower than secondary level. (See section on evidence that presents survey data which supports the respondent's argument). Antenatal care surveillance system data and Voluntary Counselling and Testing data for Malawi demonstrate higher infection levels among women with secondary or higher education than women with less education (NAC, 2004a). The MDHS also shows that HIV prevalence is higher among women with secondary or higher education (MDHS 2004, p.231). These findings corroborate those of Hargreaves and Glynn's study (2002) that assessed whether educational status is associated with HIV-1 infection in developing countries. It concluded that in Africa higher educational attainment is often associated with a greater risk of HIV infection.

This highlights that women who have a secondary education and above were more likely to have HIV than women living in rural areas who are not educated to this level. This supports my argument that the *fisi* practice which takes place in rural areas is being blamed for the spread of HIV/AIDS is not significantly contributing to the spread of HIV as women living in rural areas are less educated. Third, he refers to people in rural areas being more likely to have higher rates of STIs thus supporting my argument that rural people are being blamed for higher sexually transmitted infection rates).

With regard to the UNAIDS consultancy when I submitted my final report to UNAIDS, staff vehemently disagreed with my findings and recommendations. They told to me to revise them and sent me two documents, the HIV/AIDS prevention strategy and the National Action Framework (NAF) review, and I was told to 'try to extract good recommendations from them' (email from UNAIDS staff member, 25/06/2009). This illustrates that although I was employed as an independent consultant to review Malawi's national response to HIV/AIDS, UNAIDS wanted to have the final say over the recommendations and over their formulation. Would this be to protect professional groups working on these issues? Of course, if I did not agree to this I would not have been paid. The following extract is a journal entry I made during my time at UNAIDS.

First day at work. Arrived at NAC and no sign of Davie. I waited in the resource centre and said hello to Victor. Thought I should go upstairs and look around and found Christine. She attended Portsmouth University and studied European Studies. She also knows Tony and Martin. Christine said that 'UNDP is a nightmare'. She was referring to the length of time it takes for them to process

a contract. She said one contract took her two months to obtain. UNAIDS she said, does not administer contracts as it is perceived as a programme. I asked about logistical and technical support. Christine said she hadn't thought about it. Davie said he will explore the possibility of getting a driver for me. How do they expect me to get around without a car? Especially when they are asking me to go to Blantyre. I also asked about office space. I now have the biggest room. The sign on my door says capacity building coordinator. I wonder what happened to that person/post? (Journal entry, 08/04/2009)

I had to negotiate support in order to fulfil my contractual requirements as nothing was set up prior to my arrival to enable me to carry out the consultancy effectively. I sat in the office without a phone and no one supporting me for one week, always being told the phone was on its way. I had to knock on staff doors whom I did not know, coming across no doubt as the annoying consultant, and I had only fifteen days remaining to deliver the objectives set out in my terms of reference. So I decided to take action in to my own hands. I took a taxi and called some people who I knew to interview. Whilst I was in the taxi I received a call from the NAC's Executive Director's secretary ordering me to return to the office immediately.

I walked in to the Director's office and he was sitting on his sofa with his senior management team waiting for my arrival. He shouted at me for leaving the office and setting up meetings with stakeholders without his permission. I was then accused of not knowing anything about Malawi and HIV/AIDS in front of his senior management team. I shouted back and walked out. After this outburst he seemed to respect me but it was not easy to be accepted in the beginning. I had to prove my 'development expertise', which I assumed was already proven by successfully securing the consultancy after having been shortlisted for an interview and then being offered the job. Maybe I was seen as a threat and NAC staff had a 'suspicion of experts' (Mosse, 2011, p. 18).

In retrospect I can now see why. There were serious allegations of corruption taking place at NAC. NAC was also not disbursing any government funds to implementing agencies and NGOs had come to a grinding halt as they had no money to implement projects and programmes (see Box 2.1). However, it is difficult here to tell the whole story for fear of paralysing my career. Thus being an insider and outsider presents challenges between being a professional but also wanting to say what really happened. I discovered that this type of ethnography can cause consternation and could have repercussions for the future. Mosse refers to this and uses anthropologists in the World Bank as an example:

But by turning an ethnographic eye on how social development knowledge is produced at the Bank's headquarters and on the work of a specific group of expert actors, it is possible to see the importance of local social relations and internal organisational dynamics in the framing of global policy norms (Mosse, 2011, p. 83).

I also saw things I would never have seen as my office overlooked the car park. To my astonishment there were more than fifty NAC cars parked, ranging from four wheel drives to trucks, some older, some not so old. I asked a colleague why were they all not being used. He said some are old. They were not that old. I said why not get them fixed. He said it's cheaper to buy a new one than to purchase the parts for the cars. I could not believe that an organisation whose mandate is 'providing leadership and coordinating the national response to HIV/AIDS in Malawi' would waste so much money on vehicles.

### **Box 2.1 – NAC funding freeze cripples AIDS NGOs**

#### **The Daily Times, 22/09/2009, by Joseph Mwale**

Operations of District Aids Committees and Community-based Organisations (CBOs) have come to a standstill in many districts following failure by National Aids Commission (NAC) to disburse funds. NAC has not disbursed its annual allocations to the districts since 2008/09 financial year while other districts have not been funded since the 2006/07 fiscal year. The development was established during a media tour organised by the Ministry of Information and Civic Education with support from NAC. The tour was done in Kasungu, Nkhotakota, Ntcheu and Dedza last week. Nkhotakota District Aids Coordinator Cedric Kwizombe said most activities in the district had stopped and efforts to ask NAC officials on the issue had paid no dividends. He said the assembly receives a yearly allocation of K168 million, half of which goes to CBOs. Kwizombe said the lack of funding had disturbed the morale of CBOs in the district and the Monitoring and Evaluation (M&E) of their activities.

'The momentum is low at the grassroots. When the cash flow is regular, CBOs feel the need to come up with monthly reports. 'Some submitted their proposals in 2005, but there has been no response. It's really discouraging and it gives headache to convince CBOs on their operations without funds'. Kwizombe bemoaned. The coordinator also accused NAC officials of not consulting them when scrutinising plans drafted by district Aids committees on activities to be carried out in a particular fiscal year. Dedza District Commissioner Daniel Phiri also said the assembly last received NAC's money in the 2006/07 fiscal year. But in an interview Saturday, NAC's Executive Director Biswick Mwale attributed the problem to time spent on pent negotiations with donors.

"The period for the funds we had from donors ended last year and we have spent a year negotiating for some new funds from World Bank and Global Fund" he said.

According to Mwale, the NAC had been operating from 2003-2008 with funds from World Bank (US\$35 million) and Global Fund (US\$178 million). But Mwale said the World Bank board just approved US\$30 million two weeks ago and the money is expected to be available by December this year for its operations which includes district aids committees and CBOs. Mwale also said they have acquired US\$ 375 million from Global Fund which would be used in six years for two phases. The first phase is expected to use US\$166 million. However, Mwale said with the little funds they had, NAC had supported 710 CBOs throughout the country with K450 million in the past year. He also expressed concern over the increased number of CBOs in the country and asked district assemblies to rationalise them. According to Mwale, most CBOs are concentrated around towns and he recommended one CBO per group village headman. (Mwale, 2009).

Upon reflection I realise that I had become an 'insider' in the NAC; the organisation responsible for HIV/AIDS prevention and care in Malawi. I held meetings with the Director and Senior Management Team of the NAC and UNAIDS on a regular basis: I had become part of the policymaking process.

## Box 2.2 – Conversations in the NAC Corridors of Power

(Journal entry, 14/04/2009)

I shared the office with two consultants working on NAC's mid-term review. One consultant was a professor working at the College of Medicine. I asked him out of the married men he knew what percentage did he think were having an affair? He said 50%. The NAC M&E staff member was also present. He said it is more likely 30% and that 50% is too high. We talked about promiscuity. The NAC staff member said promiscuity is too strong a word. Men do it and women accept it if they know about it. He gave an example of a woman who left her husband because he was having an affair. Someone said to her 'Every married man is having an affair'. So she went back to her husband. Promiscuity to the NAC staff member means any relationship outside marriage. For many men he said it is 'part and parcel of their life'. Many men have a prostitute and a wife somewhere else. They think this is the life that cannot be converted. Professional women who are not married are looked after by married men. These women know how to look after themselves. They may have many married men looking after them. A lot of professional men have other women around. Also the HIV prevalence rate is higher among those women with secondary education and above compared to women with primary education and below.

He also told me that lack of communication in marriages is a real issue. I asked what lack of communication about sex? Jim said no just about normal things. You could argue about food. OK I am not cooking dinner tonight says the wife. She says the same the second night. So the husband goes off to his girlfriend's house who will cook him dinner. I asked Jim what constitutes a good marriage? He has been married a while – to a German woman. He has three children and is 43. He said honesty and openness. His wife is now a housewife. She used to work for the German Technical Development Agency (GTZ) but now wants to stay at home, he said. I said what about a nanny? He said they have a nanny but his wife still likes to stay home and 'even does their homework with them'. Jim says that his wife and children accuse him of never being around. He laughs. Still I couldn't work out whether Jim is one of these promiscuous men that he talks about. He said if he went in to a nightclub women would be all around him if he gave off the right signals, the right eye contact. Of course he said I would know all about that being a white woman in Malawi. We discussed how cheap it is to have sex with a sex worker. Both Jim and I said at the same time how much it is – 500 kwacha. I added 1500kw without a condom. We started to talk about cultural practices. I explained to him how everyone always directs me to Nsanje whenever I talk about it. He said but they do take place there more than anywhere else in Malawi. Jim said he was one of the first people in the country to write about HIV/AIDS in the newspaper to say how it really is. We also talked about transmission rates. But he said that in the villages people are more likely to have STIs. He said people wash less and especially after sex and there is less male circumcision too.

(Journal entry, 21/04/2009)

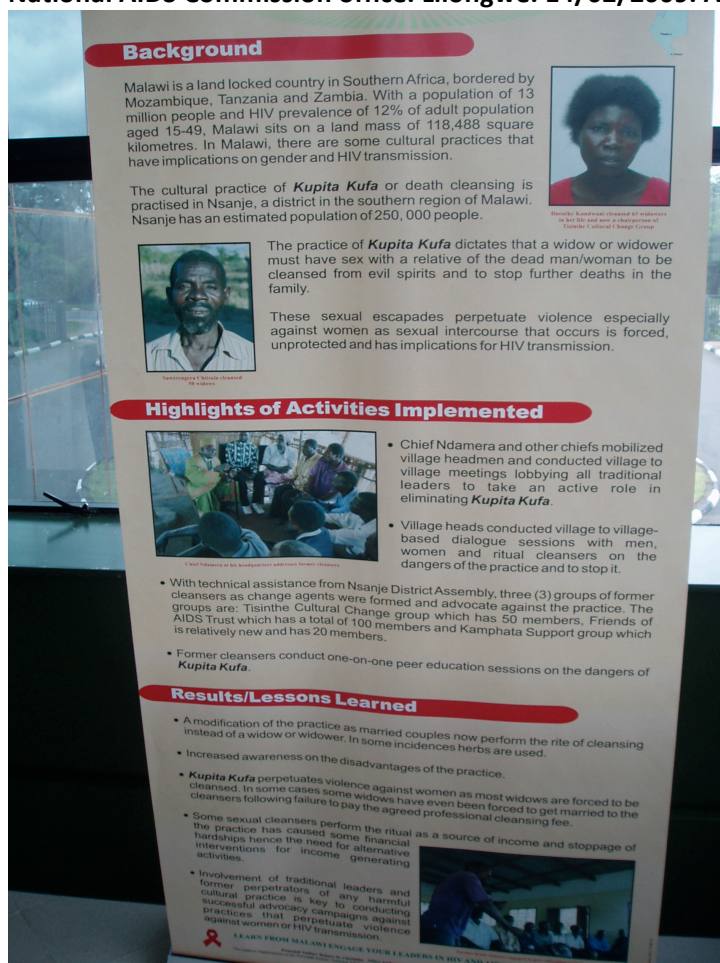
I managed to secure a driver and sometimes staff members would come with me on journeys. I travelled for hours in the car to meet stakeholders. This time in the car enabled me to have discussions related to my research. Did you have to go to initiation? No. I grew up in town. What about friends? Yes a lot of friends did that. Did they have to have sex? Yes they did.

(Journal entry, 22/04/2009)

On another journey we had interesting discussions about sex and cultural practices. But his example of a cultural practice was using condoms with his wife whilst she had her period as he was going away and they wanted to have sex. But he didn't like using condoms. He said he could see why people do not like using condoms.

I had an influential role meeting with key stakeholders working in the country on HIV/AIDS. I was responsible for carrying out a consultancy where the outcomes would influence future HIV/AIDS policy at the national level. I had access to all the key players in the country. This should not be confused with participant observation or 'observant participator'. It is more than participant observation as I was not just part of a group but I was the protagonist. I was leading the group.

**Illustration 2.2 – Photo of Kupita Kufa poster documenting Harmful Cultural Practices in Nsanje, National AIDS Commission office. Lilongwe. 14/02/2009. Author**



### Me as an actor

I acknowledge myself as an actor in this study that I describe. I have had to spend time since I returned from Malawi to reflect on my experiences, which were complicated as I stepped in and out of different roles. What I am presenting are my experiences in different roles, so part of this journey as a researcher was to become reflective of my interactions within these different roles (See chapter 2 where I discuss my positionality in more detail). As a development practitioner and researcher of the field under investigation, it is important for me to contextualize my own position in addition to that of the stakeholders I was studying. This involved looking at the Self, the Other and the relationship between them. A fundamental principle of ethnographic research is to reflect on one's own positionality. The 'reflexive turn' is the acknowledgment that a researcher is not a neutral observer of action and collector of data, but rather an insider whose values will influence the research. In my case, by employing the concept of the reflexive turn I



realised that I was an actor in my own study that affects my final work. By adopting this approach I was challenged to not let my story come across as an ethnocentric view of the culture I was studying. However Clifford and Marcus state: 'The ethnographer's personal experiences, especially those of participation and empathy are recognized as central to the research process, but they are firmly restrained by the impersonal standards of observation and "objective" distance' (Clifford & Marcus, 1986, p. 14). They separate subjectivity and objectivity. Yet as Ahearn points out, and which I agree with: 'As many ethnographers are now realising, the process of conducting fieldwork is an inter-subjective one; ethnographies, therefore, must describe the researcher's relationships with the people who are the subject of their inquiry' (Ahearn, 2001, p. 46).

Adopting a critical ethnographic approach to look at my experiences has enabled me to understand the different relations between different actors and has helped me understand relationships which could not have been gained merely utilising evidence from my interviews. As I had to deconstruct the roles of those I interviewed I tackled these issues using an ethnographic approach which allowed me to gain an insight.

### **The disciplinary context**

I have studied international development through a range of academic disciplines including political science, anthropology, epidemiology and sociology.

### **My own positionality**

The following section illustrates my major identities, which had an impact on this research and highlights how in practice these identities are interlinked and porous. Firstly, I provide information about my background, which I think is helpful in illuminating the issues that I confronted concerning my own positionality during this study.

My first degree was in French Studies and I chose to spend my year abroad studying in Senegal whilst carrying out a work placement for a West African NGO. This is when I first became interested in international development. My dissertation examined the extent to which women's lives were improved by participating in income generating projects. My findings revealed that the women who were involved in these projects found it more stressful and their lives were not improved as a result. This was my first experience of a development project that was failing. I then embarked on a career in international development and took on programme management and policy advisory roles for NGOs, governments and UN agencies. I become increasingly critical of the development work in which I had become embroiled. For this reason I decided to enrol on

a PhD programme to study in more depth theoretical debates concerning international development.

### **Participant and my role**

Whilst conducting research for my PhD I also worked as a Consultant for the UN Joint Programme on HIV/AIDS (the effect of this role is discussed in more detail on pp 43-47). This was a senior advisory role working with the Government of Malawi's National AIDS Commission and UNAIDS. Merriam et al (2001) argue that researchers are never fully insiders or outsiders. However, my insider versus outsider status changed during the course of my research at different times. For example, on this occasion I believe I took on aspects of an insider as I was a senior consultant influencing policy at the highest level in Malawi. However, perhaps those working at the UN programme saw me as an outsider. Further, I did not hide the fact that I was working as a researcher in Malawi as part of my PhD degree.

### **Participant and my identification**

Initially I wanted this study to be about those women who were being subjugated to participate in these harmful cultural practices and I wanted to interview the women who had purportedly been involved in these practices that have been mentioned in this study. But realizing this was impossible due to language barriers and the fact that I was a single, western, female researcher going out to the village to ask questions which are taboo and are not talked about freely amongst Malawians, I realized I had to change the focus of my study. This involved a trade-off. I was not able to interview women who were actually involved in the reported practices. Instead I used studies that had been conducted that interviewed women involved in the practices to increase my understanding of the practices and thereby indirectly informing this research. But I still wanted to find out why the subject of sexual cultural practices and the link with HIV/AIDS was of such interest in Malawi so I decided to research the perspectives of the people that are working on HIV/AIDS issues.

On a practical level this was more straightforward as I did not need to learn the language/s spoken in Malawi and I did not need to spend a significant period of time in rural areas to gain trust from the community. This thesis thus has focused on the narratives of those held by the HIV prevention community in Malawi concerning HIV/AIDS and sexual cultural practices. I have interviewed 133 people at the international, national and regional level including researchers, policymakers, programme managers, lawyers, government ministers, NGO staff and national and district officials and health workers. The interviews were conducted wearing my postgraduate

researcher hat and my consultant working for UNAIDS hat (see chapter two). As a white, single, female I found my identity was limiting in a number of ways as discussed above. As Hammersley and Atkinson (1995) point out outsiders may fail to understand the experiences of the informants. Further, my identity as a white European affected my research in another way. Most of the informants seem to perceive me as someone who could attract funding for their national development work thus at times I felt as if their narratives were shaped by particular agendas and interests. See page 54.

### **The story of my research journey**

My research journey started in Malawi when I visited as a Programme Manager. Once I had been told about the *fisi* during my initial visit my Malawian work colleague came to London on a field trip and I described to her my PhD idea looking at HIV and women's vulnerability in Malawi. She said that I could stay with her family in Blantyre, and that she would help me in any way she could. This was an offer that I could not refuse. I went to Malawi in 2008 and spent fourteen months there conducting my fieldwork. This study therefore captures the time period from 2008-2009.

I landed in Lilongwe in September 2008 and was picked up by my friend who worked for one of the biggest HIV/AIDS NGO network in Malawi. We travelled to Blantyre and she had invited me to stay at her house with her family. I asked my friend if I could work from her office and was fortunate enough to be given desk space. This was an invaluable opportunity as I shared an office with a policy officer and this enabled me to meet people passing by my desk. I was hoping that I would identify an organisation with which to carry out my research. It was not long after I was in my new surroundings that the Executive Director of a small CBO situated in the district of Mulanje, asked me what I was doing there and then excitedly told me about the *fisi* practice. He told me that, for him, *fisi* meant three things:

1. Surrogacy – if you see a stick on the door you should not go in as you know something is going on.
2. Kuchotsa/kutsatsa fumbi – sexual cleansing. During initiation ceremonies when a girl has reached puberty and is menstruating she is taught how to entertain her husband. The girl could be from 7,8 or 9-12 years old. She is told she must sleep with someone otherwise she will have problems. The person she will sleep with may be big or young. The impact of this a) early/unwanted pregnancy b) drop out at school c) early marriage d) contract HIV.
3. Kuchotsa milaza – concept whereby in Mulanje you may go out and you have left your husband and you sleep with other men. So you are forced to sleep with someone else who is the relative of the husband to be forgiven for sleeping with someone else (journal entry 26/08/08)

He invited me to visit his village where he ran the CBO to find out more about the *fisi*. However, after I visited his village my friend who was the Director of the HIV/AIDS NGO told me that the

practice was not particularly prevalent in that part of Malawi and that Steve had exaggerated the story so that I would visit and perhaps help him access funding.

So I returned to my desk in Blantyre with a new research idea and waited for the next person to discuss cultural practices and HIV/AIDS. Along came the Executive Director, Youth Guide Concern, based in Lunzu. He told me 'there are lots of cultural practices that go on in my village' and therefore it would be a perfect site to conduct my research. He then described at length the practice of *kusasa fumbi* and then told me:

When initiation ceremony comes to an end, the village leaders or opinion leaders in the village, they plan for the men to have sex with girls. The men are from a different community. Also women are chosen to have sex with boys. They are also from a different village. Women get women and men get men. They are paid in food. No money. Condoms are not used. There is a need to exchange fluids so cannot use condoms (journal entry, 26/08/08)

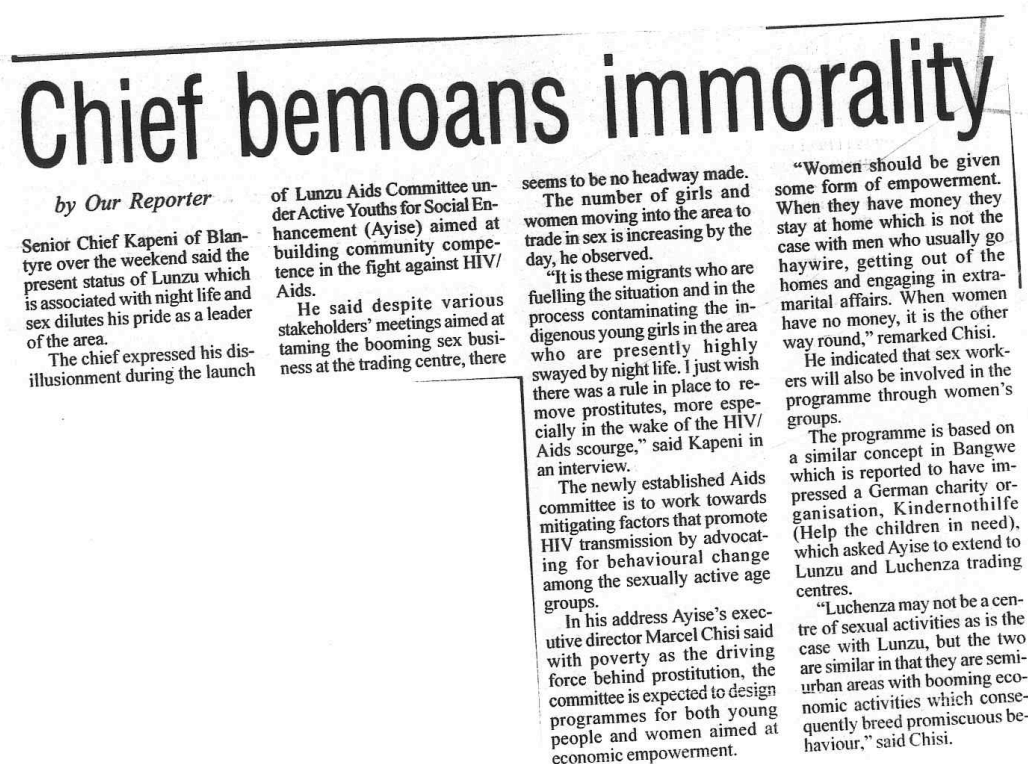
I decided to visit his CBO in Lunzu and we agreed that I could conduct my research utilizing the Participatory Ethnographic Evaluation and Research (PEER) method with the support of his CBO. At the time I envisaged my data would mainly come from this research. I designed a questionnaire and drafted questions targeted at the community level related to health and illness; sexual health; sexual knowledge, sexual behaviour and sexual health; cultural practices and gender dynamics. Peer ethnographic interviews were carried out in Lunzu outside of Blantyre. Fifteen staff members interviewed three people each which made a total of forty-five interviews. I paid for lunch and drinks when they met for training. I employed a Malawian researcher to train people that worked for a small CBO and I spent six weeks on this project.

**Illustration 2.3 – Training in Lunzu. 26/09/08 Author.**



It is important here to mention one informant who worked for UNDP who had carried out much work on sexual cultural practices in Malawi, and I asked her if Lunzu was an appropriate research site. She said it wasn't because Lunzu is a predominately Catholic area. She also told me there were influencing factors: Lunzu is a trading centre and has a high level of prostitution due to transport workers and therefore this would have an effect on the rate of HIV prevalence, which is not a result of the sexual cultural practices that take place in the area (see Figure 2.1). She then told me that 'Nsanje would be would be a good research site as it is remote' (P44, 14/10/2008). Because at this point my study was still focusing on my original research idea to look at women's vulnerability to HIV/AIDS it was then clear that Lunzu was not a valid research site. As she said prostitution took place, HIV rates could be higher as a result of prostitution and not because of sexual cultural practices. At the time when she told me this I thought the data were now useless. But in retrospect these data are invaluable as it completes the circle in my analytical frame to include the community level perspective on HIV/AIDS and cultural practices.

**Figure 2.1 – Chief bemoans immorality (18 September 2002)**



I also got the feeling that a few of the researchers that had been trained were making up stories and telling me what I wanted to hear. They were pleased that I had come to their village and I believe they saw me as someone from whom they could gain funding. However, in retrospect I discovered that this experience was normal for someone carrying out ethnographic research. As an ethnographer's mandate is an exploratory one it can be expected that initial questions that motivated the research will be refined or even transformed. The drawback is that this can be time consuming and the research may take longer than originally planned and there are also financial implications. This was indeed my experience and I discovered, as Hammersley et al. point out, 'ethnography is a demanding activity, requiring diverse skills, including the ability to make decisions in conditions of considerable uncertainty' (1995, p. 4).

After having read several studies about many cultural practices taking place in Nsanje (College of Medicine, 2005; NAC, 2006,) and told about it during my initial interviews I decided it would be a good idea to carry out my research in Nsanje. I spent days in the University of Malawi library reading the work of the Dutch anthropologist Schoeffeleers (1968; 2008) who lived in Malawi to gather information regarding sexual cultural practices in Nsanje.

At this point my research topic was very different to what it is today. Initially when I arrived in Malawi I was planning to interview women who had experienced the sexual cultural practices. But the more I found out and discussed with women, the more I realised that my research topic was doomed for failure. I somewhat naively thought that I could find an interpreter, visit a rural area and interview women about the practice. However, then I suddenly realized my limitations, and that as a foreigner, it was very unlikely that I would find the 'truth': instead, people would see me and fabricate stories for their own titillation or vested interests. People lie about their sexual experiences, so why would they tell me the truth? Margaret Mead is a fine example of this challenge when conducting fieldwork, for example see Shankman (2009) for a critique of Mead's work. I then reflected on my situation and after discussing with academics who had been working in Malawi for many years, I decided to revise my dissertation topic. I realised that I had to have an open mind and was experiencing the challenges of fieldwork. The fact that I had realised that my research topic would not work the way I had thought was an empowering process in itself.

I was also interested in the social lives of development professionals and I was invited to stay at my colleague's house where I lived with her family in Blantyre for six months. I felt very privileged to be allowed into their house. I became a member of the family, in fact, upon reflection it is only

now I realise that the mother and father took on the role as mother and father to me. They advised me not to do certain things as they felt responsible for me whilst living in their house. I also became aunty to the children. We ate together three times a day; they took me on holiday; invited me to weddings and funerals and I attended church (a couple of times). This experience was invaluable. I wasn't just a researcher – an outsider, or at least I did not feel like an outsider – but I was a participant: a key feature of qualitative research is the subjective 'insider view' and closeness to data. I found myself a member of a Malawian family, sharing their experiences; both good and bad.

I was told about personal experiences which I cannot share in detail without betraying the trust of my family, but on many occasions we discussed issues related to HIV/AIDS, sex, marriage, infidelity, promiscuity, gender relations and relationships as well as issues regarding extended families and the stress that family members put on others. This gave me first-hand insight into the 'real' issues taking place in Malawi: I wasn't reading about it but it was happening; I was a piece in a game of chess as Clifford and Marcus point out, 'the ethnographer, a character in a fiction, is at center stage' (1986, p. 14). They trusted and confided in me. This experience also gave me the opportunity to talk to the family members about my research and share ideas. Many researchers do not have the privilege of such experiences. For example, when we spoke of the practice of wife inheritance the argument was that this practice was not 'harmful' but that the man was providing economic stability to his brother's widow and that it was an economic agreement not related to sexual activity. This gave me an insight into the social lives of the development professionals I was interviewing. When I had left her house and made a visit to see my friend we talked about the office being quiet. She told me that NAC had not disbursed funds for six months so she was unable to pay her staff or implement projects (Journal entry, 04/03/2009) (see Box 2.1).

I then moved to Zomba and met with a group of researchers working on HIV/AIDS who were working for the MDCIP project, University of Pennsylvania. They had a spare room and I moved into a house, from which an NGO was also being run. I had been in contact with an American professor during my first year of my PhD as I had read about her work in Malawi and she had commented on my dissertation outline. Coincidentally, I met the research group with whom she was working and I shared a house with them.

I then moved on to the district of Balaka to interview people and gathered district level data. I chose this site because a great deal of research has already been carried out in this district as part of the MDCIP project. It was suggested to me by an American Professor of Sociology that I conduct research here. I was also invited to work on my research in parallel with an American group of undergraduate sociology students from UCLA. This enabled me to informally discuss my fieldwork and share research ideas and findings.

I decided to move to Lilongwe to conduct further interviews. Once again I stayed with one of my informants who was working for a UN agency and I rented a room in her house for six months. Again, I was able to discover more concerning the social life of a development professional. I also was able to ask questions. I asked the fifteen year old daughter about culture practices. Did she hear about them at school? Amongst her friends? Have they participated in any cultural practices? She said no they refuse. She said they know about them but they won't participate. For example, in Mulanje, girls are told to put eggs in their vaginas to lose their virginity. And amongst the Nyau the old men who wear masks are told to sleep with girls who are coming of age (Journal entry, 15/03/2009).

### **Different actors at each strand of the web**

This section presents the number of different actors I interviewed at different levels to achieve my research objectives (Table 1.1) which refers back to my conceptual web (Figure 1.3).

#### **International level**

At the international level I conducted interviews with actors from *multi-lateral and bi-lateral agencies* (Department of International Development (DFID), European Union (EU), GTZ, UNAIDS, United Nations Development Programme, US Agency for International Development, World Health Organisation). These interviews took place in Lilongwe in institutional settings.

I also conducted interviews with *International actors* (Action Aid, Alliance One, Clinton Foundation, Concern Universal, Dignitas, GOAL, The John Hopkins University, Management Sciences for Health, Norwegian Church Aid, Red Cross Society, Save the Children, Trocaire, VSO, World Vision). These interviews took place in Balaka, Blantyre and Lilongwe in institutional settings.



### **National and regional levels**

I interviewed actors at the *national government* level from Ministry of Health (MoH), Ministry of Trade and Industry, National AIDS Commission (NAC); Office of the President and Cabinet as well as MPs.

I interviewed actors at the *regional government* level including staff of the district and city assemblies and hospitals. These interviews took place in Balaka, Blantyre, and Lilongwe in institutional settings.

*National actors* from NGOs (Malawi Network of AIDS Service Organisations (MANASO); Malawi Business Coalition on AIDS (MBCA); Malawi Network for People Living with HIV/AIDS (MANET+); MIAA; Restored Hope Foundation for Rural Development (REFORD), SANASO, Toveraine, Youth Guide Concern); community and faith based organisations (Evangelical Association of Malawi); academia (Chancellor College; College of Medicine; Kamuzu College of Nursing; University of Malawi); and media (Transworld Radio); the Law Commission; and the Malawi Human Rights Commission.

### **Community level**

I employed a trainer to train staff members working for a CBO called Youth Guide Concern to carry out interviews with people living in Lunzu.

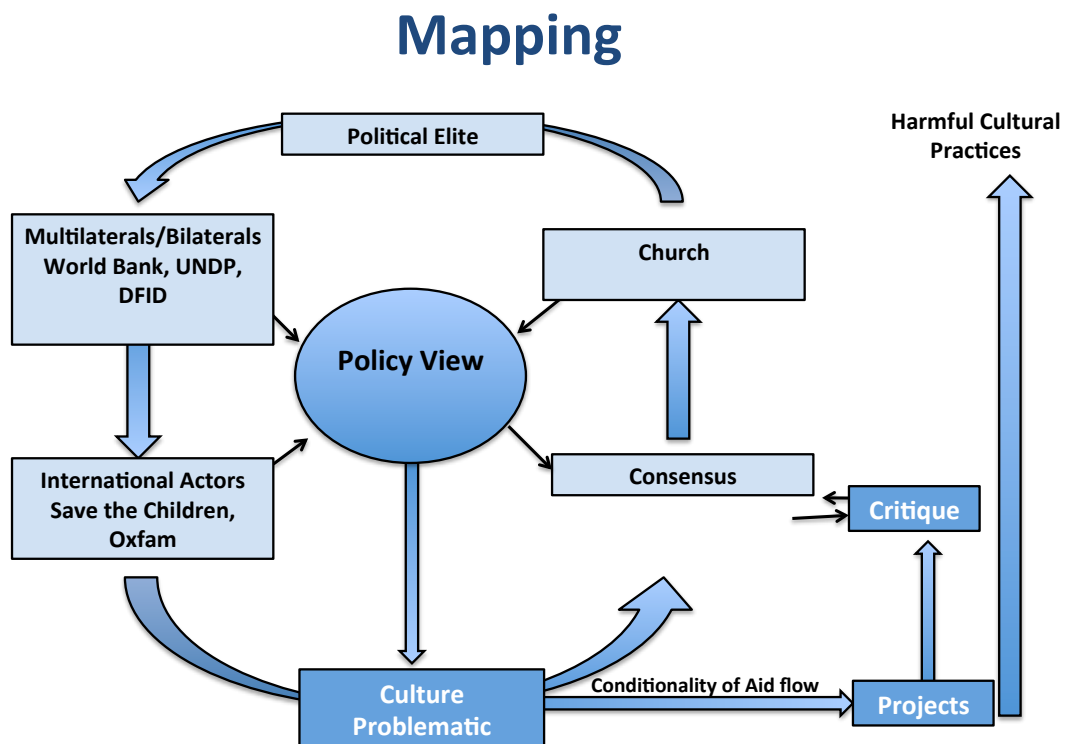
**Table 2.2 Breakdown of interviews used in study**

<b>Table 2.2 Breakdown of interviews used in study</b>	
<b>Data type</b>	<b>Number</b>
In-depth interviews with stakeholders working on HIV/AIDS	60
Semi-structured interviews as part of UNAIDS consultancy with key stakeholders working on HIV/AIDS	28
PEER interviews	45
<b>TOTAL</b>	<b>133 interviews</b>

**Table 2.3 Number of different actors at each strand of the web**

Table 2.3 Number of different actors at each strand of the web	
Different actors at different levels	Number
International level: Multi and bilateral agencies;	8
International actors (INGOs, international universities, International FBOS)	16
National government	12
District (regional) Government	7
National actors (s, CBOs, FBOs, private sector, media and academia)	34
People (rural dwellers), Lunzu	45
<b>TOTAL</b>	<b>133 interviews</b>

**Figure 2.2 – Mapping the actors involved**



The visual map is important to present here as the rest of the thesis will essentially be focused around unpacking it. It conceptualizes visually a series of relationships and these are constructed through various narratives. Narratives in turn are based on the ways in which different actors

perceive each other, and, in the context of development, 'the problem' they feel they need to solve. In this story the problem is the high prevalence of HIV/AIDS in Malawi. The narrative I document is an attempt to understand this prevalence, which in turn support policies and practice. This map is further complicated by the ways in which the different actors perceive each other; how the narratives they share between them reflect how they position each other; and what they feel they each need to hear. The narratives themselves represent mechanisms of power because by exerting them, and persuading each other to adopt them, policy and practice is influenced. So for example, the national level politicians have a perception of international donors and the funding on which they depend and want to secure. They have constructed in this story specific narratives of blame that support their objective of ensuring a constant flow of aid money into the government.

### **Interviews**

I conducted 60 in-depth interviews (Table 2.2) with a wide range of people working on HIV/AIDS prevention including lawyers, researchers, policymakers, government ministers, NGO staff, national and district officials and health workers (Table 2.3).

After obtaining ethical approval from the Ministry of Health (MoH) in Malawi I asked questions relating to themselves, their job, and what they liked and disliked, to find out more about their social lives as development professionals. Then questions generally focused on the themes of cultural practices, gender and HIV/AIDS to find out to what extent they thought cultural practices contributed to the spread of HIV/AIDS. My main question was 'I am very interested in policy and programmes on HIV/AIDS and gender and cultural practices. I am trying to find out your point of view. What do you think about the link between cultural practices and HIV/AIDS and what has your organisation been doing on this issue?'

As this study was exploratory I used the process of snowballing to identify informants. This enabled interviewees to be easily identifiable, willing to be interviewed and generous with suggestions of others to interview. Having positioned myself in an office in one of the largest HIV/AIDS NGOs in Malawi it was relatively straightforward to identify informants at an early stage. I followed up recommendations by contacting potential interviewees by phone, and in person, to request an interview. I adopted this method because I was targeting a particular group of people who needed to be selected because of who they are and what they know, rather than by chance.

Since English is the official language in Malawi the respondents were fluent and an interpreter was not required. Interviews lasted between thirty minutes to two hours. With the permission of the respondents, the interviews were taped and then fully transcribed. If the respondents seemed uneasy about being recorded, notes were taken and typed up after the interview. I transcribed some interviews myself as well as employing an undergraduate student at the University of Malawi to transcribe some. The reason I hired someone to help with the transcribing is because I found it to be a very tedious and time-consuming task, but also because I was giving someone a job and therefore building her skills. I made sure they were transcribed as soon as possible so that I could pick up on emerging themes and analyse the data as I went along, and if I needed to conduct a second interview I could easily follow up whilst I was still in the field. I asked the interviewees for their consent to conduct the interview. Some were interviewed more than once. I did not use a guide as such to plan my interviews but I discussed my ideas regarding desired outcomes of the interviews with a Professor of Sociology that I met in Malawi who provided useful guidance and advice, and I conducted the interviews accordingly. I attempted to elicit great understanding of the responses through various forms of probing with no set structure and no particular order. The process was iterative and I found I needed to interview three informants more than once.

I decided to conduct interviews face to face. Although this was far more time consuming than a telephone interview (for example, once I travelled six hours for an interview only to receive a call from the woman for whom I was waiting to apologise that she could not make it), I do not think I would have been able to conduct my research through telephone interviewing as the issues discussed were very sensitive. I assured all interviewees that their responses would remain confidential and anonymous. Only one interviewee said that I would need to obtain approval from the Government Department for which she worked.

In terms of interview structure, I employed a relatively open-ended strategy as opposed to using rigid, static methods, such as semi-structured interviews or questionnaires. I decided that in order to explore the ways in which cultural practices and HIV/AIDS were understood the study would utilise in-depth, open interviews. But I would not describe my approach as completely unstructured as I did prepare some research questions, although I did not ask them in any specific order and, on some occasions, only asked very few questions; and oftentimes research questions emerged in the course of the interview. However, before I commenced with the open interview I had a set of questions I would ask the interviewee to make them feel at ease and relaxed. These were: What I would like to do is ask you some personal questions about yourself and your work

and then we will talk about what your organisation does; What is your home area?; Did you grow up there?; Is your family still there?; Where did you go to secondary school?; Did you obtain a degree?; Can you tell me about the jobs you have had since graduation up until what you are doing now?

My approach was therefore one of discovery and exploratory in nature – I allowed the interviewee to speak freely and I posed questions when needed and when the time felt right. My aim was to ascertain the perceptions of the interviewee on the themes of sexual cultural practices, gender and HIV/AIDS, rather than impose my own ideas or lead the respondent. The aim of qualitative interviewing is to obtain rich, detailed information; and sometimes it would not seem like an interview as such but more conversational in style. As Burgess (1994) points out, unstructured interviewing tends to be very similar in character to a conversation.

With regard to sample size it was not determined by probability theory but by achieving saturation. I decided when the number of responses seemed sufficient since actual numbers were not the priority of this study. I evaluated my sample size in the context of the study and the theory which then emerged therefore representation relates to quality rather than quantity. Authors such as Corbin and Strauss (2008) and Dey (1999) postulate that it is rare for any category or concept to reach saturation as there will always be more properties and dimensions to investigate. However, I argue that I had reached saturation when the same names continued to crop up as recommendations for interviewing and that I was passed the same document on cultural practices and HIV/AIDS produced by the Evangelical Association of Malawi on several occasions.

As previously mentioned I also conducted a peer ethnographic training where I employed a trainer to train fifteen staff members who interviewed three people each, making a total of forty-five interviews. These questions were targeted at the community level and were related to health and illness; cultural practices; sexual health/knowledge/behaviour; and gender (see Appendix 4).

I also conducted twenty-eight semi-structured interviews for a UNAIDS consultancy. Purposive sampling was used to identify respondents by the management of the NAC, UNAIDS staff and myself. I interviewed a wide range of people, which included some of the people I interviewed for the sixty interviews mentioned above. They mainly held positions of directors, programme managers and advisers. Questions focused on macro level issues relating to national HIV/AIDS responses to the NAF; Monitoring and Evaluation (M&E); and finance and administration (see

Appendices 6 and 7). I conducted face-to-face interviews in all three regions in Malawi to ensure geographical representation. Due to time constraints, surveys were also sent to respondents by email and fax to increase the total number of respondents and nine completed questionnaires were returned by email or fax. The 133 interviews fed into my overall analysis and relate back to my analytical frame (Figure 1.3).

### **Funding proposals**

In addition to interviews I obtained forty-three funding proposals at Balaka District Assembly submitted by CBOs in the district. These proposals were active, approved but not funded. I wanted to see if harmful cultural practices were referred to by CBOs and the district government to construct narratives of blame to obtain funding, which in turn can then be taken on by international donors to justify continual funding of HIV/AIDS programmes. See chapter five for an analysis of these proposals.

### **Literature search**

I searched academic literature to build up a picture of how HIV/AIDS and cultural practices had been addressed in the international field. I identified literature by searching for key works relating to HIV/AIDS in Sub-Saharan Africa in electronic databases. I also conducted physical searches of the libraries of organisations in Malawi and the UK. The range of sources I consulted ensured that this review was comprehensive and included many types of documents: policy documents; training manuals; peer-reviewed articles; grey literature including unpublished research reports; proceedings from conferences and meetings; newsletters; policy briefs; and PowerPoint presentations. Although I focused on documents referring to HIV/AIDS, cultural practices, human rights and gender, the review was far too extensive and I collected far too much data than was necessary. Two colleagues, both of them key players in the HIV/AIDS field, also gave me access to their private documents.

Offices of government agencies, districts and NGOs were visited to identify and collect additional policy and programme documents. Often documents were difficult to obtain. People withheld information or pointed me to the website which when I visited, had no information uploaded. Newspaper archives were searched for relevant articles published after 1998 and articles gathered spanning a ten-year period. I also kept a journal and recorded notes of the situation I was studying but I also made notes of my personal experiences and feelings as well as typing up relevant newspaper articles I came across. Looking back I wish I had kept more journal notes.

### **Conferences and meetings**

I attended many meetings whenever the opportunity arose. For example, I attended the Regional HIV/AIDS Research Dissemination Conference for the Media on 19/12/2008; the Parliamentary Committee Meeting on HIV/AIDS on 13/01/2009; the Demographic Health Survey Meeting and the NAC conference. These meetings provided excellent networking opportunities as well as obtaining further data. I took notes during the meetings and obtained presentation slides.

### **Data analysis strategy**

Analysis of interview transcripts and fieldnotes took an inductive approach. 'Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis' (Patton, 1980, p. 306). Thomas identifies three salient points that are consistent with the inductive analysis approach:

1. To condense extensive and varied raw text data into a brief, summary format;
2. to establish clear links between the research objectives and the summary findings derived from the raw data and to ensure that these links are both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research); and
3. to develop a model or theory about the underlying structure of experiences or processes that are evident in the text data. (Thomas, 2006, p. 238)

Data were analysed adopting elements from grounded theory (Glaser & Strauss, 1967), which is common when adopting the inductive approach (Strauss & Corbin, 1998) where line, sentence, and paragraph segments of the transcribed interviews and fieldnotes are reviewed to decide what codes fit the concepts implied by the data. I used the analysis of my early data as a way of raising new research ideas and I continuously questioned my findings. As mentioned earlier, the research I conducted in a village in Lunzu I thought would be the bulk of my data; but after I had gathered the data and spoke with an informant who had considerable knowledge and expertise of cultural practices in Malawi she informed me that Lunzu was not a useful research site so I was forced to re-evaluate my questions and findings and continue the data-gathering journey.

In-depth interview data (n=60) were the main data source used in this thesis and these data were coded. I identified patterns in my data by means of thematic codes and each code was compared to other codes to identify similarities, differences, and general patterns. For example, I saw recurring themes and words that interviewees would use, such as 'harmful cultural practices', 'christianity' and their naming towns and villages that they felt the cultural practices were located such as Nsanje and Mangochi. Findings from each coding process were recorded in a codebook as a part of interim summaries. Saunders, Lewis and Thornhill (2009) recommend the use of interim summaries to keep a record of progress to achieve conclusions, including what has been

discovered to date and what needed to be accomplished to ameliorate the quality of findings.

To conclude this section data were reduced and analyzed by means of thematic codes and concepts (see Box 1). Themes emerged as a result of reading the interview transcripts many times and taking on board what I discovered during the initial literature review. At successive stages, themes shifted from being relatively unimportant to becoming major, overarching themes based on the evidence provided by the data. The emerging themes (Box 2.3) became the major findings of my study.

**Box 2.3 – Themes addressed in this thesis**

1. Harmful cultural practices	2. HIV/AIDS	3. Gender-based Violence
Understanding the Link between Harmful Cultural Practices and HIV	Understanding of the epidemiology of HIV	Understanding of harmful cultural practices and violence towards women
Link between HIV and <i>fisi</i> practice		

**Conclusion**

In this chapter I have demonstrated how the influential work of Mosse (2011) and Crewe and Harrison (1998) helped me to develop my analytical framework, which illustrates the many different actors involved in influencing policies and programmes on HIV/AIDS and sexual cultural practices in Malawi. This is important as the rest of the thesis will essentially be focused around unpacking the analytical framework. I described my role as an actor in the research process and how I came to have an insider’s view by positioning myself as a consultant in the NAC, and by living with development professionals. Finally I described the methodology I used, the data I collected, and the data analysis strategy I adopted.



## **CHAPTER 3 The Situation in Malawi: Development Aid, HIV/AIDS and Cultural Practices**

This chapter is structured as follows. First, a brief history of the development aid situation in Malawi is given to highlight the reliance of the National Government on external aid to address high HIV prevalence rates. Second, I provide data from the consultancy I carried out for UNAIDS and set the donor scene on HIV/AIDS prevention in Malawi. I demonstrate how the HIV pandemic is widely considered an emergency and I highlight how HIV/AIDS have been represented as an exceptional circumstance, justifying specific policies that carefully target the high prevalence rate. Third, I look at HIV and cultural practices in Malawi and present the epidemiology of HIV to demonstrate that sexual cultural practices I have identified in this study do not contribute significantly to the spread of HIV. And finally, I present a more complex overview of how patriarchal values lead to the subordination of women and render them helpless when negotiating safe sex and this is one of the underpinning reasons behind HIV/AIDS.

### **Population and geography**

Malawi, affectionately known as the Warm Heart of Africa, is a landlocked country in sub-Saharan Africa bordered by Mozambique, Tanzania and Zambia. It is small – less than half the size of the UK – with a population of 15.4 million (National Statistical Office [NSO], 2008) and has an intercensal population growth rate of 2.8 percent per year. Despite 85 percent of the population living in rural areas Malawi is extremely densely populated with a population density of 139 persons per square kilometre in 2008. Its economy is mainly dependent on agriculture, which accounts for 30 percent of the Gross Domestic Product. Tobacco, tea, and sugar are the major export commodities (National Statistics Office and ORC Macro 2011). Malawi has three administrative regions; Northern, Central and Southern which are divided into twenty-eight districts. It has nine major ethnic groups. The national language is *Chichewa*, spoken, and English is the official language. Malawi was ruled by Britain and known as the Nyasaland protectorate from 1891 until July 1964, when Nyasaland became Malawi, and gained republic status in 1966 (National Statistics Office and ORC Macro, 2011).

Despite having notable natural resources, according to the United Nations (UN) Malawi is referred to as one of the world's least developed countries, displaying a low Human Development Index (HDI) rating along with low socioeconomic development indicators. Its ranking on the UN's HDI is 171 out of 187 countries; 0.385, below the mean for sub-Saharan Africa of 0.389 and its per capita

GNI is estimated at \$911, below the mean for sub-Saharan Africa of \$2050 (UN, 2011). In other words, Malawi is facing devastating levels of poverty, and people are dying, which is not only reflected by official statistics but also by the number of coffin shops present on the streets of Lilongwe and Blantyre. Two thirds of the population live below the national poverty line and more than one in five people live in ultra poverty – unable to afford basic minimum food requirements (UN, 2011).

### **The aid scene**

Malawi has been receiving aid since its independence in 1964. According to the World Bank the gross national income per capita in 2011, was US\$360, with 50.7 percent of the population living below the national poverty line (World Bank, 2013). The Government of Malawi relies heavily on external aid to purportedly improve the economy and the welfare of its people. External aid amounted to 40 percent of the national budget and between 2007-2009 aid contributed approximately a fifth of the country's GNI (World Bank, 2011). In 2008 Malawi received close to US\$1 billion in official development aid including from Britain, Japan, USA, the IMF, the World Bank (Myroniuk, 2011). Despite this aid dependency, Malawi experienced rapid growth between 2005 and 2010 and its economy grew at an average of 7 percent. The World Bank credited this to 'sound economic policies and a supportive donor environment' (World Bank, 2013). When the former President Bingu wa Mutharika and his Democratic Progressive Party won a landslide second term in the May 2009 elections it was seen as a remuneration for their success since their first election victory in 2004. However, since 2010 Malawi's economic growth began to slow (Wroe, 2012). According to the World Bank this was due to a deterioration in the policy environment (World Bank, 2013). This has resulted in foreign exchange and fuel and electricity supply shortages and the cost of living keeps going up.

In the late 1970s the International Monetary Fund and the World Bank offered financial assistance to poorer countries, whilst applying a neoliberal economic ideology as a precondition to receiving the funds. Many countries accepted the economic liberalisation measures and introduced rigorous structural adjustment policy reforms. Malawi was one such country. In 1979, with support from both institutions, and in response to a declining macroeconomic situation, the Malawi Government implemented economic stabilisation and structural reforms (Conroy et al., 2006). The IMF stabilisation policies aimed at restoring external sector balances through exchange rate management reforms and balance of payment support through Stabilisation Adjustment Loans (SALs). On the other hand, the World Bank provided development and reconstruction funds

through Structural Adjustment Policies (SAPs) and the Fiscal Restructuring and Deregulation Programmes (FRDP) (Malawi Government, 1999).

These structural reforms were adopted in an attempt to liberalize the economy, broaden and diversify the production base, and allocate resources more productively (Munthali, 2004). Although the specifics of SAPs differ, four basic elements are always present: currency devaluation, the removal/reduction of the state from the workings of the economy, the elimination of subsidies in an attempt to reduce expenditures, and trade liberalization. Such prerequisites are intended to lead to the 'adjustment' of malfunctioning economies in order to become viable components of a global system (Riddell, 1992).

The IMF and World Bank argued that such programmes would reduce poverty. However, this model of development, whereby the North impose their conditions on the South, came under attack. Critics subscribe to the view that the programmes of the IMF and the World Bank in fact increase poverty. They postulate that following the ideology of neoliberalism has required poor countries to reduce spending on social issues including health, education and development, while debt repayment and other economic policies have been made the priority (Sadasivam, 1997; Macleans, Geo-Jaja & Mangum, 2001). Evidence shows that neglect and underfunding of the social sector particularly education and health, negate the development of a skilled labour pool, the capacity and capability build-up in research and policy, and the provision of the management talents demanded in an adjusting economy. As Stiglitz points out:

The IMF likes to go about its business without outsiders asking too many questions. In theory, the fund supports democratic institutions in the nations it assists. In practice, it undermines the democratic process by imposing policies. Officially, of course, the IMF doesn't 'impose' anything. It 'negotiates' the conditions for receiving aid. But all the power in the negotiations is on one side—the IMF's—and the fund rarely allows sufficient time for broad consensus-building or even widespread consultations with either parliaments or civil society. Sometimes the IMF dispenses with the pretence of openness altogether and negotiates secret covenants. (Stiglitz, 2000, p. 56)

One report critical of World Bank conditionality produced by the Dutch NGO ASEED was based on desk research from country case studies including Malawi. The report concluded that privatization and liberalization policies that are neither designed, nor desired by countries are still pushed through by the World Bank; it also reported that the implementation of World Bank promoted policies correlated with an increase in levels of poverty. The report called for the Dutch government to demand a phase out of economic policy conditionality, which would have brought it in line with other European governments, including the UK and Norway (ASEED, 2008).

The IMF in 1999 replaced Structural Adjustment Programmes with Poverty Reduction Growth Facility (PRGF) and Policy Framework Papers with Poverty Reduction Strategy Papers (PSRP) as the policy framework for determining loan and debt relief. PRSPs set out a country's macroeconomic, structural and social policies to improve growth rates and reduce poverty. Such strategies for reform were necessary for World Bank loans or lending by the IMF under the poverty reduction and growth facility. However, many critics uphold the view that the PRSPs are as equally detrimental as the SAPs. Countries still have to fulfil donor criteria; therefore, aid is still tied to conditionalities. Further, they did not incorporate gender, race and poverty interests (Bretton Woods, 2004).

The Millennium Development Goals (MDGs) are also a further initiative to reduce poverty. Economic growth rates are not considered part of the MDGs, however there is widespread agreement that the MDGs have placed poverty reduction at the centre of the development agenda at least in international discussions and policy discourse (Watkins, 2011). At the Millennium Summit in September 2000 the largest gathering of world leaders in history adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets, with a deadline of 2015. The MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions-income poverty, hunger, disease, lack of adequate shelter, and exclusion-while promoting gender equality, education, and environmental sustainability. They are also basic human rights-the rights of each person on the planet to health, education, shelter, and security. The purpose of the MDGs was not to change thinking but to change policies and outcomes. They were designed to 'encourage sustainable pro-poor development progress and donor support of domestic efforts in this direction' (Manning, 2009, p. 19).

Critics of the MDGs say they were cobbled together in order to make politicians look grand for the UN millennium declaration in 2000; targets were set in the absence of any idea of how they were going to be met, how much it would cost, or where the money was coming from. The 'one size fits all' target percentage reductions mean that countries that have achieved a lot in the past have big difficulties in meeting the goals, and gains (or lack of them) took no account of distribution across socioeconomic groupings and that they are a factor in the rise of disease specific global programmes instead of sector-wide reforms. A further criticism of the MDGs is that they do not track misconceptions concerning the HIV virus. As England said: 'We will not achieve better health care for the world's poor without better national health systems to fund and deliver it, and we

will not achieve that without a better international system for aid' (England, 2007, p. 565).

Malawi decided to adopt a MDG-focused national plan to reduce poverty called the Malawi Growth and Development Strategy (MGDS 2006-2011) (Kenny & Summer, 2011). The MGDS presented a policy framework that addressed six thematic areas which were sustainable economic growth; social protection; social development; management and prevention of nutrition disorders and HIV/AIDS; infrastructure development and improved governance. Despite developing a 'home-grown overarching national policy for creating new wealth, for achieving sustainable economic growth and development and for combating endemic poverty' (GoM, 2007, p. 2) the former President of Malawi, Bingu wa Mutharika, faced a strict set of aid conditionalities to disburse the US\$5,3 billion in foreign aid received between 2004-2011 (World Bank, 2011). He had to run the Malawian economy along guidelines set out by the IMF, abide by various UN agreements, and adhere to Malawi's constitutional framework. Under his rule Malawi faced serious problems with international donors. In November 2009, the Malawian President accused the World Bank and the IMF with causing foreign exchange shortages by forcing the country to liberalize the economy (Bretton Woods, 2013). Throughout 2010 the IMF pressured the administration to devalue the Malawi Kwacha in order to encourage investment and trade but the government ignored the advice. The IMF took the unusual step of asking a group of donors to release their budget support grants to Malawi, which they had been withholding until a new IMF programme was approved. The IMF board shifted the decision for a new programme for Malawi to mid February, raising fears that donors would continue to withhold \$545 million in aid.

International donors became increasingly concerned with the government's failure to devalue the currency and its repeated unconstitutional behaviour, including the stifling of opponents, refusal of holding local elections and Mutharika spending eight million pounds on a private jet. This was expressed when the Common Approach to Budgetary Support (CABS) group, containing Malawi's two biggest donors (the EU and DFID), called a meeting with the government in March 2011. The group announced that it was suspending aid and that it would permanently withdraw budgetary support if the government failed to address its concerns. A leaked cable from the British High Commissioner demonstrated more explicitly why donors were worried. The Commissioner, Fergus Cochrane-Dyett, described Mutharika as 'becoming ever more autocratic and intolerant of criticism' (The Guardian, 2011). The cable also indicated the willingness of the British government to suspend aid if the current state of affairs persisted. When the cable came to light in April, the government promptly expelled the diplomat from the country and Britain responded by

announcing that it would review all of its ongoing financial support of the Malawian government.

The UK Department for International Development, then Malawi's largest bilateral donor with US\$121 million donated per year, of which \$49 million went to funding Malawi's public health sector, made its final aid disbursement to the country in March 2011 and decided not to renew a six-year spending commitment. Other development partners also decided to end or suspend general budget support to Malawi (The World Bank, The EU, the African Development Bank, Germany and Norway) (Tran, 2011), or tried to force change on a host of issues, including Malawi's enforcement of an anti-homosexuality law and government threats to freedom of speech and association. The World Bank withheld \$40 million in funding and Germany suspended \$16.5 million in funding because of the anti-gay laws. Additionally, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) rejected a \$565 million plan due to mostly technical reasons. In total, 40 percent of Malawi's budget comes from foreign donors (Donnelly, 2011).

Following on from the Common Approach to Budgetary Support meeting Mutharika attacked Malawi's donors in a widely reported speech. He accused them of siding with civil society organisations against the government and claimed that, as he was Malawi's leader, donors should privilege their relationship with him. Mutharika's speech did not directly address the concerns raised by donors, referring to them only as 'lies' spread by civil society groups. Donors' decisions to withhold funds had a detrimental impact on Malawi's economy and healthcare system as Malawi's health sector is nearly entirely donor funded. With foreign aid covering about 90 percent of the cost of all medicines in Malawi, drug stock-outs became more common and physicians frustrated they were unable to prescribe medicines, leading to low morale, IRIN (2011) notes. The former President Mutharika stated that Malawi should become far less dependent on donors despite Malawi's reliance on donor aid, which helped lead to substantial gains, including putting 270,000 people on antiretroviral treatment since 2004 (Donnelly, 2011). The former president praised China for its unconditional aid and noted that China does not demand democratic reforms, good governance and anti-corruption drives as a condition for aid and trade (Nyasa Times, 2012).

This is an important section as it has set the development aid scene in Malawi and demonstrates the powerful and influential role international donors play in influencing policy and programmes in Malawi. It highlights how aid conditionality can lead to failure. It also demonstrates how funding is donor led and if donors are not happy with what is happening in the country to which

they are supplying aid, whether it is the way money is being spent or the type of policies the government implements, then they will withdraw funds. It further illustrates how donor policies do not take into account in-country situations and make their own conditions for the release of funds. In all these points made above I make a case that international aid is linked to conditions that often are not evidence based but based on the perceptions often highlighted by the Malawian elites. Further it shows that funding flows from donors can often be volatile and reflect priorities that are not shared by national governments. The next section looks at HIV/AIDS in Malawi.

### **HIV/AIDS**

UNAIDS, the joint United Nations programme on HIV/AIDS, was established in 1996 in an attempt to coordinate efforts to curb the pandemic. At the first ever Special Session on HIV/AIDS of the United Nations General Assembly (UNGASS) in 2001, UN Member States strengthened the response to Millennium Development Goal 6 by unanimously endorsing the *Declaration of Commitment on HIV/AIDS*. This *Declaration* included time-bound pledges to generate measurable action and concrete progress in the AIDS response. Signed by 189 world leaders, the Declaration agreed that HIV/AIDS was a national and international development issue of the highest priority (UNAIDS, 2006). This signed declaration led to increased funding for international HIV/AIDS programmes. At the five-year review of implementation of the *Declaration of Commitment* in 2006, UN Member States reaffirmed the pledges made at the 2001 Special Session. Also, in the *Political Declaration on HIV/AIDS*, Member states committed to taking action to move towards universal access to HIV prevention, treatment, care, and support by 2010 (UNAIDS, 2008).

### **Aids exceptionalism**

AIDS had then become not just a health priority but a global development priority. This can also be seen in the case of Malawi. The National HIV/AIDS Policy (2003) in its preamble summarises the impact of HIV/AIDS as:

- A public health issue because it directly affects the health of large numbers of people in society and reduces the overall health status and well being of the nation.
- A social issue because it adversely impacts families and communities resulting in excessive medical expenses, depleted family savings and leading to disposal of assets.
- An economic issue because it leads to a decline in economic growth, by reducing the productivity of the labour force.

- Development issues because it is weakening institutions and destroying institutional memory in both the public and private sectors—destroying their capacity to formulate, analyze and manage public policies, and develop programmes and strategies essential for economic growth. (GoM, 2003, pp 2-3)

UNAIDS was created because of the argument that the virus was seen as exceptional and discourses on HIV/AIDS have described the virus as exceptional. AIDS exceptionalism – the idea that HIV requires a response above ‘normal’ health interventions – began as a Western response to the virus (Smith & Whiteside, 2010) and the international community have also said it was exceptional (see Whiteside & Smith, 2009; Dionne, Gerland & Watkins, 2013). AIDS exceptionalists emphasise the importance of human rights issues in relation to AIDS. Those against exceptionalism, and particularly well-known, is England, who holds the view that funding for health systems and funding for HIV amounts to a zero-sum game: ‘until we put HIV in its place, countries will not get the delivery systems they need’ (England, 2007, p. 1073). In other words, the HIV pandemic kick-started the introduction of policies never introduced before in public health. This section highlighted how HIV/AIDS has been identified as an urgent problem in Malawi with significant policy and donor attention placed on reducing transmission rates (this section answers my research question three).

According to UNAIDS figures in 2007 an estimated 33 million people were infected with HIV worldwide of which 2.5 million people were newly infected and there were 2.1 million AIDS-related deaths (UNAIDS, 2007). Southern Africa is the area hardest hit by the pandemic, accounting for 68 percent of the global population living with HIV and almost 32 percent of all new HIV infections and AIDS-related deaths globally. It is projected that by 2015 more than 45 million people will have died from AIDS-related illnesses globally. A further 200 million people will be directly affected, based on conservative estimates that only 1 in 5 members of the family will be affected by each person who dies, and an additional 200 million people will be less directly affected (Poku, 2005). However, the long-term impact of HIV/AIDS is hard to measure, because there is a differential impact over time as an infected individual’s health deteriorates, and a time-lag between infection and death (Poku, 2004).

### **HIV in Malawi**

This study is concerned with heterosexual transmission, which, as is the case in most developing countries, accounts for approximately 80 percent of infections in Malawi. There are two HIV strains: HIV-1 and HIV-2. HIV 2 is rare and most commonly found in West Africa (Grant et al.,



2001). This research is concerned with HIV strain 1 (HIV-1), the only strain identified in Malawi. With the advent of highly active antiretroviral therapy (HAART), HIV-1 infection is now manageable as a chronic disease in patients who have access to medication and who achieve durable virologic suppression (Palella et al., 1998).

Figure 3.1 – No AIDS in Malawi

# No aids in Malawi —village headman

by Peter Makossah

A village headman from Chief Mponda's area in Mangochi has said there is no HIV/aids scourge in the country and that it is not the duty of traditional leaders to tell people in communities about a disease that does not exist.

Group Village Headman Makunganya made the remarks on Wednesday from his home when a group of Journalists attending a Malawi Human Rights Commission workshop on the role of the media in combating discrimination and intolerance

against people living with HIV/aids visited his area for a field trip to assess the impact of the scourge on the ground.

"There is no disease called Aids in the country as government and other people claim. What we have is a plague. God is very angry with what we are doing. You won't tell me that people were not dying in the past? What killed them? Was there Aids at that time?" queried Makunganya.

He said people are failing to work hard in life fearing they would die since it is projected that everybody will die from the disease.

When asked what role as a chief he plays in sensitising his subjects on the pandemic Makunganya retorted that it is not his duty and responsibility to tell people about an imaginary disease.

"It is not my duties and responsibility as a chief to talk to my subjects about diseases that are created to confuse people," he said.

But Orison Chaponda, a principal education, information and training officer at the Malawi Human Rights Commission (MHRC) said the headman's views are a clear indication that there is need for people in the country to be sensi-

tised on the dangers of the scourge.

Said Chaponda: "This is why we invited media practitioners so that they see the real situation on the ground and see how people understand the scourge. The media must come in to remove these misconceptions."

Malawi is an important case study because it is situated in the region hardest hit by the pandemic. By 2006 Malawi was one of ten countries with the highest prevalence. Malawi has one of the highest national prevalence rates in the world and suffers from one of the highest HIV prevalence rates in sub-Saharan Africa, with adult (15-49) HIV prevalence estimated at 11 percent (UNAIDS, 2006). Heterosexual contact is the principal mode of HIV transmission, while mother-to-child transmission (MTCT) accounts for about 25 percent of all new HIV infections (NAC, 2004).

Within Malawi HIV prevalence varies: prevalence is greater in the south (20-22 percent) than the north (8 percent) and centre (7 percent); and greater in the urban than rural areas, although it has spread to formerly less infected rural areas (MDHS, 2004). This is very significant because harmful cultural practices are largely rural practices but yet infection rates are lower in these contexts. This highlights the inaccuracy in the elites' narrative blaming rural harmful cultural practices for high prevalence rates. The problem is ironically much higher in urban areas where the elites live.

According to reports, the first AIDS case was diagnosed in Malawi in 1985 (GoM, 2012). Prevalence had escalated from 1.7 percent in 1987 to 14.3 percent ten years later. In recent years as the epidemic has matured the prevalence is now declining. In the early stages of the epidemic more men were infected than women, but as it matured 20-40 percent more women are infected than men. In 2008 at the time the fieldwork took place 57 percent of infected adults were women. The total population of women that were HIV positive was 13.3 percent, compared with 10.2 percent of men. HIV prevalence rates do not differentiate between those recently infected, whereas the incidence rate measures the number of new cases arising in a given period in a specified population.

According to the MDHS report 2004, 40 percent of newly reported HIV infections occurred in people under the age of 30 years and of these, almost 60 percent occurred in women and girls. Women thus start getting the infection at a younger age than men; the prevalence among women age 15-19 is 4 percent compared with less than 1 percent for men of the same age. However, HIV prevalence among women is higher than that for men until age group 30-34 and 35-39. At ages 40-49, the prevalence among men is again lower than the prevalence among women. The key point is that HIV prevalence rates are higher amongst women age 30-34 (18 percent) compared to 3.7 percent of women age 15-19. This supports my argument that cultural practices which involve young girls' initiation into womanhood cannot be blamed for the spread of HIV when infection rates are higher amongst women aged 30-34 (MDHS 2004 p. 230).

### **Malawi's response to HIV/AIDS**

This next section explores Malawi's response to the HIV pandemic. It describes funding for HIV in Malawi and how funding has changed over time and how that situates within the overall aid provision.

In 2004, a set of guiding principles for national AIDS responses, known as the 'Three Ones' principles, were agreed upon by implementing donor and development partners and institutions.

UNAIDS has played a role as facilitator and mediator for all partners in country-led efforts to apply the principles. The ‘Three Ones’ are considered the optimal architecture to ensure that partners at country level join forces to reach the goal of universal access for prevention, treatment, care and support.

The ‘Three Ones’ principles focus on greater national ownership, harmonization and alignment. In 2005, to strengthen the application of the ‘Three Ones’, national governments, bilateral donors, civil society, the GFTAM, and UNAIDS established the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors. Its purpose was to develop a set of recommendations to enhance key components of the AIDS response – for example, the quality of AIDS action frameworks or strategic plans. The Global Task Team also recognized that more intense efforts would be needed to create strong organisational relationships and partnerships at the country level to support an improved AIDS response.

### **Box 3.1 – The ‘Three Ones’ Principles**

The ‘Three Ones’ are:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners (e.g. a national AIDS strategic framework and/or action plan);
- One national AIDS coordinating authority with a broad based multisectoral mandate;
- One agreed country-level Monitoring and Evaluation (M&E) system.

Malawi met the requirements of the ‘Three Ones’ at the national level by having one coordinating body (the NAC), one national framework (the NAF) and one M&E framework.

### **The National AIDS Commission**

At the time of conducting this research the National AIDS Commission (NAC) was established to provide overall leadership and coordination of the national HIV/AIDS response. It is the national authority for HIV/AIDS in Malawi. NAC’s objectives are:

- To reduce the incidence of HIV and other STIs;
- To improve the quality of life of those infected and affected by HIV/AIDS;
- To mitigate the impact of HIV/AIDS on the Malawi society; and
- To manage any emerging issues related to HIV/AIDS.

To achieve these objectives, NAC is responsible for:

- coordinating the National multi-sectoral response to HIV/AIDS;
- facilitating the development and implementation of Government policies on HIV/AIDS;
- mobilizing resources for HIV/AIDS and facilitate access to those resources by organisations involved in HIV/AIDS activities;
- advocating that all political, community, civil society, religious and traditional leaders play a strong, sustained, and visible role in the prevention of the spread of HIV, the care of people with AIDS, orphans, care providers and all those affected; and
- monitoring and evaluating the national response to ensure an effective and efficient use of resources.

It is in the mandate of NAC to coordinate the M&E of all HIV/AIDS interventions in the country. As such, NAC plays a leading role in developing the National M&E Plan and in ensuring proper data collection, management and dissemination. NAC compiles data that have been collected by its partners and assists partners with the development of appropriate M&E strategies, systems and tools. It also provides capacity building where needed, to ensure collection of high quality data. The Planning, Monitoring, Evaluation and Research Department in NAC is responsible for coordinating the national HIV/AIDS M&E system.

The functions of the NAC Secretariat are to:

- provide day to day coordination of the multi-sectoral national response to HIV/AIDS;
- liaise with Government, donors and other organisations and agencies in HIV/AIDS programmes and related health services to oversee implementation of the National HIV/AIDS Strategic Plan;
- coordinate the implementation of the National HIV/AIDS Strategic Plan, raise and receive funds and donations to be applied for the national HIV/AIDS programme;
- ensure grant proposals for funding meet grant facility agreements and support an effective and efficient response to the epidemic;
- develop an Integrated Annual Work Plan (IAWP) and budget;
- ensure policy development to guide the HIV/AIDS response;
- provide information and guidance to stakeholders as requested;
- publish any technical or other information and communication as it deems necessary or expedient for the coordination of the HIV/AIDS response;
- establish and build partnerships that support the implementation of national HIV/AIDS

programmes; and

- ensure an effective and efficient national M&E framework for HIV/AIDS.

### **The National Action Framework**

In response to the challenge of HIV/AIDS the Government of Malawi, in close collaboration with donor government/agencies and the United Nations family, developed the National Action Framework (NAF 2005-2009). The NAF guides the implementation of a multi-sectoral response from 2005 to 2009 and recognizes the importance of high level political support and commitment at all levels; partnerships with a wide range of stakeholders; a coordinated response based on the principle of the 'Three Ones'; consideration for gender, stigma and discrimination and involvement of Persons Living with HIV (PLHIV); the use of cost-effective, evidence based interventions. It was developed, so it was claimed, through a consultative and participatory process, informed by a performance evaluation of the previous framework and evidence of effectiveness.

The NAF has an overall goal and eight pillars. The goal of the NAF is *to prevent the spread of HIV infection among Malawians, provide access to treatment to PLHIV and mitigate the health, socio-economic and psychosocial impacts of HIV/AIDS on individuals, families, communities and the nation*. The eight pillars are as follows: Prevention and behaviour change; treatment, care and support; mitigation: socio-economic and psychosocial; mainstreaming, partnerships and capacity building; research and development; monitoring and evaluation; resource mobilisation, tracking and utilisation; and national policy coordination and programme planning.

### **The National Monitoring and Evaluation Plan**

The National HIV/AIDS Monitoring and Evaluation (M&E) Plan was created to track progress in implementation of the National HIV/AIDS Action Framework for 2005-2009. The goal of the Plan is to provide Malawi with relevant and accurate information that would be useful in evidence-based decision making, planning and implementation of HIV/AIDS interventions. The M&E Plan sets the minimum performance standards for managing and achieving accountability benchmarks for the national HIV/AIDS response. It has been aligned and harmonised with the NAF and has enhanced the principle of the 'Three Ones'.

### **Annual Integrated Work Plan (AIWP)**

NAC and its partners also produce IAWPs. These plans encompass the integration of all activities by major implementing partners supported by funds through NAC or outside the NAC funding

mechanism and the premise for the Plans is the 2005-2009 NAF. The main focus of the IAWPs was to achieve greater decentralization in the national response by directing more resources to communities through the local authorities (district Assemblies), increase attention to gender needs, and direct the national response to interventions and programmes stressed as key in the NAF 2005-2009.

In 1999/2000 a National Strategic Framework (NSF) for HIV/AIDS was developed to cover the period 2000 to 2004. Based on an End of Term Review of the NSF, which used a nationwide participatory and consultative approach, the Government completed a National HIV/AIDS Action Framework (NAF), to galvanize an expanded, multi-sectoral, national response to the epidemic for the period 2005-2009. The End of Term Review of the NSF revealed challenges and new developments in the fight against HIV/AIDS that were not envisaged when it was developed.

The NAF is a fundamental reference point for all stakeholders involved in the national response to HIV/AIDS. It defines Eight Priority Areas, namely; (i) prevention and behaviour change; (ii) treatment, care and support; (iii) impact mitigation: economic and psychosocial; (iv) mainstreaming, partnerships and capacity building; (v) monitoring and evaluation; (vi) research; (vii) resource mobilisation, tracking and utilisation; and (viii) national policy coordination and programme planning.

### **Partners involved in the national HIV/AIDS response**

A desk review was carried out to identify key partners involved in the national response in Malawi. Partnerships are needed to ensure an effective HIV/AIDS response. Several platforms have been established including:

1. the Malawi Partnership Forum, with membership from all HIV/AIDS partners;
2. the Pooled Donor Group and the HIV/AIDS Development Group (HADG);
3. The Malawi Global Fund Coordinating Committee (the Country Coordinating Mechanism);
4. the Local and International NGO HIV/AIDS Fora;
5. the Malawi Interfaith AIDS Association (MIAA);
6. the Malawi Business Coalition on AIDS (MBCA);
7. the Malawi Network for People Living with HIV/AIDS (MANET+);
8. the Malawi Network of AIDS Service Organisations (MANASO).

NAC facilitates these partnerships, and supports coordination between stakeholders. Further key partners involved in the response are listed below however this list is not exhaustive.

First, the Office of the President's Cabinet (OPC). The President is the Minister Responsible for HIV/AIDS, and provides overall leadership on matters of HIV/AIDS. The Minister also appoints the NAC Board of Commissioners. The Department of Nutrition, HIV/AIDS in the OPC is the lead Government agency in the national response to HIV and Nutrition, and is responsible for policy, oversight and high level advocacy. The NAC provides leadership and coordination of the response. The specific roles that NAC plays are: 1) Guiding development and implementation of the NAF; 2) Facilitating policy and strategic planning in sectors, including local government; 3) Advocating and conducting social mobilization in all sectors at all levels; 4) Mobilizing, allocating and tracking resources; 5) Building partnerships among all stakeholders in the country, regionally and internationally; 6) Knowledge management to document, disseminate and promote best practices; 7) Mapping interventions to indicate coverage and scope; 8) Facilitating and supporting capacity building; 9) Overall monitoring and evaluation of the response; and 10) Identifying and facilitating HIV/AIDS research priorities.

Second, the Ministry of Health (MoH). The MoH plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention and care. The specific roles of the MoH include: 1) Planning and implementing the Health Sector AIDS Strategy; 2) Coordinating health sector thematic areas; 3) Providing technical support for HIV/AIDS policy development; 4) Providing technical support to other sectors; and 5) Surveillance for HIV/AIDS/STI and behavioural surveys.

Third, the Central and line Ministries. Central ministries such as Ministry of Finance, the Ministry of Economic Planning and Development, the Department of Human Resources Management and Development, the Law Commission and the Human Rights Commission directly or indirectly support the national response. Line Ministries provide services up to the community level. Ministries, departments and para-statal organisations have established focal points for HIV/AIDS, and are expected to mainstream HIV/AIDS into their sectoral work, provide technical support to the response, and organise workplace interventions for staff. All ministries have a budget line for HIV/AIDS activities.

Fourth, Local Authorities coordinate the implementation of the response at district, city level and community levels. They have the responsibility to mobilize resources for community programmes, implemented through CBOs, Support Groups, and Community AIDS Committees

(CACs). District development committees (DDCs) and Area Development Committees (ADCs) complement the work of local NGOs.

Fifth, Development Partners support national priorities, and facilitate implementation with funding capacity building. The development partners assist the government's response in areas such as empowering leadership; mobilization of public, private and civil society; strategic information; and facilitating access technical and financial resources at national level.

Sixth, Private Sector organisations under the coordination of the Malawi Business Coalition on AIDS (MBCA) have the responsibility to mainstream HIV/AIDS through workplace policies and programmes.

Seventh, NGOs, Faith-based Organisations (FBOs) and CBOs form the core of the implementing agencies and carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NAC. The National HIV/AIDS Strategic plan and the NAF of Malawi acknowledge the need for engagement of people living with HIV/AIDS in the national HIV response. A number of organisations have been established at the national and district levels. In general, these organisations are engaged in advocacy, capacity building, networking, and service provision. Among the notable ones are Coalition of Women Living with HIV/AIDS (COWLHA), Malawi Network of AIDS Service Organisations (MANASO), Malawi Network of Religious Leaders Living with or Personally Affected by HIV/AIDS (MANERELA+), Malawi Network of people Living with HIV/AIDS (MANET+), National Association for people Living with HIV/AIDS in Malawi (NAPHAM) and Teachers Living Positively (T'LIPO). These organisations have collaborated in the development of the NSF and joint reviews of the national response and are involved in ongoing provision of prevention, treatment, care and support services.

And eighth, faith-based organisations in Malawi are committed to and involved in promoting Universal Access to prevention, treatment, care and support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups. The Malawi Interfaith AIDS Association (MIAA) and the Christian Health Association of Malawi (CHAM) are two key faith based organisations present in Malawi.



The Malawi Global Fund Coordinating Committee (MGFCC) provides governance and oversight to programmes supported by the GFATM, and consists of GoM, development and implementing partners, and communities affected by HIV/AIDS, TB and Malaria.

Figure 3.2 – Tight trousers spreading AIDS

# Tight trousers spreading Aids'

by Edwin Nyirongo

Some women in Chilumba in Karonga have said tight trousers should be banned in the country because they contribute to the spread of HIV and Aids.

The sentiments were expressed on Monday during the closing ceremony of a training workshop organised by the Livingstonia Synod Aids Programme (Lisap) aimed at finding ways of fighting HIV and Aids in the area. The workshop involved religious and community leaders.

One of the participants, Witness Munthali, a respected woman at Chilumba, said tight trousers have contributed greatly to the spread of HIV and Aids because women deliberately wear them to seduce men.

wear tight trousers to tempt men. And men, weak as they are, sleep with the women thereby spreading the Aids virus," she said.

Munthali observed that incidents of rape are on the increase because of the way women dress.

She suggested that the dressing code be revisited to restore the dignity that women were known for in the past.

Another lady, Lestina Kondowe, said while she did not see any problem with women putting on trousers, sizes should be put into consideration when one buys them.

"Trousers are very good because a woman is able to run or bend comfortably. But trousers should be worn to cover the body, not to expose it further," she said.

Reverend Heston Mfune of CCAP in Chilumba blamed the increase in HIV and Aids on the... solution to improper dressing on the part of women was to put dignity back in the younger generation because he felt that the old ones may have problems reversing their cultural values.

Lisap Zone Coordinator McNills Jere said his organisation has intensified the training of church and community leaders on the dangers of HIV and Aids in order to save the lives of people and thereby develop the country.

Jere said during the discussions, participants were given freedom to suggest ways that could help reduce or prevent the spread of the disease.

He said Chilumba was targeted because it has one of the highest HIV infection rates in...



Clothes like these said to be seductive—Pic: Nation Library

has brought unnecessary behaviour. "When multiparty de- could do anything and dress anyhow, which put cultural values...

## **The Epidemiology of HIV**

Cultural practices such as widow cleansing and *fisi*, when a man is hired to have sex with females as a one-time event at initiation, have been identified as spreading HIV. Many people that I interviewed were unaware of the disease's epidemiology and believed that if you have sex with an infected person once you are highly likely to have contracted the virus.

However, given the epidemiology of HIV *fisi* cannot account for the spread of the epidemic; at least if it is practiced as the tradition says it should be practiced, as a one-time event for cleansing or at initiation. If it is just one time, even if the *fisi* is HIV+, there is a very low probability that the girl or widow would become infected (or that the widow would infect the *fisi*). Some individuals may well become infected through a traditional practice, however the key questions about these practices are linked to potential risk of infection, which in turn depends on: how frequent is sex, how likely is it that one of the partners is infected, and how likely it is that the sex is with a condom. Watkins (2003) conducted research in Balaka, Lilongwe and Mzuzu as part of the Malawi Diffusion and Ideational Change Project (MDICP). She found in these three sites it is widely known that AIDS is sexually transmitted and fatal; however, the probability of becoming infected in a single act of intercourse with an infected person is vastly overestimated.

A study by Boily et al. (2009) suggests that it is extremely difficult to quantify the risk of HIV infection after sexual intercourse with an infected person. If we assume the man is not infected, then obviously the girl will avoid infection. If we assume the man is infected the probability of infection during one coital act is very low. In fact the probability of HIV-1 transmission per coital act in Malawi is unknown. However, two studies do provide evidence on HIV-1 transmission per coital act. First, one study carried out by Boily et al. (2009) involved a review and meta-analysis of observational studies of the risk of HIV-1 transmission per heterosexual act. Sexual transmission estimations were mainly divided in two categories: per act transmission probabilities, which quantify the risk of infection per sexual contact and per partner transmission probabilities, which measure the cumulative risk of infection over many sexual acts during a partnership. As authors point out per-act transmission probabilities are methodologically challenging to quantify (Shiboski & Padian, 1996; Boily et al., 2009). This is a crucial point. How does one measure the probability of infection of one sexual act between the 'older man' and 'young girl'? The answer is we just do not know. We know from scientific evidence that there is a risk- but we do not know much about that risk. It depends on the stage of HIV, other STIs and other co-morbidities. The risk is higher at later stages of HIV compared to early stages (Boily et al., 2009).

Indeed, no clinical trials have been carried out in Malawi to provide evidence to suggest that the *fisi* practice is contributing to the spread of the HIV virus. Gray et al. (2001) also conducted a study of rates of HIV-1 transmission per coital act in Rakai Uganda. They discovered that the average rate of HIV transmission was 0.0082 per coital act (p. 1403). Risks of transmission per act were higher during early and late stage HIV infection. These data were collected from stable heterosexual couples, whose main risk was through vaginal intercourse. While transmission rates of HIV during vaginal intercourse are low under regular circumstances, they are increased many fold if one of the partners suffers from a sexually transmitted infection causing genital ulcers.

It seems that far more men are likely to be infected by bar girls (although sex may not be so frequent with a bar girl, she is highly likely to be infected) because of the high number of different partners she will have intercourse with and by marriage to someone who is infected (sex is likely to be more frequent than with extramarital partners, and condoms unlikely to be used). A lecturer at the University of Malawi told me that, considering no-one knows how prevalent the cultural practices are and what proportion of the population is involved, then it is far more likely that social networks have the potential to spread HIV. In other words, the number of sexual partners and levels of promiscuity facilitated through social networks are largely urban based. It was his view that it had become increasingly common in urban centres for men to engage freely in sex with multiple partners both before and during marriage and this behaviour if studied could well explain the current epidemic. He said there is no robust research but that people just talk about it (P49: 24/10/2008).

In addition to viewing widow inheritance and *fisi* as relatively unimportant in epidemiological terms, the focus on traditional cultural practices is similar to the approach to culture that the ethnographers (anthropologists) of the colonial era took: they were fascinated by the exotic practices they discovered in villages which they viewed as evidence of the uncivilized nature of the communities they observed (e.g. *sati* in India) and that, perhaps, fascinate visiting *wazungu* (white people), when they hear about *fisi* for the first time (S Watkins, personal communication, October 12, 2013). Over extenuating the link between *fisi* and HIV/AIDS transmission serves to project an image of rural communities as backward and uncivilized. This link, as my data presented in the next chapter highlights, has been constructed by the urban elite searching for an explanation for high transmission to present to the donor communities. The explanation, despite the lack of biomedical evidence, is readily accepted by western donors because of the eurocentric lens through which they view poor Africans. The presentation of *fisi* as fundamentally barbaric

and a key root of HIV/AIDS transmission is similar to the distorting way in which the missionaries in Malawi presented female circumcision, signalling it out as evidence of the backwardness of the entire culture which needed to be entirely transformed into something better e.g. Christian (see chapter five where I present data on the role of the church).

All those I interviewed had never seen a sexual cultural practice take place, but the practices were still perceived as negative and are seen as a 'problem'. On one level informants are saying the practices do take place. On another level researchers who had spent a considerable time conducting fieldwork in two districts in Malawi, told me they never heard people in the villages talking about sexual cultural practices. For example, I asked a researcher who had carried out 16 months of fieldwork in a village in Balaka, if people at the village level referred to so-called sexual cultural practices and gender violence at all. She said they did not even amongst people living in Yao territory (J Verheijen, personal communication October 14, 2013). This is particularly relevant to my argument for two reasons. First, she conducted fieldwork in Balaka, a district where I also stayed and conducted 25 percent of my in depth interviews (See Appendix 2). She also said she was working with the Yao tribe. Studies and my interviews reveal this particular tribe is frequently blamed for carrying out the sexual cultural practice of *fisi*. (See pp 67, p120 and p131). However, after having spent 16 months with this tribe Verheijen did not find any evidence to suggest that the practices take place.

Wroe also found that when he conducted research in Dedza in 2013 he did not hear anyone talk about sexual cultural practices and certainly did not link these practices to HIV/AIDS (D Wroe, personal communication, October 14, 2013). This demonstrates that while the Malawian elites seem to be concerned to demonstrate a link in two districts in Malawi people are unaware of any association between HIV/AIDS and harmful cultural practices.

As I have shown, although statistics reveal that prevalence rates are higher amongst women what I have argued through this thesis is that the explanation is more complex than that presented by the Malawian elite. Women are rendered vulnerable to sexual abuse and exploitations by a patriarchal system that sees them as inferior and objectifies them for the purpose of male sexual pleasure. The problem then is not the behaviour of girls and women, but constructions of masculinity that legitimate male sexual behaviour, multiple partners, prostitution, and rape within marriage (rape within marriage is not a criminal offence). All these acts disproportionately increase women's chances of contracting HIV/AIDS, because in situations where the woman is not

consensual to sex, it is forced making her physiologically vulnerable to transmission as bleeding and absorption of bodily fluids becomes more likely. As I show in the next chapter, this more complex explanation is not widely held by my informants. If it were a different set of policies and projects to be implemented that focused much more on male behaviour rather than on cultural practices, then the impact on girls and women would have more potential to empower them.

### **Views on culture**

As this thesis addresses certain cultural practices the next section looks at the concept of culture. The concept of culture is problematic. According to Tylor culture is 'that complex whole which includes knowledge, belief, art, morals, law, custom and other capabilities and habits acquired by man as a member of society' (Tylor, 1871, p. 1). Culture can therefore be seen in a general sense as what constitutes humanity (it is then opposed to 'nature') or it can be seen in a specific sense as what distinguishes a group of people (a specific society) from another one. In other words, culture in the specific sense is 'the patterned way of life shared by a group of people' (Nanda, 1987, p. 68). In the context of AIDS, African culture on beliefs and practices are said to contribute to the spread of HIV.

Current views on culture from an anthropological perspective are far more useful in thinking about AIDS - for example ways that men and women construct sex and gender (Parker, 1991; Schoepf, 1992; Gupta & Weiss, 1993). The reality is the socio-economic environment and how gender relations including power and gender-based violence become part of the environment. Dynamics of power relations have become a major focus for current research, particularly regarding issues pertaining to HIV and women. These can be diverse and can have positive and negative impacts on HIV vulnerability. Many practices may have existed to protect women, such as widow inheritance, but in the advent of HIV/AIDS are now identified as a risk factor, gender plays an important role in structuring perceptions of risk. According to Gustafson (1998) not only are males and females troubled by different risks, they perceive the same risks in a dissimilar way.

Cultural norms are widely held in Malawi that women should be inexperienced and naive in sexual matters and that pleasing men is the primary goal of sex (P7: 30/12/2008, P26: 5/12/2009). Indeed, from very young ages, girls are treated as sexual beings whose primary objective is to please men, while boys are never taught what it takes to please a woman sexually. A review of cultural beliefs and practices influencing sexual and reproductive health and health-seeking behaviour (Matinga, 2003) found that, as in other countries in the region, the main risk factor

concerning sexual and reproductive health in Malawi is that 'being a man' means being dominant and in control, specifically in sexual liaisons. Females who want acceptance in society are expected to be meek, and sexually submissive to the point where it is not acceptable to say 'no' to sex (Coombes, 2001). This may reflect the fact that whereas Malawi's complex history has resulted in the co-existence of both matrilineal and patrilineal kinship systems, both are strongly patriarchal (i.e. power lies with the male members of the family). The belief in the 'powerlessness' of females in sexual decision-making continues to place both women and men - young or old, married or unmarried - at great risk.

The following is an excerpt from my journal notes.

Angela is currently working as a Consultant employed by UNDP. She is working with the Ministry of Agriculture on a communications strategy. She and I talked over lunch about relationships. Angela is from Uganda. We talked about African men. She said African men are the same wherever you are. They have extra-marital affairs and they perceive having more than one woman as moving up the social ladder. She told me her husband had an affair and she did not find out until she was informed that one of the children had died. But not her child, the child her husband had fathered with another woman. Angela is still married to him and I asked why? Why have you not divorced him? She said that in Africa it is difficult to divorce your husband. It is frowned upon – a type of social stigma is attached to divorce. She explained that if she were to divorce her husband then everything she has achieved in her life would mean nothing. (Journal entry, 07/02/2009)

This conversation highlights how male promiscuity is problematic for women locking them into relationships in which their sexual behaviour is highly controlled through views of modesty. They are vulnerable to infection by a construction of masculine sexuality that positively pursues promiscuity. This reality again contests the argument that prevalence is higher in rural communities that carry out harmful cultural practices. Women's weak societal position and practices that remove choice from them compound gender imbalance (Geisler, 1997, p. 92). Men offering to pay more money to sleep with prostitutes without a condom (see Box 2.2) or refusing to wear condoms forces women into unprotected sexual practices. This male dominance extends to exposing powerful elite women to STIs through the sexual behaviour of their men who have mistresses therefore high socio-economic status is, in Malawi, a risk factor for HIV-1 infection and higher HIV prevalence rates are found amongst well-educated women. The societal norms that enable men to engage in multiple sexual relationships both before and after marriage are manifested in extra-marital relationships, divorce and marriage-remarriage cycles. One informant told me 'there is this belief that for you to be recognized as a man in the society you have to have multiple partners' (P42: 07/07/2009). Another informant told me that 'men take pleasure in having multiple sexual partners' (P41: 28/04/2009). Women perceive that they are at risk because their husbands have unprotected sex with other partners and because women are much less

likely to engage in higher risk sex than men (MDHS, survey 2004 p. 201). Men perceive that the risks they face arise from having unprotected sex with other partners. This will persist as long as unprotected pre- and extra-marital sex is seen as a demonstration of manhood and whilst women's weak societal position continues to limit their agency in challenging it.

In Malawi, the government's national HIV/AIDS policy stipulates that: 'many practices, including polygamy, extra marital relations and customary practices such as widow and widower inheritance, death cleansing, forced sex for young girls coming of age (*fisi*) increase the risk of HIV infection' (GoM, 2003, p. 24). In Malawi practices exist that are perceived as culturally acceptable but said to spread HIV by legitimizing high-risk behaviour. These include *chokolo* (widow inheritance), *nthena* (widower given wife's younger sister in the Northern region) widow cleansing, *m'bvade* (unmarried female's post-natal abstinence is concluded by surrogate sex), the use of *fisi* (surrogate) in male fertility in most ethnic groups; the use of *fisi* in initiation rites among the Yao; and the belief that STIs, including HIV, can be prevented by charms and 'vaccines' (Lwanda, 2005, p. 125). Powerful and pervasive beliefs and practices, based on deep-rooted associations between sex, health, and illness, continue to influence sexual and reproductive health and health-seeking behaviour. However, given the secrecy that surrounds beliefs and practices which are linked to fertility, plus the many variations from village to village, it is very difficult to be specific about the extent to which these practices are continuing to take place or where they take place (P26: 5/12/2009; P37: 18/3/2009) which makes the link between them and HIV/AIDS transmission more tenuous.

I will now look at the following practices; polygamy, *fisi* and widow inheritance. I will demonstrate that cultural practices said to be barriers to AIDS prevention are not important compared to other more fundamental problems which are similar to those found everywhere else in the world i.e. extra-marital relationships and promiscuity.

*Polygamy* has been identified by the Government of Malawi as accelerating the spread of HIV. If one partner is infected within a polygamous family the number of persons at risk becomes higher than in a monogamous family. But it is not polygamy which spreads HIV but the practice of unsafe sex. A polygamous family in which all partners practice safe sex in their extramarital affairs is no more at risk than a monogamous family, particularly given that men in a so-called monogamous relationship may still be having affairs. Therefore what is important is not polygamy or monogamy but the practice of safe sex in extra-marital relationships. Furthermore, the legitimization of

promiscuity is the key risky behaviour trait. Fighting against polygamy will not make people practice safe sex. Further, polygamy is deeply ingrained in a number of African cultures, and is part of a complex set of social and economic relations, which means it is unlikely that the practice could be eradicated. Finally despite the extensive polygamy discourse, monogamy dominates in Malawi. The extent of polygamy in Malawi was measured in the 2004 Malawi Demographic Health Survey. Overall 84 percent of all currently married women are in monogamous unions, 12 percent are in polygamous unions with one cowife and 3 percent are in polygamous unions with two or more cowives. These statistics demonstrate that only a small percentage of women are in polygamous unions. This raises questions why the Government of Malawi is concentrating on changing this practice as a root trigger of HIV/AIDS.

*Widow inheritance* is also cited in Malawi's HIV policy as a practice that contributes to the spread of HIV. Wife inheritance is a practice whereby widows are 'inherited' by a male family member of her late husband, often the brother. It was initially designed as an economic relationship, so that the wife and her children could continue to be supported, but is now considered a risk factor in HIV/AIDS transmission. According to Watkins (2008) it is unlikely that widow inheritance does much to transmit HIV. Here it is important to note that the probability of transmission of HIV in a single act of unprotected intercourse is very low – 1 in 1,000 (.001) if there are no current STIs and if the sex occurs outside the brief window period or at the end, when viral load is high. Even if there are other risk factors the risk increases to 8 in 1,000 (.008), still low therefore the probability of the virus being passed on from the brother to the widow or vice versa is very low. However, if the widow or the brother had contracted HIV before the widow inheritance practice took place then if unprotected sex is carried out the probability of contracting the virus can increase. As Lwanda (2005) points out he noted five examples of educated Christian men who had inherited their relatives' widows with tragic results. There were clear signs and symptoms suggestive of HIV/AIDS illness in all cases. Again it is not so much the practice that is conducive to the spread of HIV but the practice and negotiation of safe sex which is crucial to the fight against the epidemic.

*Fisi* is also described in Malawi's HIV policy as a practice which contributes to the spread of HIV during initiation ceremonies. In Thyolo, Malawi, traditional counsellors provide information on the expected conduct of young girls and wives (reinforcing the submissive role) during initiation. Girls who have started menstruating are separated from those who have not. They are advised to 'avoid' male friends because of pregnancy and STIs. Some initiates report that they are taught



how to respond to future husbands when having sex, although secrecy prevents further access to information on this issue. In some areas initiates are taught not to be afraid to sleep with a man and that to deny your body to a man is a 'sin'. During these initiation ceremonies information on sex, sexuality and maternal health is provided. However, rapid external societal changes have taken place, which have brought about changes to the nature of some rituals. For example, traditionally, when a girl and boy who had reached puberty were accepted as 'girlfriend and boyfriend', the closing of the initiation ceremony would present the opportunity for them to consummate the relationship.

As such, they then transformed into adulthood as a married couple. However, amongst some societies, this natural union has been replaced with a ritual in which a man hired as a *fisi* (hyena) performs the sexual act with the female initiates. One explanation for such a practice may be that the introduction of formal education schedules has resulted in girls being initiated at a younger age, and before they are considered ready for marriage. According to Coombes (2001), such rituals are said to increase exposure to STI/HIV and pregnancy, and undermine the human rights of children, and their ability to recognize and resist sexual abuse. This example is clearly an example of abuse and it is implicitly violent but the probability of the young girl (who is a virgin) contracting the virus from the hyena during one sexual act even if the hyena has AIDS is very low (as demonstrated previously when talking about widow inheritance). I have already presented data that shows the transmission rate in this age group to be low therefore no correlation between the *fisi* practice and HIV/AIDS can be evidenced. I have identified three cultural practices which are said in the Law Commission report and by the National AIDS Commission to be conducive to the spread of HIV. However, I have argued that it is not in each case the cultural practice itself but issues regarding negotiation and practice of safe sex (which is also true of practices that do spread AIDS e.g., promiscuity). I will now argue that women's weak position in society is the main cultural contributor for high HIV infection rates amongst women.

### **Gender norms**

In anthropology today culture is not seen as static. Thus socio-cultural factors such as gender play significant roles in the success or failure of health programmes. They shape health-related beliefs, behaviours and values (Kleinman, 2004). 'Gender' refers to the expectations and norms shared within a society about appropriate male and female behaviour, characteristics, and roles (Gupta, 2005). Power relations have a clear causal link with violence or the threat of violence within sexual relationships, and violence, in turn, influences health. Blanc (2001) argues that gender-

based power in sexual relations is frequently unbalanced and that women usually have less power than men.

According to Musopole, 'within the African worldview(s) sexuality is one of those very strong vital forces that make life secure, meaningful and worthwhile' (2006, p. 13). Musopole explains how women are considered to be the passive element and that being barren (unable to get pregnant) is a great curse for a clan and for a woman (p. 14). Men are considered to be the active element they are the seeds and the planters: 'with pride they declare that one garden is not enough for a man. The more women they have sex with, the greater their reputation, they consider themselves as cocks and bulls or he-goats' (p. 15).

Authors (Tawfik & Watkins, 2007; Schatz, 2005; Hattori & Nii-Amoo Doodoo, 2005; Chimbiri, 2007) argue that women do exert some agency in relation to their own sexuality and will use extra-marital affairs as a way of negotiating a better life – either the accumulation of goods or just better treatment. It stands to reason that some women at least must be acting in a promiscuous way given the norms already described in relation to male sexual behaviour. However, in my research, whilst I acknowledge women as active agents and do not wish to reinforce them as passive victims gendered social and sexual norms influenced by cultural beliefs and practices do make it hard for women to exert decision making power and challenge male promiscuous behaviour. (See Box 3.2 below). Many practices may have existed to offer women economic security, such as widow inheritance, and now in the advent of HIV/AIDS are identified as a risk factor; gender therefore plays an important role in structuring perceptions of risk. This may reflect the fact that whereas Malawi's complex history has resulted in the co-existence of both matrilineal and patrilineal kinship systems, both are strongly patriarchal (i.e. power lies with the male members of the family). The belief in the 'powerlessness' of girls/women in sexual decision-making continues to place both women and men - young or old, married or unmarried - at great risk. As an interview with a lawyer from the Human Rights Commission told me (see Box 3.2):

**Box 3.2 – P26 Interview with a Lawyer**

It's normal for men to have multiple sexual partners but not because that is a cultural practice, no, that is an issue of behaviour. But you see that that issue of behaviour is very much influenced by our culture. And hence, we all know worldwide that HIV/AIDS is fuelled by multiple sexual partners, especially in cases where people are not resorting to protected sex. And that is the case in Malawi. Another link that you can see between the influences of our culture on HIV/AIDS spread is that women tend to take a subordinate role in society, usually they are voiceless. So you find that in cases where a man and a woman want to engage in sexual intercourse, you find that the woman is so powerless; as a matter of fact you don't question what a man wants to do, especially for the rural

folk. They will never demand for protected sex, they never bargain for things like condoms. There are a number of factors that contribute to this; the economic factors, because women are trading sex for money and that leaves you at a very bargaining point; the cultural practices that have employed us as women not to question the ways of our husbands for instance. so you find that in the many family set up the women can not say to their husbands that *you know what I think lets go without sex because I don't know if you've been handling yourself right*, No, ok but can we please have protected sex. But, what is the case to me is that our culture has influenced our behaviour, where the man is superior the woman is subordinate, where it is the sign of masculine power to have as many sexual partners as you can, and where it is actually law as custom for a man to have as many wives as possible, and you see how that can really offer a very environment for the transmission of HIV/AIDS coupled with of course other factors. When you look at the issue of HIV/AIDS, mind you, I like a holistic approach to the factors that fuel it because they work so much in complementation of each other, you can never isolate culture as a separate factor, you see that also the economic factors come in because if the women were empowered economically then maybe this whole question of men having multiple sexual partners would have died a natural death because sometimes you are forced to be in the polygamous arrangement because you want to benefit economically. So, when you go try and also explore how these other factors are complementing. The dual system of the law that we have at the moment, I know if you go back to the law commission they will tell you that they've tried to consolidate our marriage laws into one act, and maybe you may wish to explore how they have tackled this issue that for as long as that legislation remains the bill the situation at the moment is that our law recognizes marriages that are constructed under the marriage act that's strictly polygamous marriages, then it recognizes marriages that are constructed under the Christian rights act and customary marriages, which are potentially polygamous; and which, unfortunately, so many of us are governed by. Even myself, I constructed a religious marriage, I went to my church, the Roman Catholic Church; but at the end of the day that's not a marriage under the marriage act. If my husband were to choose to have another wife, he could (P26: 02/05/09).

Another informant told me:

A real man must propose a woman because a woman does not propose a man. So the traditional practice is that you wait for a man to propose you and therefore men take pleasure in having multiple sexual partners and they are known as these are the real men. On the other hand women feel they have to be proposed. That's a sign that you are beautiful. If nobody proposes you, you must be an ugly woman. So those are parts of the social cultural practices that are taking place. While on the other hand traditionally you are initiated not to say no to sexual intercourse because if you say no you are sending the man to another woman and you lose out. Especially in marriage and therefore women have no power to negotiate for safer sexual intercourse. So you have that dilemma. And women are expected to be faithful while it is ok for men to be promiscious. So there is an imbalance. So these are some of the cultural practices that are out there. (P41: 28/04/09)

These passages clearly reveal the root of risky behaviour in Malawi focusing on male promiscuity which is a defining characteristic of heterosexual masculinity.

### **Risky behaviour?**

The advent of HIV/AIDS has provoked a reinterpretation of the impact of cultural practices. They have suddenly been identified as 'risky' or harmful. Some studies carried out have used culture as an explanation for high-risk behaviour which in turn can lead to HIV infection (Rushton & Boegart, 1989; Rushing, 1995; Caldwell, Caldwell & Quiggin 1989). However, targeting specific population

groups as opposed to addressing sexual behavioural issues to a general population is unhelpful. Many cultural practices as illustrated are harmful and violent towards women but do not adversely leave them vulnerable to transmission. Incorrect messages regarding HIV transmission rates are relayed which inhibit effective implementation of programmes. Further, there is danger in using culture as an explanation without understanding the specific context (Oppong & Kalipeni 2004). The category of risk stands for a type of social thought and action. In order to deal with social phenomena such as HIV, risk behaviour needs to alter. The difficulty is how to change behaviour which requires an understanding of the forces behind it? My study reveals two main obstacles to HIV/AIDS eradication; patriarchy and the power dynamics of Malawian society which becomes part of a hegemonic process that helps dominant groups to maintain, reinforce and obscure the HIV/AIDS discourse; that the *fisi* practice is spreading HIV/AIDS.

Beck identifies two perspectives that have traditionally been used to analyze risk behaviour: 'natural objectivism' and 'cultural relativism' (Beck, 1995, p. 162). The natural objectivist approach is based upon scientific knowledge and economic calculation. This model has dominated institutional risk-assessment practices within medicine, health, law, economics and engineering. Within these fields of inquiry, risks have been perceived as measurable phenomena to be identified, assessed and quantified which are therefore compatible with the realist position. With the cultural relativist approach the meaning of risk cannot be objectively determined. Risk is a social reality constructed via the reproduction of shared ideas and values. For relativists, perceptions of risk are culturally formed as a result of the interplay between institutional discourses and individual subjectivities. Thus, relativists posit that risks are inseparable from cultural belief systems and cannot be meaningfully objectivized (Dean, 1999). As a result, cultural relativism is closely aligned with social constructionism within social science. For Beck, he chooses neither natural objectivism nor cultural relativism but flits between two approaches:

I consider realism and constructionism to be neither an either-or option, nor a mere matter of belief. We should not have to swear allegiance to any particular view or theoretical perspective. The decision whether to take a realist or a constructionist approach is for me a rather *pragmatic* one, a matter of choosing the appropriate means for a desired goal. (Beck, 2000, p. 211)

A problems with Beck's risk perception is that he fails to account for the collective and symbolic aspects of risk perception. Risks are not approached in objective isolation by lay actors, but in situated settings with cultural baggage. They must be sensitive to the *mélange* of social, economic and cultural factors which underpin public perceptions of risk. Second, he focuses on what he describes as 'western cultures'. Culture in western societies is on the whole more individualistic

than most social contexts in a country such as Malawi. An example of this can be seen in the failure of AIDS prevention programmes in parts of Africa where the focus has been on individual behavior change (See Beck in Mythen 2004, p95).

In the context of culture-relativism and the study of HIV/AIDS there are problems with the cultural relativist approach particularly in terms of gender and gender based violence. This is the case in Malawi where the girls involved in the practice are not considered of equal status to men who carry out the practice therefore the dominant understanding of human good will be likely to put girl children at a disadvantage. For example where sexual exchange takes place, young girls who are participating in the *fisi* practice may not realize they are subject to unjust treatment such may be the level of normalization of gender-based violence and male promiscuity. So in other words, it is the process through which certain normative views become embedded that must not only be identified but deconstructed if progress on HIV/AIDS is to be achieved.

### **Conclusion**

In this chapter I have looked at the influence national actors have in shaping international perceptions of harmful cultural practices and HIV/AIDS and although that wisdom has shifted it is in part taking a long time to get there because the issues are thrown off course by particular narratives that have been constructed by different elite groups focusing blame on poor, rural communities painted as backwards. This is unhelpful in understanding the real impact practices have on women's lives but also in terms of identifying the root cause of HIV/AIDS.

In order to prevent the spread of HIV the international development community and the Government of Malawi have introduced policies and programmes to eradicate certain practices, which they see as conducive to the spread of HIV. However, I have demonstrated that it is not the practices as such that are increasing infection rates but the underlying behaviour associated with practices, particularly women's subordination and the inability to negotiate safe sex. Women's low status in Malawian society makes them powerless and often unable to speak openly about their own sexual needs. One might disagree with widow inheritance, polygamy and encouraging sex during young people's initiation, but one might also disapprove of homosexuality. It is problematic to use AIDS prevention programmes to fight against practices which are clearly not responsible for the transmission of the virus. It is a waste of resources to focus campaigns on eradicating harmful cultural practices in relation to HIV/AIDS programmes. These campaigns should be reframed as part of the eradication of gender-based violence and promotion of

women's rights. What is important is to make new sexual relations safe, by using condoms and to challenge risky sexual behaviour.

This chapter began by presenting the aid situation in Malawi. It has demonstrated how the HIV pandemic is seen as a priority and significant political and monetary focus has been placed on it. It has also looked at HIV and traditional practices in Malawi and presented the epidemiology of HIV to demonstrate that the specific sexual cultural practices identified in this study do not contribute significantly to the spread of HIV. It is worth acknowledging that there are a range of other sexual cultural practices that do contribute to the spread of HIV however the focus of this study is the sexual cultural practice of *fisi*. It concludes that women are rendered vulnerable to sexual abuse and exploitations by a patriarchal system that sees them as inferior and objectifies them for the purpose of male sexual pleasure. The problem is not the behaviour of girls and women, but constructions of masculinity that legitimate male sexual behaviour, multiple partners, prostitution, and rape within marriage. All these acts disproportionately increase women's chances of contracting HIV/AIDS, because in situations where the woman is not consensual to sex, it is wholly forced.

## **CHAPTER 4 Policies on Harmful Cultural Practices and HIV/AIDS**

In the first section of this chapter I show how harmful cultural practices have emerged as a development issue in global conventions and policies over the past ten years starting with current policies and mapping backwards. In the second section I look at the shift from the global level to the national level and demonstrate how international policy has influenced national policy on HIV/AIDS and harmful cultural practices in Malawi. I then use data collected in Malawi to show how national stakeholders, largely the political elite, have constructed narratives around HIV/AIDS and cultural practices in Malawi which reflect their own narrow and biased view that the backwardness of village people is to blame for the high prevalence of HIV/AIDS.

### **Global policies on gender-based violence, HIV/AIDS and harmful cultural practices**

The UN Secretary General highlighted in a report in 2012 that ‘the Political Declaration on HIV/AIDS recognized the harmful effects of unequal gender norms and practices and pledged concerted action to eliminate gender inequalities’ (UN, 2012, p. 19). In the 2011 UN Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS (UN, 2011) member states agreed to ‘pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection’ (UN, 2011, p. 8). This current global policy suggests that in order for women to reduce the risk of contracting HIV, gender-based violence needs to be addressed. Although this particular declaration does not name specific harmful cultural practices, it mentions the ‘harmful effects of unequal gender norms and practices’ (UN, 2011, p. 9).

In its resolution 2003/45 of 23 April 2003, on the elimination of violence against women, the Commission on Human Rights affirmed that the term ‘violence against women’ meant any act of gender-based violence that resulted in, or was likely to result in, physical, sexual or psychological harm or suffering to women, including, among others, crimes committed in the name of honour, and traditional practices harmful to women, including female genital mutilation, early and forced marriages, female infanticide and dowry-related violence and deaths. It strongly condemned such violence. It emphasised that violence against women and girls, including female genital mutilation and early and forced marriage, could increase their vulnerability to HIV/AIDS. The Commission called upon states to condemn violence against women and girls and not to invoke custom, tradition or practices in the name of religion or culture to avoid their obligations to eliminate such violence.

In this resolution we see that the terms or categories of violence against women and gender-based violence have both been adopted. We also see that specific practices are listed that are deemed harmful to women with the suggestion that these practices may increase women's vulnerability to HIV/AIDS. This resolution is more detailed than the political declaration on HIV/AIDS and calls on member states to condemn violence against women and not to invoke 'custom, tradition or practices in the name of religion or culture to avoid their obligations to eliminate such violence' (UN 2003, p. 4). These global policies show how cultural practices, gender-based violence and HIV/AIDS emerged as key development priorities. The UN General Assembly in its January 2002 Resolution on Traditional or Customary Practices affecting the health of women and girls called upon all states to ratify or accede to the Committee on the Elimination of Discrimination against Women (CEDAW), and to adopt national measures to prohibit traditional practices.

The emergence of harmful cultural practices in global development conventions and policies came about at the 1993 World Conference on Human Rights. The UN Declaration on the Elimination of Violence Against Women (UN, 1993) made the link between gender-based violence and harmful cultural practices and defined violence against women as 'any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women' (UN, 1993, p. 1). Under article 2 it stipulated that violence against women should be understood as:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. (p. 2)

On 7 February 2000 resolution A/RES/54/133 was adopted by the UN General Assembly:

'Traditional or customary practices affecting the health of women and girls'. There are several important points stated in the resolution which are relevant to my doctoral research and hence why I quote from it extensively. Firstly it:

Emphasizes the need for technical and financial assistance to developing countries working to achieve the elimination of traditional or customary practices affecting the health of women and girls from United Nations funds and programmes, international and regional financial institutions and bilateral and multilateral donors, as well as the need for assistance to non-governmental organisations and community-based groups active in this field from the international community. (p. 4)



In other words, it is encouraging international donors to provide technical and financial assistance to developing countries working on eliminating traditional practices because it feels it significantly increases women's vulnerability to violence. Second, it called upon member states to:

(a) To ratify or accede to, if they have not yet done so, the relevant human rights treaties, in particular the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, and to respect and implement fully their obligations under any such treaties to which they are parties;

(b) To implement their international commitments in this field, *inter alia*, under the Beijing Declaration and the Platform for Action of the Fourth World Conference on Women, the Programme of Action of the International Conference on Population and Development and the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights;

(c) To collect and disseminate basic data about the occurrence of traditional or customary practices affecting the health of women and girls, including female genital mutilation;

(d) To develop, adopt and implement national legislation and policies that prohibit traditional or customary practices affecting the health of women and girls, including female genital mutilation, and to prosecute the perpetrators of such practices;

(e) To establish or strengthen support services to respond to the needs of victims by, *inter alia*, developing comprehensive and accessible sexual and reproductive health services and providing training to health-care providers at all levels on the harmful health consequences of such practices;

(f) To establish, if they have not done so, a concrete national mechanism for the implementation and monitoring of relevant legislation, law enforcement and national policies;

(g) To intensify efforts to raise awareness of and to mobilize international and national public opinion concerning the harmful effects of traditional or customary practices affecting the health of women and girls, including female genital mutilation, in particular through education, the dissemination of information, training, the media, the arts and local community meetings, in order to achieve the total elimination of these practices;

(h) To promote the inclusion of the discussion of the empowerment of women and their human rights in primary and secondary education curricula and to address specifically traditional or customary practices affecting the health of women and girls in such curricula and in the training of health personnel;

(i) To promote men's understanding of their roles and responsibilities with regard to promoting the elimination of harmful practices, such as female genital mutilation;

(j) To involve, among others, public opinion leaders, educators, religious leaders, chiefs, traditional leaders, medical practitioners, women's health and family planning organisations, the arts and the media in publicity campaigns with a view to promoting a collective and individual awareness of the human rights of women and girls and of how harmful traditional or customary practices violate those rights;

(k) To continue to take specific measures to increase the capacity of communities, including immigrant and refugee communities, in which female genital mutilation is practiced, to engage in activities aimed at preventing and eliminating such practices;

(l) To explore, through consultations with communities and religious and cultural groups and their leaders, alternatives to harmful traditional or customary practices, in particular where those practices form part of a ritual ceremony or rite of passage;

(m) To cooperate closely with the Special Rapporteur of the Subcommission on the Promotion and Protection of Human Rights on traditional practices affecting the health of women and the girl child and to respond to her inquiries;

(n) To cooperate closely with relevant specialized agencies and United Nations funds and programmes, as well as with relevant non-governmental and community organisations, in a joint effort to eradicate traditional or customary practices affecting the health of women and girls;

(o) To include in their reports to CEDAW, the Committee on the Rights of the Child and other relevant treaty bodies specific information on measures taken to eliminate traditional or customary practices affecting the health of women and girls, including female genital mutilation, and to prosecute the perpetrators of such practices (UN 2000, p. 4).

This is also significant as it also upon member states to adopt and implement policies presented by the UN to reduce harmful cultural practices.

UNFPA also makes the link between women, human rights and HIV/AIDS on its website:

Violence against women has been called the most pervasive yet least recognized human rights abuse in the world. The Vienna Human Rights Conference and the Fourth World Conference on Women also gave priority to this issue and Violence against women is both a cause and consequence of AIDS. Research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of contracting HIV. Male (or female) condoms are irrelevant when a woman is being beaten and raped. Moreover, forced vaginal penetration increases the likelihood of HIV transmission. In addition, the fear of violence prevents many women from asking their partners to use condoms, accessing HIV information, and from getting tested and seeking treatment, even when they strongly suspect they have been infected. Many women are in danger of being beaten, abandoned or thrown out of their homes if the HIV-positive status is known. If HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls. (UNFPA, 2013)

In 2000 a conference report produced by the United Nations' Educational, Scientific and Cultural Organisation (UNESCO) identified a number of key 'cultural features' of relevance in HIV/AIDS prevention, treatment and care in Central and Southern Africa. These were identified as: Individual Based (premarital sex, extra marital sex, infertility, forced sex, sex for pleasure, life skills, fatalism, poverty, unemployment and migration); Family Based (extended families, forced marriages, widow inheritance, domestic violence, gender relations, female genital mutilation and unemployment); Community Based (complacency, discrimination, fears and stigma, social exclusion, traditional healers and medicine, perception and interpretation of illness, illiteracy, poverty, herbal medicine, crime, alcohol and substance abuse); and Institutional Cooperation - Religious institutions and leadership, cultural leaders, NGOs and decentralization. The report adds:

These country assessments have revealed important advancements in the use of the cultural approach to health development. The Conference has noted that cultural factors can be used to mitigate the impact of HIV/AIDS, if effectively integrated policies and programmes are focused at individual, family, community and at national/international levels. Pilot and case studies have shown that interventions at these levels can make significant improvement in the fight against HIV/AIDS. (UNESCO, 2001, p. 7)

The aforementioned paragraphs demonstrate how global policies have been addressing the issues of gender-based violence, harmful cultural practices and HIV/AIDS over the past ten years and how the UN has called upon member states to adopt measures to address such issues. What is confusing and blurred in these policy documents is exactly how the links are or are not understood between HCP, GBV and HIV/AIDS. The documents often (as shown above) list practices and views that are detrimental to gender equality and breach human rights, but what is not set out is how HCP promote values and beliefs that sanction behaviours that render women vulnerable to HIV/AIDS transmission. Confusingly, many declarations and resolutions exist that focus on individual dimensions such as 'gender-based violence', 'harmful cultural practices' and 'HIV/AIDS', without clearly articulating the link between them, this does not help national governments who are expected to implement these policies.

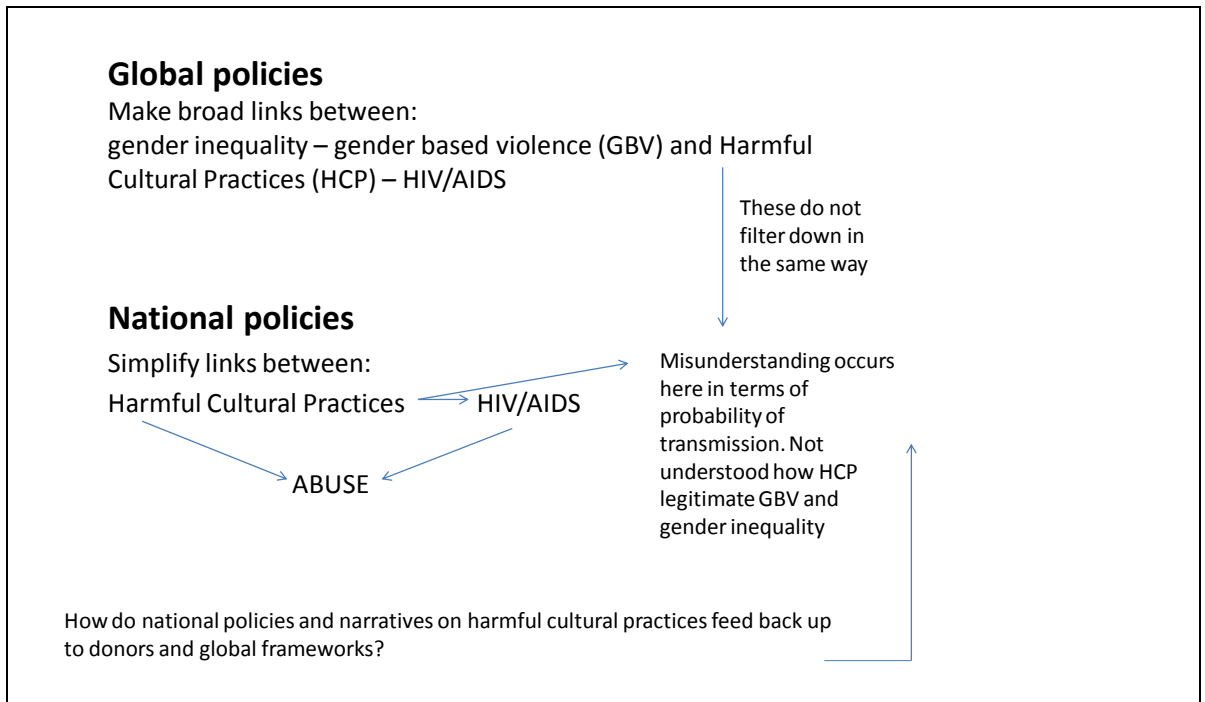
#### **How did Malawi respond to global policies?**

At the 63<sup>rd</sup> UN General Assembly session (2008) agenda item 56 was on the Advancement of Women. Under this chapeau the committee discussed: i) Trafficking in women and girls; ii) Intensification of efforts to eliminate all forms of violence against women; iii) Eliminating rape and other forms of sexual violence in all their manifestations, including in conflict and related situation; and iv) Improvement of the status of women in the United Nations system. In Malawi's statement to the UN on this agenda item, it stated that gender-based violence is a problem for women and girls in Malawi which reinforces the subordination of women and promotes sexual abuse which leads to injury, HIV infection and unwanted pregnancies. The statement also highlighted one of the challenges Malawi faces as it is 'weighed down by gaps between commitment and implementation coupled with continuing contradictions between customary laws, national laws and international commitments' (GoM, 1998, p. 2).

This section demonstrates that at the international level policies are explicitly identifying harmful cultural practices as an obstacle to women's empowerment and to reducing women's vulnerability to HIV/AIDS. As demonstrated with the issue of anti-homosexuality in chapter three we see that a similar pattern has emerged regarding calls to change cultural practices in that the Malawian elite disapprove of their existence – not because they actually see the link with

HIV/AIDS but because they see them as a challenge to their modernity. It also shows how in the case of Malawi pressure from international frameworks to deliver policies is juxtaposed with the political landscape in Malawi in which, as this chapter highlights, national laws seem to reflect the elitist views of a few. International policies differ to implementation at the national level revealing differences in the way actors at these levels perceive the HIV/AIDS and harmful cultural practices problem. At the national level complex internal hierarchies are at play out of which flow rather distorted narratives on who is to blame and why for Malawi’s high prevalence of HIV. I will now look at policies on harmful cultural practices, HIV/AIDS and gender-based violence in Malawi highlighting this disjuncture between how they are talked about in global documents and national frameworks.

**Box 4.1 – Difference between global policies on Gender-based Violence, Harmful Cultural Practices and HIV/AIDS and those at the national level**



**National policies on harmful cultural practices and HIV/AIDS in Malawi**

In this section I address two issues to answer my research questions 4 and 5. I show that the Government of Malawi at the national level oversimplifies links between HIV/AIDS, gender-based violence and harmful cultural practices. I also demonstrate through my interviews that the GoM decided to draft a new piece of legislation on HIV/AIDS to focus on eradicating harmful cultural practices as a trigger for HIV/AIDS. The legislation largely emerged as a response to the pressures

from international donors on the Government of Malawi to find a solution. Malawi's national HIV policy stipulates that:

Some customary practices increase the risk of HIV infection. Among these are polygamy, extramarital sexual relations, marital rape, first aid to snakebite victims, ear piercing and tattooing (mphini), and traditional practices such as widow- and widower- inheritance (chokolo), death cleansing (kupita kufa), forced sex for young girls coming of age (fisi), newborn cleansing (kutenga mwana), circumcision (jando or mdulidwe), ablution of dead bodies, consensual adultery for childless couples (fisi), wife and husband exchange (chimwanamaye) and temporary husband replacement (mbulo). (GoM, 2003, p. 21)

Here as Box 4.1 demonstrates we can see how at the national level a direct link is made between sexual cultural practices and increase of risk of HIV infection; this is a different narrative to those at the international level as we saw earlier with the UN political declaration on HIV/AIDS where the links are not articulated so clearly and where the concern is not so much that HCP directly lead to sharp increases in HIV rates but that they help to sustain an environment in which women are vulnerable to violence. Sexual violence is known to lead to higher transmission rates – but not the HCP themselves.

The following policy statement clearly highlights the direct link the Malawian government made between harmful cultural practices and HIV/AIDS prevalence rates.

Government, through the NAC, undertakes to do the following:

- in partnership with civil society including religious leaders, sensitise traditional leaders and their subjects on the dangers of customary practices such as death cleansing (kupita kufa), forced sex for young girls coming of age (fisi or kuchotsa fumbi), newborn cleansing (kutenga mwana), consensual adultery for childless couples (fisi), wife- and husband-exchange (chimwanamaye), temporary husband replacement (mbulo), and sucking of blood (to help snakebite victims), all of which practices may lead to HIV infection.
- ensure that traditional leaders stop or modify unsafe customary practices to make them safer in order to prevent HIV transmission, or promote alternative customary practices which do not place people at risk of HIV infection (GoM 2003 p. 21).

In 2006 a special Law Commission was set up in Malawi to develop a new piece of legislation on HIV/AIDS. In 2008 a report entitled 'Report of the Law Commission on the Development of HIV/AIDS Legislation' was published. Because the report's content is critical to my argument I quote from it extensively:

At the UN General Assembly in June, 2001, Heads of Governments agreed that strong leadership at all levels of society is essential for an effective response to the epidemic: leadership by Governments in combatting HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector; and that leadership involves personal commitment and concrete actions. Following these

recommendations of UN General Assembly, the NACP [National AIDS Control Programme] was replaced by a new institution, the National AIDS Commission (NAC) in July, 2001, which was constituted as a public trust. (Law Commission, 2008, p. 8)

This demonstrates that as a result of the UN General Assembly Special Session on AIDS in 2001, the Government of Malawi decided to make a fundamental shift in the way that HIV/AIDS was being addressed in the country, eventually ensuring that NAC report to the Office of the President and Cabinet. This was done with 'a view to bringing the highest political office to commit fully to fighting the epidemic and to ensure Government oversight activities at the highest political level' (2008, p. 8).

According to the report, the basis for HIV/AIDS reform was a result of two submissions made to the Law Commission: one from the Department of Nutrition and HIV/AIDS calling for a legislative framework to govern HIV/AIDS issues and one from the NAC calling for a legislative institutional framework to allow for its effective functioning. The special Commission was then established for several reasons including developing a new piece of legislation on HIV/AIDS. The report explains why:

The Commission opted to develop a new piece of legislation on HIV/AIDS principally because the Commission considered the issue of HIV/AIDS as a cross-cutting multi-sectoral issue and as such inappropriate to be tackled under the existing piece of legislation. Secondly, the Commission considered that the proposed law on HIV/AIDS combine issues of prevention and management of HIV/AIDS. (Law Commission, 2008, p. 9)

This is an important point as the Commission refers to HIV/AIDS prevention. However, perhaps as a result of global development policies and the call by the UN for member states 'to develop, adopt and implement national legislation and policies that prohibit traditional or customary practices affecting the health of women and girls' (2000, p. 2, see also, p. 77), did the Government of Malawi decide to draft a new piece of legislation on HIV/AIDS to change specific cultural practices. As the lawyer from the Law Commission revealed:

This reform has come about as a result of various international fora including Cairo ICPD 1994 and Beijing Platform for Action, 1995. It is also stated in the Constitution under Chapter IV human rights Sections 20 and 24. In 1994 a new constitution was introduced including a Bill of Rights. This was a period of new thinking in which human rights needed to be unpacked. (P23: 02/02/2009)

Furthermore when I attended a Parliamentary Committee Meeting on HIV and AIDS who were considering the proposed legislation. a Lawyer from the Malawi Law Commission stated that the UN has raised issues of criminalization that he thinks are pertinent and should be included in the legislation. The Chair proposed that the points made from the floor are taken into consideration

and are included in the proposed legislation at the Secretariat. The MPs agreed. (Journal entry, 13/01/2009)

The report refers to international frameworks including CEDAW:

The vulnerability of women and girls to HIV/AIDS is aggravated by certain cultural and religious practices. The Commission further observed that such practices not only violate the dignity of females but are usually practiced without the express consent of women and befall females mainly on the basis of their sex or marital status. The Commission observed that while the rights to participate in a culture of choice is protected under the Constitution, in most cases, women participate in cultural practices without given free consent due to high dependency on men as wives, mistresses and children. The Commission noted that beyond exacerbating the spread of HIV/AIDS, these harmful practices violate women's rights and also denigrate as such. To this end the Commission concluded that these practices were discriminatory against women. (Law Commission, 2008, p. 33)

The customs and practices in question include widow inheritance, widow cleansing, sexual relations associated with initiation or rites of passage and swapping of spouses, among many others. Most of the cultural practices revolve around sexuality and so it is an integral part. Noting sexual contact as one of the most common forms of transmission, the International Conference on Population and Development (ICPD) Programme of Action with respect to reproductive rights and reproductive health, sets out key recommendations for addressing the spread of HIV and STIs.

The Commission also noted the State's obligation to take all appropriate measures in all fields, including introduction of legislation, in particular relating to culture, for purpose of guaranteeing the exercise and enjoyment of human rights and fundamental freedoms on the basis of equality of the women (see article 3 of the CEDAW). The Protocol also urges State parties to prohibit and condemn all forms of harmful practices which negatively affect the rights of women and which are contrary to recognized human rights standards Article 5 CEDAW). With respect to sexual and reproductive rights, the Protocol urges State parties to observe a number of rights of women in connection with HIV/AIDS including the right to self protection and protection from STIs including HIV/AIDS: and the right to be informed of the health status of her partner, particularly if he is infected with HIV/AIDS Article 14 (1). The Commission observed that during consultations participants were generally in agreement with the prohibition of the cultural practices that are perceived to spread HIV infection. However the participants were strongly divided on the issue of polygamy (p. 34).

Section 24 of the Constitution required the State to pass legislation to eliminate customs and practices that discriminate against women and the National HIV/AIDS Policy which reiterates the

call for outlawing of customs and practices that perpetrate the risk of infection with HIV. The Commission recommended that any person who subjects another person to a harmful cultural practice shall be guilty of an offence and shall be liable to a fine of K100,000 and imprisonment for five years. Under the 'First Schedule' eighteen so-called harmful practices are listed. *Fisi*, the practice with which my own doctoral research is concerned, is number two on the list.

The lawyer as mentioned on the previous page who was working for the Malawi Law Commission carried out most of the preparatory work for two pieces of proposed legislation; one on gender equality and one on HIV/AIDS told me that both pieces of legislation differ as follows: 1) gender equality is related to harm with respect to women in terms of women based purely on their sex. This may include STIs. 2) HIV/AIDS is related to harm with respect to HIV infection.

Cultural practices, he said, have to be covered under both laws. The idea is not to have a case by case study but that the issue of cultural practices falls 'within realm of social regulation'. I asked about evidence to inform decisions to implement the two laws. He said it is not an issue of evidence-based research but rather 'an issue of risk'. I delved further and we talked about the probability of transmission of HIV. 'The truth is in our Commission they told us that it is not very likely from one sexual act'. He said that 'statistics are figures that may just apply to you'. In other words if there is 1 percent chance of contracting the disease then you may be the 1 percent. He pointed out that the issue is also about age of sexual debut. 'Therefore infants may not take levels of precaution'. As a result there is an 'exposure element' which is taken into account rather than the actual risk. In other words children have the right to be protected from all risk – however high or low (P23: 02/02/2009).

We talked about different types of '*fisi*' - Initiation '*fisi*' and conception '*fisi*'. He said for the initiation '*fisi*' prohibition and regulation both come in to play. 'If you are caught then you are punished'. I asked what is the punishment? 'Punishment is imprisonment but if the *fisi* is HIV+ then the punishment is more severe.' I asked about the Commission to which he referred. It was set up in 2007. It comprised an academic who is 'a PLWHA'; a Pathologist; a Priest; a retired civil servant; a representative from NAPHAM; the Head of NAC; a Minister, a representative from Ministry of Justice, a Law Commissioner and two lawyers from the Law Commission. He described it as 'an ad hoc group that has now disbanded'. Members' selection was based on 'relevance and expertise and involvement in the subject' (P23: 02/02/2009).



I then asked which type of law do 'cultural practices' fall under? This appears to be a contentious issue. Some agree and some don't that it falls under criminal law. In terms of developing the proposed legislation the Commission adopted the following three approaches: not to ignore criminal law approach; look at human rights approach and address public health law. There is a law on public health, which was introduced in 1948, that does not include HIV/AIDS. The public health law does deal with all curable diseases which he described as 'explosive diseases' i.e. tuberculosis, cholera. He said that HIV is different – 'the manifestation of the disease is different' (P23: 02/02/2009). He said a largely accepted hypothesis by the Parliamentary Committee is that a 'fusion' between public health and criminal law is needed (P23: 02/02/2009).

He explained there are turbulent times in Parliament regarding passing of laws and big problems as during the last five years not many bills have been passed. I asked where the idea came from to implement such reforms. The idea for the new legislation came from the gender related laws reform programme, which originally came from the Law Commission. There are three parts to this programme:- 1. Inheritance and succession, 2. Report of the law commission on the review of the laws on marriage and divorce and 3. Gender equality.

The Law Commission drafts reports, which are then presented to government. They are 'gazetted' – an endorsement process by government which means they are now a public record. The Cabinet then looks at the document and makes a decision. The document is then presented to Parliament as a government bill, and given a first reading then a second reading. It then goes to the legislature because it has been adopted by government, and an arm of legislation then enacts it. I asked when does he think the legislation on cultural practices will be passed. He said he thought it may happen after the elections in May 2009 but the law was never passed. At the time there were many bills waiting to be passed. For example, the Criminal Law Bill had been waiting to be passed since 1998. The Lawyer went on to provide his critique of the bills. He made two points. First, he said Malawi is not a heavily regulated country. There is a certain freedom to do what one wants beyond the law. He says even if a law is passed it does not mean it is enacted upon but 'looks good in statute books'. Second, he added that there is a strong donor influence to 'do this and do that' and that is why certain pieces of legislation are being drafted (P23: 02/02/2009). This is an important point as it demonstrates the key role donors play in influencing national policy. Further, whereas there is evidence that there is a process of policy scrutiny there seems very little evidence that such a process has any major tangible outcomes on changing policy. However, a close analysis of this process is outside the remit of this doctoral research.

He started to talk about issues of regulating testing and counselling. He mentioned a discussion concerning a law to introduce compulsory testing for pregnant women. He said the 'NGOs were up in arms'. He talked about couple testing - that women need to get tested with their husbands. But he said what is really happening is that women are 'hiring spouses' to attend the clinic with them. He said there are positive aspects of cultural values but there seems to be 'a quest to destroying everything'. Here he is not specific about whom in this episode given the context of the conversation as whole he seems to be applying responsibility to donors. He continued by explaining that 'There is also a pressure to modernise and things are moving faster than society is. If you kill a practice you erase a value and create a vacuum which is difficult to fill'. He said 'What is the principle behind it? How does it affect everyone else?' He personally feels the country should bring in regulation rather than prohibition. He talked about law reform and what law reform actually means. He described it as 'urban legislation – legislation for the elite'. He started to explain *Chokolo*. He said that *Chokolo* is defined as the person who is inherited whereas *Chiharo* is the actual practice. He gave an example of a brother's death. If his brother dies he is responsible for the wife. Some men choose to have sex with the wife which is 'chauvinistic'. However, not all men do and the man may just provide financial support. So if *Chokolo* is prohibited the wife stops receiving support. He said there is a need to be open-minded. He also blames NGOs for trying to change cultural practices (P23: 02/02/2009).

He attended a meeting in Blantyre, which was trying to 'sensitize' chiefs on cultural practices. During the meeting the chiefs said that they have changed the cultural practices. Then whilst he was having a one-to-one with a chief, the chief whispered in his ear 'Why are you trying to take away our privileges?' Privileges here could mean that men have carte blanche to have sex with young girls or women who have started their first menses. Therefore my interpretation is that the chief is referring to taking away their privileges by not allowing them to have sex with young women. Another person interviewed said: 'But also the traditional leaders themselves, although they might hide information, sometimes they can slip off the tongue and tell you some stuff' (P25: 04/02/2009). This point suggests that traditional leaders may not be telling the truth but instead telling those who visit the villages what they think they want to hear, e.g., that the practice is no longer carried out.

One problem with the piece of legislation is how to monitor it, for if it were implemented it would be so difficult to enforce that it raises questions over its viability and the real motives for its design.

#### **Box 4.2 – P5 Interview with a Member of Parliament**

Aaah I was there for a long time and even when we had our own way of coordinating our activities on HIV/AIDS, we were forced to abandon that and take the approved structure by the World Bank and create the National Aids Commission in the way it is now. Aaa, soo, international NGOs have played a big role in fact they call it policy dialogue but it was not really a dialogue but it was a monologue aah so, that's one.

I think aaah, eeeh there has been a lot of international pressure on what the programme on HIV/AIDS should be, aaa, there is also much concern about HIV/AIDS and money of course came from rich countries and big international organisations. And really the agenda was dictated by the international world.

Yaah, when we started the fight against HIV/AIDS the most difficult community that I met were the religious community, the faith based community later on that's how it was labeled. I conducted a workshop for them, in 2000 I think, February, I was lucky because then I was vice president so I could add some power to command (laughter). And I chaired it myself. I said I wanted bishops, the highest echelon of Christianity as well and the Islamic organisations and they responded. We were in the Capital Hotel for eleven hours, I said nobody is going out; no one is going out, if you wanted tea it would be brought in and in that room toilets are inside there, so you just go at the back (laughter). So it was tough, but at the end we, we had an agenda at the end we had twelve points that we said we should discuss I don't remember all of them but they thought I was making it wrong, of course one point about condoms which could, and therefore, Catholic bishops could not ... but we agreed that you know, alright, this on the pulpit, we are not saying that you go and talk about condoms but also respect our responsibility as government to inform the population so don't preach against us (P5: 18/12/2008).

This passage from Box 4.2 reveals that international NGOs influenced the policy process and that the World Bank exerted pressure to lead the creation of the National AIDS Commission. The statement from this informant fits within my argument concerning how donors can have an influential role in the policy process (See chapter 3 where I provide a critique of the World Bank and Structural Adjustment Policies and aid conditionality). For example the MP describes how the Government of Malawi was forced to abandon their own plans and replace them with a structure approved by the World Bank. What would have been interesting to know is what would have happened if the Government of Malawi had decided to continue with their own plans. Would funding have been withdrawn by the World Bank? Because the World Bank injects significant funds in Malawi in the prevention of HIV and AIDS, the Government of Malawi may have been careful not to offend or challenge the donor. Furthermore because the Government of Malawi lacks financial power it may only play a limited role in policy making. This passage also throws

doubts on the assumption in policy analysis that national governments are completely in control of their public policy making processes.

One informant working for ActionAid also made several important points (see Box 4.3); women not knowing that a law exists because they are illiterate; problems with accessing information as well as dealing with the judicial processes and the perpetrators:

#### **Box 4.3 – P36 Interview with a Policy Advisor**

Because a piece of legislation doesn't do anything if you don't report it, and if I don't know about it, it doesn't do anything. So there is that gap, that major challenge in terms of implementing and most of the people that we deal with they are illiterate, they can't read. So that's one challenge in terms of the gap. Filling the gap between the policies that are there and the grassroots that cannot read. And the other challenge is women's actual participation, actual participation in terms of women knowing that these laws are there to protect them. And sometimes you find that ya, we don't have a lot of justice delivery mechanism ya, where you should walk ten kilometers to access justice. I mean, it becomes a challenge because if I'm raped, it means it's already a problem and for me to walk ten kilometers to and fro and it's a frustrating process because you are told come back! come back! Come back, you know, the following day. So people give up easily. So we don't have local Justice delivery systems that are effective. And you find that the chiefs are mostly men, men who would want to protect their fellow citizens..., men –who have perpetrated aah... So there is that challenge in terms of getting the chief's buy in to protect women. To use the law to protect women. To understand the laws but also to protect women to be pro-women because some of them they don't listen they just no! this is gender nonsense. You know they... they... they switch off. Ya. And then the other challenge in terms of, the police. The police they don't have capacity especially for the case. You find that when you report a case it takes very long for you to get to the court. So it's not like instant. And sometimes you get threats from the person who has perpetrated you and there is no protection. The protection is not forthcoming so you are afraid you withdraw the case or you know you get tired. You get frustrated in the long run. So there is that I don't know what you can call it. That disconnect in terms of what the law can say, can provide in terms of provision and what really happen on the ground (P36: 15/03/2009).

This interview extract in Box 4.3 highlights that even if policies are implemented to protect women from violence the women may be unaware of the laws that are there to protect them. It also highlights the difficulty for women to proceed with court cases as she says those making decisions are men and these men will protect other men and not listen to women and see their issues as 'gender nonsense'.

As another informant working for UNAIDS said (see Box 4.4):

#### **Box 4.4 – P25 Interview with a Programme Officer**

Having legislation is one thing but we grappling with the actual translating of these laws into practice and actually being able to apply them. Usually when they are drafting these laws they have a special commission which is supposed to consult whatever; so I think there might be a group of people who are already doing that, I haven't been consulted. Even in the Ministry of Women I think they wanted to have as a piece of legislation on cultural issues. Maybe they had to do something - the ministry, because of too many of the cultural practices that, I mean I am talking from the perspective that I find. It's a good idea but somewhere let's look at how best we

are implementing the legislations that are in place right now, you know, then go further if we see that there is no other way because otherwise the traditional leaders forum it's like we are killing ourselves in the foot as well, you know, because we think we're hoping that this group can be of influence on a lot of communities because they have a lot of power. But can we come with the legislation unit, yes, now saying ok the state is saying this but if you do it, it will go further down because the leaders feel like they are left out, you know. So, they can be able to address cultural issues without really having to go, unless they are completely, probably out of context, you know, they are really not doing anything (P25: 04/02/2009).

The interview above once again reveals the challenges governments face to implement policy at the national level. She says that the Ministry of Women wanted a piece of legislation drafted on cultural practices but as she highlights it would be difficult to implement it because of the traditional leaders' forum. Thus it also highlights the challenges governments face working with national groups, in this case the traditional leaders forum, who exert a considerable amount of power.

One Lawyer interviewed told me about her own research on polygamy (see Box 4.5):

#### **Box 4.5 – P27 Interview with a Lawyer**

When you look at the sort of statistics I found, you find that in some cases polygamy was highly practiced in areas where they had said it is illegal. Whereas in the countries where they had said it is legal, in some cases you saw that the percentages of polygamy were low. So I say to myself, what could be the ratio. And I also made an analogy, which is not in my thesis, with female genital mutilation; in some areas they tried to go the legislative way and ban it, but to find that the prevalence rate of female genital mutilation was actually higher than in the areas where they had said ok, let's not legislate against it. Now, the law commission will tell 'you what was the missing point?'; the missing point is, and this is what we say the law commission, you can not really successfully legislate on culture, practices that are embedded on culture unless you adopt a very comprehensive or holistic approach, whereby that kind of legislation should be complemented by other non legislative measures. I am sure you have already looked at this kind of issue in your study, to say 'do we have an inspective civic education mode for this kind of practice?' civic education, empowerment, because, if we talk of civic education per say where at least the majority of the population you are targeting is educated then they will begin to appreciate the issues to say 'oh, probably this is why this kind of practice should be abandoned'. Civic educate them so that they begin to appreciate the issues, so that we don't just impose on them to say this is that, ought to stop it. Empower them because you most variably find that where these kinds of practices are highly practiced because people believe in some value that is attached to them. So, for example, polygamy, female genital mutilation, it's all a means of securing marriage, I need to stay in marriage; but if people are empowered economically and with information they begin to see that probably a marriage is not all there is, I can survive outside of a marriage, you know. So, I said in my thesis that we need a holistic approach which should complement the legislation element. Other than that, we just drive the practice underground and it is heavily practiced and it is risky and dangerous, because now that you've made it illegal, people will no longer come into the office and say you see they did this to me and it offers all room for all kinds of abuse. So, that's how I looked at it, and in our submission to the Malawi Law Commission we said as much.

Then the other issue is, we look at international human rights instrument, what have they said the CEDAW, the Protocol, to the African charter of women, you will see that the emphasis is on eliminating harmful cultural practices, in some instances modifying. I will emphasize harmful,

you know, first you have to do the kind of research you are doing then you will conclude is this harmful. After that stage, you'll say what's the best way of handling the issue; elimination or modification. So for example, in Kenya, on the issue of female genital mutilation, they did a pilot study where they said 'should we eliminate female genital mutilation? Their answer was to look at the values that underpin the practice. And they found that it was actually an avenue where girls were given the necessary information as they get the right of *passage to womanhood*. So they said, we can not do away with this because it's actually a source of informal education, most of the girls in the rural areas do not go to school anyway; so if we find a grouping where we can put them together and give them the right information. They modified the practice in that they were to have the initiation ceremonies without the cutting but including HIV/AIDS messages into the information package, and it was actually improved now to say, the current issues in the society. So, at the end of the day, you had these girls who would go out into the public and say we've been initiated and be acceptable culturally, but without the harmful element. I am not sure if the Malawi Law commission did that kind of approach, to examine each and every cultural practice and to say this is harmful in this regard, let us recommend for its modification, or there is nothing we can do to this except for its elimination, I'm not sure if that was done; we made that kind of submission to them (they receive all sorts of submission, and what they do with them we really can't tell, you can only do so much) (P27: 05/02/2009).

This section addresses research question five regarding how international frameworks are difficult to implement on the ground and how the Government of Malawi has struggled to make relevant global connections. Instead, highly complex legislation emerges which has little resemblance to the on the ground realities and is certainly not evidenced. The legislation does however satisfy donors who are happy to see money channelled into programmes conceived to realize the laws. Also see chapter 6 which responds to this research question.

### **The Malawian elite**

In this section I look at the role of the Malawian elite in constructing policy on HIV/AIDS and harmful cultural practices and how they position themselves in the development arena in relation to the international donors. Literature in the international development arena about national elites is difficult to find and there is not much that exists on this important group who are the conduits of resources and information from the offices in the capital of international organisations such as World Bank, USAID, DFID, World Vision to their branch offices. These elites control the flow of information between INGOs and national government departments. The country nationals are crucial – the big donors can't do anything without them, and alternatively the big donors rely on people in their national offices for information (e.g. what programmes are needed, what programmes that they implemented were successful what not) (Watkins, 2008). As this thesis demonstrates international donors develop policy and fund programmes based on very little information about what goes on in Malawi, which is a concern – this is the case even when the INGOs do have district-level offices.

Malawians who work in the development field can be described as elites (Watkins & Swidler, 2009; Myroniuk, 2011). They stand out from the average Malawian as educated to secondary and tertiary levels. They are involved in the distribution and implementation of millions of pounds worth on aid and on whom international expectations fall to decrease the transmission of HIV (Myroniuk, 2011). They are part of a small, relatively well off group. Many positions of employment in Malawi related to development and HIV/AIDS exist as a result of funding from international donors. In order to qualify for a position one must be able to speak English and be literate. Watkins and Swidler's research on elites breaks them into three groups: local elites, interstitial and national elites (Watkins & Swidler, 2009). The principal feature of interstitial elites is that despite their education and their aspiration to fulfil their families' hopes and escape the agricultural labour and petty trading that define village life (Englund, 2006, pp. 87–95), their lives are precarious. By village standards, they are an educated elite; by the standards of the elites who work for NGOs in the capital, they are not sufficiently educated to be hired at a high salary to implement donor projects (Watkins, 2008).

The next section presents excerpts concerning the elite to show how they maintain their status by framing narratives on the causes of HIV/AIDS which serve to keep themselves in jobs. As these interviews reveal the elite move around frequently due to job uncertainty and short-term contracts. For example, I asked one officer what he liked about working with NAC. He told me it was the level of activity and level of interaction working with various partners. He said it was high level. He also said he liked the interaction with the donor community; heads of offices and country directors for different international NGOs including heads of bi-laterals such as DFID, NORAD, CIDA, WB, UNDP, UNAIDS. When I asked him what he disliked about his job he said:

The misunderstanding about NAC from local partners, the indigenous groups like CBOS, like Malawian NGOs. All they think about when they think about NAC is money. We have a meeting to discuss about M&E. They expect you to talk about money. It derails focus from the national response. (P3: 13/03/2009)

I said to him what does your job entail. He said, 'Facilitating partnerships, mainstreaming, capacity building'. I asked what does this actually mean? He said it means 'Providing guidance, development of policies and strategies on those areas and providing technical assistance in those areas and monitoring how effective those are' (P35: 13/03/2009). This interview reveals the pivotal position many elites find themselves in acting to translate and oversee donor policies into actual programmes. It also reveals the short-term nature of this work, which highlights how the

existence of a strong narrative of blame around HIV/AIDS prevalence that will take a long time to reverse can serve to provide job security as donors will find longer-term programmes in response to them.

I interviewed a Communications Officer working for GOAL based in Blantyre. He was born in the district because his father used to work for a company that involved moving from one place to another so time and again they made a point to see people, his grandparents. I asked him where did he go to secondary school? He said: 'I think it was just natural but uh since from standard 1 you don't have a choice your parents say go to school so we get to standard 8 and then you proceed to secondary school'. What is striking about his response is he says it was just natural. He is telling me that he is elite as he took it for granted that he would go to secondary school. He then tells me:

Since graduation I have worked for two organisations the first one was Malawi Writers Union. It was an arts and culture organisation. I worked as a Project Officer. Later on I was editor for an arts and culture magazine which they introduced whilst I was still there. I worked there for two years. Afterwards then I joined GOAL. (P1: 28/11/08)

When I ask him about his job, I hear a lot of jargon—'cross cutting, middle managers, communication mechanisms'.

#### **Box 4.6 – Case study of P34 Partnership and Liaison Officer**

P34 has worked at NAC for five years. Prior to NAC he worked for Plan International as a Programme Coordinator on livelihoods and HIV/AIDS. He was also a local United Nations volunteer at UNDP. He said he 'got paid handsomely' doing emergency fieldwork – he then corrected himself to say 'more correct to say 'humanitarian affairs'. He worked at UNDP for one and a half years based in Nkhata Bay. The UNV contract was for two years; the maximum time one can be a volunteer. But he left early to 'follow his wife' as she had a permanent job. He said his time at UNDP was 'enriching'. Malawi at the time was experiencing a hunger crisis. He said 'I was at the forefront providing situational analysis for whole country'. He holds a Bachelor's degree in public administration. After UNDP he worked for USAID as a regional coordinator in Lilongwe working on electoral monitoring -this was five years go. He was working on the electoral support system and remained in the post for six months only. When I asked him why he only worked for six months he said the contract was only for nine months so he left to find another job. He also worked for Plan International and UNDP in related fields. I asked him why the NAC. He said two things. One because of the area of focus – HIV/AIDS. He said UNDP was a 'vulnerable continuation'. He also said that the perks at NAC are higher than USAID and the contract longer – three years. He said the salary is higher and that it is possible to renew contract after three years. He said he wants to stay at NAC he added that the organisation has to be interested in keeping you as well.

In both these cases two things are apparent. The high demand these elites are in from international stakeholders and the short-term nature of their work. These same two factors characterise the career of my next informant.



#### **Box 4.7 – Case study of a Programme Officer**

##### **Education and career of a Programme Officer working for GOAL Malawi**

P7 and his colleague greeted me at the bus depot in Balaka. The office was closed as it was Christmas holidays but he was happy to meet me on his day off. We made our way to a motel to hold the interview. P3 from GOAL Blantyre suggested I meet with P7.

P7 is 29 years old. He grew up in Machinga. His father is from Zomba and his mother is from Machinga but both parents are now in Machinga. He attended secondary school in Dedza for four years. After secondary school he attended Trinity College of Nursing in Nsanje for three years. Then he worked at Trinity hospital for two years. Then he moved to Medicin Sans Frontiers to work on an HIV/AIDS project for three years in Dowa, Central Region, North East of Lilongwe. He studied nursing then through the work he had been doing with MSF, he was involved in and HIV/AIDS project and HIV/AIDS activities like Prevention of Mother To Child Transmission (PMTCT), home based care and then he was responsible for an Infection Prevention Programme, and he was heading that department at Dowa District hospital. He was with MSF working hand in hand with the hospital trying to support them. He was also responsible for the ARV programme.

After close to three years the programme (the mission) which they were running came to an end. The Mission was closed so he moved to GOAL Malawi to work on an HIV/AIDS programme. Initially he was responsible for PMTCT, HIV Testing and Counselling and Home Based Care for Balaka. When asked how he felt about the programme coming to an end Jimmy said he had a good experience at MSF, he was exposed to many activities as far as HIV/AIDS programme is concerned but then at the end he heard that the mission was being closed when the project came to an end It was a shock to him as he asked himself 'what am I gong to do?' I need to find another job, I need to move out of this place, I have to go somewhere. I don't know what it will be like so finding a new job it wasn't a nice experience.

I asked a staff member at NAC in terms of Behaviour Change Interventions do you think NAC is having an impact? He said, "It is probably best to talk to the people in BCI but so far so good as there are high levels of awareness about behaviour for example faithfulness". He also said that cultural dimensions underpin behaviour and that what we do is rooted in cultural beliefs. I asked him what he meant by cultural beliefs. He said, "There are so many in Malawi. Originally farmers had very good intentions – mostly to focus on the family but that norms and beliefs had to be redefined due to HIV. Because of levels of education especially in rural settings it is difficult to change cultural beliefs. The main problem of cultural beliefs is education, which form part and parcel of life. In urban areas they have changed them but if you go to villages they still exist and he said that the reason for that is because of levels of education". I asked him how does he know that. He said, "It is difficult to see and to interact with people. They say these are people from NAC let us tell them what they want to hear". One woman from Nsanje said 'these men are lying. Once these visitors go back, we will continue those practices' (P19: 12/01/09). These examples demonstrate how he is blaming the people who live in rural areas for cultural practices that are sexually risky who he describes as uneducated. By blaming the uneducated villager he is placing himself apart as a member of the urban and educated elite. The explanations provided by the elite not only help them secure longer contracts by ensuring donors fund more long-term

programmes but also maintain the social hierarchy that sees them in positions of decision-making power.

### **Narratives of blame among the Malawian elite: 'Harmful cultural practices spreading HIV/AIDS'**

In this section I draw upon my analytical framework presented in chapter one and I analyse interviews, training manuals and policy documents to evidence how the links between HIV/AIDS and harmful cultural practices are understood by the Malawian elite. Several pertinent issues are addressed in this section: although you can have elites within villages too, i.e., village elites creating distance from themselves and poorer families, I demonstrate what I have termed the 'Malawian elite', how they (the Malawian elite) perceive rural communities as backwards; the way the elites distance themselves from the villagers therefore demonstrating their 'eliteness'; their backwardness is given as the reason for cultural practices and are in turn blamed for the spread of HIV; this as argued previously is a distortion of reality.

I conducted an interview with a Minister and asked her to give her views on cultural practices and HIV/AIDS and the relationship between probability of transmission and infection. She explained:

There are initiation ceremonies that take place; the ceremonies like hyena. When somebody reaches puberty they initiate sexual intercourse. In relation to the cultural practices you find that young girls have their sexual debut at a very tender age. And that in most cases the new infections are higher in young girls. And it is because most of them are having the sexual intercourse with older men who may have already been infected so that is the *direct link between that and this one*.....Now when you look at that to be very honest with you in terms of policy, we are a little bit lagging behind. Because you do not expect a person like me to go out and deal with those things. You need the traditional leaders like the chiefs, the traditional initiators, the traditional counsellors to deal with the problem. Let them understand it is an issue, let them understand that it is contributing to the spread of the disease of the HIV virus. (P41: 28/04/09)

There are many inaccuracies in this passage; firstly, and as argued previously, new infection rates are not higher in young girls. On the contrary, infections are higher amongst married women and there is now considerable evidence, both from Malawi and elsewhere in the region, that marriage is a major risk factor for HIV (UNAIDS, 2004; MDHS, 2010). A study carried out by the Malawi Diffusion and Ideational Change Project (MDICP) at Penn University found that in three rural districts for women aged 15-24 the prevalence rate for unmarried women was 1.5 percent whilst for married women it was 6.1 percent. The probable explanation for lower HIV prevalence rates among unmarried women is that sex is infrequent and that partners were mostly unmarried men.

The Minister says most initiates are having sexual intercourse with older men who may have already been infected. The sexual practice to which she is referring takes place only in certain regions in Malawi, mainly amongst the Muslim populations, therefore only a small percentage of the total female population would be participating in the practice. However, to date it is unknown to what extent the practice is carried out as a nationwide study has not been conducted. She also rightly says 'may have already been infected'. It is not known if the 'older man' is infected or not as the man is not tested before having sexual intercourse with the girl. And indeed it is extremely difficult to quantify the risk of HIV infection after sexual intercourse with an infected person (Boily et al., 2009).

The older man and young girl referred to by the Minister would not be a couple and the sexual act would take place only once. Therefore without testing for HIV it is impossible to know if the girl is infected by the man during the sexual practice of *fisi*. Interestingly the Minister then goes on to talk about policy, that Malawi is 'lagging behind' and that a person like her is not expected to deal with 'those things'. This suggests that a person in her standing should not have to address such issues, thereby revealing her lack of understanding of the relationship between HIV/AIDS and the sexual practice to which she refers. She instead puts responsibility back to the village chiefs to deal with the problem and that they should understand that the practice is contributing to the spread of HIV however she does not understand the facts herself. Yet this senior politician is at the heart of the policymaking scene in Malawi and is responsible for designing policies on such issues. This is one example that demonstrates why a review of the policymaking processes is critical for this thesis.

Whilst interviewing the Minister I pointed out that the NAC has policies in place to address HIV prevention and cultural practices and I said that I did not think anyone knew the extent to which the practice takes place in the country. The Minister responded:

We have scanty information. That is why as an office we are saying we want a comprehensive nationwide study. So that because each district is unique in terms of cultural practices in its own way so we want to deal with them within that uniqueness. You can't say one jacket fits all the districts because of the background, the practices, the behaviours, they are totally different. (P41: 28/04/2009)

In the quotation cited above the Minister clearly wants to strengthen the evidence and that the evidential base is seen as needed. A major research study is required to try to understand more about the practices that take place. The task here is not to find ways of increasing ministers'

willingness and ability to give more weight to what the evidence shows, but to assist in carrying out the research in order that evidence can be used to inform policy decisions. She reveals that there is a lack of relevant data for policymakers to draw upon. Her comment also emphasises a significant disjuncture between the catastrophic amount of funds that donors contribute to HIV policies, and an ensuing lack of actual impact (see Box 4.8).

**Box 4.8 – P41 Interview with the Head of Nutrition and HIV/AIDS**

Previously Malawi as a nation was a secret nation. A secret in that we didn't have TVs we didn't have videos. We didn't have pornography. We didn't have some of these things they are coming in as new things. So you have certain behaviours and changes that have come in or practices that have come in that were not there. In terms of policy as an office we are now moving where we have already developed a proposal where we want to do a comprehensive study on cultural practices from Nsanje to Chipita for every district. And document them. Having documented them we will form a chiefs' council or a chiefs' committee then we will form the initiators' committee, the traditional birth attendants' committee then we use these committees to identify those who have an education and train them on addressing the cultural practices. So that we identify the good ones that we can use. For example soon after delivery three months must pass before having sexual intercourse.....That's a cultural practice but it is a good one. It allowed the woman to recover fully but at the same time it was protecting against sexually transmitted diseases and the man was told the minute you have sexual intercourse with another woman the child is going to die. And which man was willing to let the child die? You see. There were those. And these are the good cultural practices. So we wanted them in their own set up to identify the good cultural practices the harmful cultural practices and promote the good ones. Let me say not really discard. But let's say modify the harmful ones so that they can work better.

What we see, in districts where HIV was lower, it's a rural district, it's developing quickly and the prevalence is rising. And behind that we know it is the cultural practices. The prevalence in young people, the new prevalence in young people still remains quite high at 18 percent we know it is because of the cultural practices. So we are more than ready to do the practice but to inform policy. We are not looking at it to inform HIV national response. No. Because this is where our donor partners get confused. When we put out our proposal they will see we are already giving our money. Yeah but NAC is not solving the global issues of Malawi. It is doing work that is looking at coordinating the implementation of the national response. But from the global aspects we have to look at these like er these socio-cultural aspects. We can't not just deal with within the closed component we have to look at it from a broader perspective (P41: 28/04/2009).

What is clear in this interview (Box 4.8) is the direct and over simplified link being made between HCPs and HIV/AIDS transmission as well as the assumption that is made that the cultural practices are to blame for the increase in HIV prevalence rates in rural areas. This assumption is made without any evidence.

#### Box 4.9 – P25 Interview with a Programme Officer

I mean practices like for instance we have what we call *fisi*, you know all those ones, those are negative. You know what I mean? Those are really negative practices. Basically, I think there is going to be, I am not sure because there is a consultant that has been hired to give an inception report on how best we can be able to 'cause you know cultural issues the moment you go to the communities and start saying 'ok, we've come here we want to know the negative cultural practices, they are not going to tell you. It's something that is really sort of a secretive thing within the community. Ok, there has to be somebody who is living within the community to be able to, after sometime to be able to get this kind of data. However, we do have some leaders that are coming out openly; we have some chiefs, nowadays, that are really acknowledging that these things are happening. For instance, we have this Kwataine, he is a chief in Ntcheu where the stakeholders meet all people who are dealing with women and HIV/AIDS issues; he actually came out and said 'you know, lets not hide, indeed these things are happening in our communities, and some of them it's even us the chiefs that are perpetuating these cultural practices, so we need to do something about it ourselves. So we just want to get at least some information trying to use focus group, not focus group, one on one interviews with the leaders within the communities that are doing initiation ceremonies. Yeah. We want to get their opinion because they are very instrumental in terms of knowing cultural issues, but mmm many are major keys within the community in all sorts of issues. Aah, they the role models within the communities that we could try get them and try to hear from them; their views. But also the traditional leaders themselves, although they might hide information, sometimes they can slip off the tongue and tell you some stuff. So, we don't want just to interview everybody, you know (P25: 04/02/2009).

This interview excerpt (Box 4.9) fits with my argument as it demonstrates how a Malawian elite is making the assumption that these 'negative' practices take place in rural areas thus distancing herself from the villages and demonstrating her 'eliteness'. It also shows how she thinks the village chiefs themselves are to blame as she says the chief said that they themselves are perpetuating these cultural practices. However, the ways in which these HCP's renders women vulnerable to violence and the identification of this violence as the dimension that causes high instances of HIV/AIDS is missing despite the fact she says 'stakeholders meet all people who are dealing with women and HIV/AIDS issues'.

When I interviewed the Acting District AIDS Coordinator, Balaka 2009 he told me that during a proposal writing training, CBO members were asked to mention some of the cultural practices that are practised in their areas. When I asked why he said:

We feel that maybe some of the cultural practices are contributing to the spread of HIV/AIDS. So maybe we want to see if they know that these *cultural practices can contribute to the spread of HIV/AIDS*, how can they end those cultural practices or how they can tackle those problems.  
(P13:07/01/09)

Again the oversimplification is clear, the wider implications of these practices for and on women's lives is not understood. I asked him why he felt the need to talk about cultural practices and he laughed. I said is it in your policy or mandate to say I need to ask them about cultural practices?

He said we do that just because it's a mandate of the job, it's a mandate of the job to tackle each and every issue that can contribute to HIV/AIDS. Here we see he does not talk about the empowerment of girls and women or a reduction in GBV. I asked him where did his understanding of the issues come from? He didn't understand my question so I rephrased it and said if you think cultural practices contribute to the spread of HIV/AIDS, why do you, where have you learnt that they do. He said:

You know, there are some things you don't need to learn, but you can just think and prove yourself that when doing this this can happen, when doing this this can happen. But I will say that I have attended a number of workshops whereby people share experiences and whatsoever, in so doing it's when I have known some of these things. (P13:07/01/09)

When I asked him where he said 'a number of workshops, maybe some of them maybe review meetings conducted by NAC, some of them maybe some of the stakeholders'. I asked him when people talk about the cultural practices which ones do you think are contributing to the spread of HIV/AIDS? He said 'maybe the initiation ceremony and *kuchotsa fumbi*, (in *Chichewa it is kulowa kufa*)'. I said, how did you hear about these practices. He said:

Yeah, no no, it's like just because people have been saying much on these cultural practices so that maybe people should stop this. So it's not even maybe to hear without asking, but these policies are been done aaah, down down down down so that maybe a lot of people should not see that people are doing there that just because people have already said no stop this, no stop this. So these are happening but in dark corners. I said so like in secret? He said yeah yeah in secret. (P13:07/01/2009)

In interviews with members of the medical profession the hazy understanding of harmful cultural practices was clear. Given how little clear knowledge of harmful cultural practices, prevalence and nature of the practices exist it is further strange that harmful cultural practices have been brought so centrally into policies on HIV/AIDS: e.g. a Nurse from the Kamazu College of Medicine who was in Nsanje from December 2007 – April 2008 and worked on a study addressing cultural practices and HIV/AIDS) told me:

Sexual practices that fuel HIV/AIDS are 1) *fisi* – used in special circumstances; 2) widow inheritance, 3) sexual exploitation of young and first sexual experience of young initiates and 4) polygamy - but can be protective because of the wives but not if husband has girlfriends. *Fisi* is not a generic term. *Fisi* is a man to hire if man is impotent. He is discreetly hired. *Fisi* means male infertility and the man might choose a *fisi* and the woman does not know about it (P11: 29/10/08).

I spoke with a director of a local NGO and asked him his definition of the *fisi* sexual practice. He told me there is *kutchosa fumbi* and *fisi*:

1. *Kutchosa fumbi* – Initiation ceremony. Give counselling to young girls who have just grown up to give them advice and how they can live with elders and the like. Sometimes they do advise them to have sexual intercourse with the boys in the villages. So it's like to see if they can have pregnancies and a child. It's like to test/check if they can have a child. After that ceremony they get boys or men to have sexual intercourse with those young girls. The girls are aged 12-18. 2. *Fisi* – You get married, man is failing in home to have a child. So you consult another man so he can have a child within the family. It's a consultation issue. It is not usually ladies but men sometimes. (Journal entry: 11/11/2008)

### **Narratives of blame among the Malawian elite: 'Rural communities as backwards'**

This section demonstrates how respondents perceive rural villagers as backwards and how those that live in rural areas are to be blamed for the spread of HIV. For example one respondent said:

So you find that in cases where a man and woman want to engage in sexual intercourse, you find that the woman is so powerless; as a matter of fact you don't question what a man wants to do, especially for the rural folk. (P26: 05/02/2009)

Whereas the respondent suggests that gender imbalance in sexual relationships is problematic across Malawian society she places particular emphasis on the rural population as the worse group for patriarchal power. The 'rural folk' are thus especially to blame for gender imbalances - blaming the rural male in particular for sexual dominance and reinforcing the stereotype of the sexually, virile village man and the powerless rural, woman.

#### **Box 4.10 – P15 Interview with a District Youth Officer**

R=Respondent, S=Samantha

R: These cultural practices were revealed by the community members themselves; they said yes, these are the cultural practices which we feel are contributing to HIV.

S: Do you think it will be a problem, a big problem or a small problem or –

R: When we look at cultural issues usually it can be simple but for those which, for the Balaka district here, I understand these are very big problems.

S: Why?

R: Aaah, you know cultural issues are regarded as very very important behaviour in a village setting.

S: Ok.

R: So they can't go away with those unless we have to change some of the cultural issues, not to completely put them out but just change them so that at least they should be friendly to the women.

S: How will you ...?

R: Aaah, as a district, first of all our aim is to enlighten the community on these cultural issues, because they have been with these cultural issues since time immemorial.

S: Yah.

R: So we have to tell them, we enlighten them as to why, we say that these cultural issues are exposing women to HIV/AIDS. They have been doing these things since time in memorial, so they don't know it is there, but when you enlighten them it is for them to think that oh no we need to change our behaviour.

S: Do you think they will change their behaviour as a result of you discussing?

R: Changing behaviour is a slow process, so we hope with our continued information on these issues they are going to change.

S: Key issue in Balaka, I mean in terms of HIV prevalence rate? What do you think is the main problem as regard to HIV/AIDS in Balaka? Is it cultural practices or is it something else?

R: You know cultural practices are there, but we can say there are so many things. The other side we are looking at cultural practices, but we also have to look at the behaviour of the community.

S: Yeah, So how are you looking at them?

R: Aah, when I look at the behaviour of the community, the behaviour of the community around, in townships yeah; usually in townships we have all those people who are going out, they don't have money and what. But I don't know, I think we should say, for the things which are, because I have to say things which I have seen myself.

S: Sure.

R: I can not say I have seen people doing that and that because these are the things which are

S: Ok.

R: Yeah.

S: Like you said, cultural practices, you haven't seen them happen?

R: Aah I should say yes but the people themselves, because these issues were given to me by the traditional authorities, they said they are happening in the villages.

S: And these aah, these traditional authorities, they want them to change, do they want to change?

R: Yeah.

S: They said that to you?

R: Yeah, they want to change because when we have given them the questions which are which are the cultural issues, you would see that they are contributing to HIV/AIDS. And I said what do you think this could be changed or what do you think we can reduce HIV/AIDS looking at those cultural issues; I think it's also highlighted on the paper. I've already said that behavioural change is a slow process; we need to still enlighten them more so that at least they have to change. (P15:07/01/2009)

In Box 4.10 the informant told me about sexual cultural practices taking place and blamed people living in rural areas. He said that sexual cultural practices are taking place in the district of Balaka that are spreading HIV. This fits with my argument as I argue that those working in HIV/AIDS think certain sexual cultural practices are spreading HIV but the epidemiological evidence demonstrates that this is incorrect. (See p.22). He also says that although he has never seen a practice take place he has been told about them by the traditional authorities. This point highlights once again how people working on HIV/AIDS report that the practice takes place even though they have never witnessed it themselves thus perpetuating the misconception concerning the link between sexual cultural practices and HIV/AIDS.



The following is an excerpt from an interview carried out with the midwife working at Balaka District Hospital (see Box 4.11):

**Box 4.11 – P8 Interview with a Midwife**

Ok, so I will just ask some questions about the cultural practices. Maybe you could just tell me if your, like what cultural practices take place in Balaka that you say you are aware of that might contribute to the spread of HIV/AIDS?

R: Yeah. The ones I'm aware of it's like *kusasa fumbi*, and this *kusasa fumbi* it's after the girls have been, after the –

S: Yah.

R: Then they go to, they say *chinamwali* where are being taught how they can maybe play sex with the men, then after that they are told to practice.

S: Ok.

R: So they take just any other person.

S: Yah.

R: Yah.

S: So when does this cultural practice take place, what do you think or know?

R: Aah, I don't know much but, you mean in terms of months or –

S: Yah.

R: Most of the times it's during the dry season.

S: Yah, ok. So probably between, around I don't know, May?

R: I think around July, August, September, these months.

S: Ok. And do you hear about the cultural practices much or not really? I mean in terms of your work, is it an issue for you?

R: Yah, of course we hear because we usually know them when they go into the street singing from the *chinamwali* site.

S: But in terms of, do you hear in your work?

R: No.

S: No one mentions it?

R: Mmhmm.

S: So maybe it's not quite a big issue regarding the prevalence rate of HIV/AIDS, it's not something that really, do you think it's a big issue in terms of spreading HIV/AIDS?

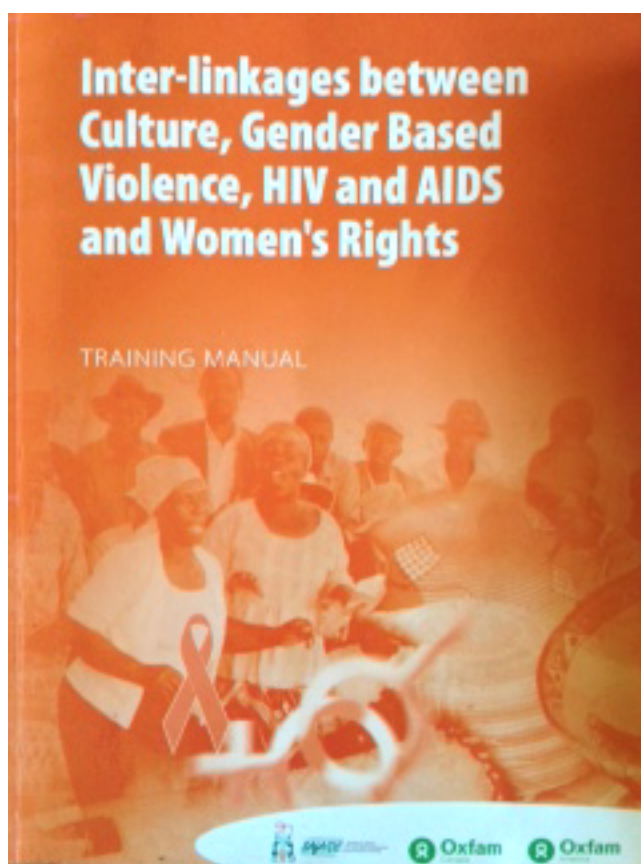
R: Yah, it is. Because around the town we can not say much but when you go into the villages that's when you see a lot of people practising those.

S: Ok, do you think it's in most areas?

R: Yah, it is in most areas because this area is full of the Islam they are the ones who practise these a lot than other tribes (P8: 30/12/08).

In a training manual produced by Oxfam and SAFAIDS entitled 'Interlinkages Between Culture, Gender-based Violence, HIV/AIDS and Women's Rights' it states: 'This training manual seeks to make development agents aware that there is not much that can be achieved in the response to HIV/AIDS if society does not deal with the root cause of the problem – CULTURE' (Oxfam and SAFAIDS, 2008, p. 5). The manual's cover depicts a photo of African women and men singing and dressed in informal attire, which suggests they are from a rural area. The manual was developed for use by community workers and volunteers, HIV/AIDS programmers and programme implementers, CBOs and FBOs and provides a step-by-step guide on how to run a four-day workshop and includes hand-outs.

Figure 4.1 – Training manual



The manual goes on to talk about ‘the role of culture in HIV prevention’.

Culture is important for understanding the HIV/AIDS epidemic in sub-Saharan Africa. It helps to explain, in part, the high HIV/AIDS prevalence rates, particularly amongst women. Numerous cultural beliefs and practices, such as wife/husband inheritance, polygamy, spirit appeasement, lack of communication about sexual matters between men and women, gender inequity and culturally-sanctioned extramarital affairs and infidelity among men, have been tied to the high rates of STIs including HIV (2008, p. 26).

This manual largely ignores epidemiological evidence and does not draw on any evidence to support its claim and instead blames cultural practices for high HIV prevalence rates. The manual also provides a hand-out which lists eight negative cultural practices that are linked to gender and HIV. Such manuals imply that culture is negative. ActionAid’s country strategy paper 2005-2010 also makes reference to ‘negative cultural practices’ (2005, p. 13). These manuals also contradict global policy documents linked between cultural practices and gender-based violence which is very confusing.

### **Distortion of the reality**

As mentioned above the actual risk of HIV infection from one act of heterosexual intercourse is 1 in 1,000 or less (Gray et al., 2001). However, what is interesting is that many Malawians believe that HIV is easily transmitted. In several surveys conducted in a research project, the Malawi Diffusion and Ideational Change project (MDICP), which look at the role of social networks in influencing responses to the AIDS epidemic in rural Malawi, respondents were asked how likely it was that one act of sexual intercourse with an HIV infected person would lead to infection for the other partner. More than 95 percent said the probability of transmission was either certain or highly likely (Watkins et al., 2011).

Furthermore, ethnographic journals recorded by Malawian high school graduates who wrote down anything they overheard concerning AIDS – what Watkins et al. (2011) refers to as ‘hearsay ethnography’ revealed that Malawians come to the conclusion that if a person has had sex with someone who is already infected then that person will also be infected: ‘Thus, when a young man says, after his first sexual encounter with a young woman who he hopes will be his “real girlfriend,” that “Indeed, friend, if Grace has AIDS, she has given it to me, I couldn’t resist her attractions”’ (Simon, 2001, cited by Watkins et al., 2011, p. 442).

In another excerpt the point above is made again in that if a husband is infected then the wife must be and vice versa:

She said, ‘Yes indeed, people say that lying together is dying together. If he has HIV/AIDS, I have HIV/AIDS but I know that we don’t have it’.

And I asked, ‘How do you know? Did you go for a blood test?’

She said, ‘I know myself and he told me one day that he doesn’t have HIV/AIDS. He went for a blood test and found that he doesn’t have it.’ (Simon, 2001, cited by Watkins et al., 2011, p. 442).

These points reaffirm my argument concerning Malawian’s claims that HIV is easily transmitted through heterosexual intercourse.

A lawyer working for the Human Rights Commission asserted: ‘let me tell you this thing of us, men want to have sexual intercourse with younger women because they believe that they are virgins and therefore they don’t have HIV’.

#### **Box 4.12 – P36 Interview with a Policy Advisor**

R: Because you know culture, culture in Malawi is so... it's something that leads to many problems; it leads to many problems. And when we talk about culture you need to break it down. Because even raping of children, small children is out of belief, out of cultural belief that say maybe when you sleep with a six month old baby you get healed of HIV/AIDS. So I'm looking at culture as something that has brought more harm than good in terms of upholding people's identity or you know...

S: Do you really think that happens?

R: You mean raping children? Ahh!

S: Really?

R: Really... it's rampant.

S: Rampant! (P36: 15/03/09).

The country director of Trocaire told me that Trocaire was looking to conduct:

Cultural research linked to HIV and women's vulnerability, for example women that sell sex for fish. To do a good piece of solid research – and look at aspects of that vulnerability – why are men so stark? Why do they have to have 3-4 wives? Cultural stuff – some believe that during harvest of fish they need to have sex with someone else. Useful for advocacy and furthering other projects (P27: 10/03/09)

And as a former Minister explained:

This was the truth and then we formed a technical subcommittee because there were a lot of technical communication which was about condoms and the small holes there and the rubber and the virus is smaller and it can go through so how so we wanted to correct this technical misinformation. But I must say that since then there have been improvements and they have formed their own organisation called the Malawi Interfaith Aids Association (MIAA) (P5: 18/12/08).

#### **Conclusion**

This chapter has demonstrated that the Malawian elites' view is that cultural practices are harmful (from policy documents, interviews and newspapers) and how this argument is made and what evidence is presented. The epidemiology of the virus contradicts their views that transmission probability is low. The elite blame rural people for the high HIV prevalence rates, pinpointing their cultural practices described as backward and contrasted against their own enlightened status.

The 'harmful' side of these practices is an 'imagined fact' in terms of how they contribute to high prevalence rates but also in terms of where they are observed. In my interviews it was clear that the Malawian elite knew relatively little about harmful cultural practices, and where they were practiced. The inconsistencies and inaccuracy in the explanations given in my interviews serves as further evidence that a narrative of blame has clearly been constructed that seeks to pin blame

on rural communities and a set of 'backward' beliefs. Furthermore, there is a disconnect between the urban elite and rural villagers. The urban elite distance themselves so blame other sections of society, particularly those that live in rural areas. They do not just blame a cultural practice but portray these communities as being backward as they want to maintain their own image on a par with international donors. Their reality is thus distorted.

I also looked at where their perception of harmful cultural practices comes from and the motivation for holding them. Many respondents perceive themselves as elite and urban and want to disassociate with Malawi's image of a very poor country, they do this by contrasting themselves against rural villagers who they claim to be backward and not like them. The urban elite in general are religious, Christian, their religion, the result of conversion during the missionary phase of Malawi's history, has become for them an identifying mark of their developed enlightened status. Their Christian beliefs contrasted against the traditional practices of the rural 'other' who remains uncivilized and unenlightened. I also argued that a further motive exists for maintaining these narratives of blame. They secure longer term positions for those elites awarded responsibilities for eradicating them. In the next chapter I delve deeper into the role of Christianity has placed in shaping these narratives of blame.

## Chapter 5                      How the Church Frames AIDS

Figure 5.1 – Photo of poster with the President of Malawi encouraging abstinence. Author: J Verheijen



This chapter explores the role of religion in the fight against HIV/AIDS and analyses the influence of the church in shaping the views of the Malawian elite. I demonstrate how all the Malawian elites I interviewed attend church and also how religion has influenced the way they think about HIV/AIDS, cultural practices and rural people. First, I provide the religious context in Malawi. I then use my data to show how religious elites perceive cultural practices as negative and the backward positioned against their Christian beliefs they perceive as enlightened. The argument I present in this chapter is evidenced by my critical analysis of interviews, newspaper articles and policy documents as well as secondary academic sources.

When I use the word church I intend it to broadly mean an institution as well as individual believers. In my interviews with members of NGOs, INGOs and civil servants it became clear to me that those working for religious institutions hold similar views to the Malawian elites. In fact the Church is so influential in shaping the perspective of the elite that the two are often indistinguishable and there is an overlap between the elites who are religious. Both groups' agendas are also promoted by the narrative of blame of the *fisi* practice. The Church is using the

practice to undermine non Christian practices. So although these groups have different interests both were served well by promoting the *fisi's* responsibility for the spread of HIV/AIDS.

Some figures are church leaders as well as holding more secular positions, for example one person I interviewed was a journalist as well as a Reverend. My analysis of interviews has to account for the impact the religious views of individuals has had in shaping public discourses on HIV/AIDS.

### **Religious context in Malawi**

Malawi is a very religious country; it is estimated that 77 percent of the population is Christian, 15 percent Muslim, and 8 percent practice traditional African religions (Barrett, Kurian & Johnson, 2001). The major Christian denominations as a percentage of the total Christian population are Roman Catholics (25 percent), mission Protestants (20 percent), and African Independent Churches or AICs (17 percent). Groups like evangelicals and Pentecostals are on the increase in Malawi, particularly in urban areas, and together account for about 32 percent of the country's Christians (Jenkins, 2002). Evangelicals and Pentecostals are less numerous in rural areas than in urban areas, and Muslims are largely concentrated in the South of the country. These figures are an estimation of the percentage of Malawi's population by religious affiliation. They are provided by national denominational organisations rather than based on representative surveys of national populations and therefore may be incorrect (Trinatopoli, 2006). One informant stated: 'About the religious groups, they are making progress but the most difficult are the Pentecostal and evangelical group' (P5: 18/12/2008).

Gathering data on religious affiliation is further complicated by the syncretic nature of religion in Malawi which results in hybrid religious groups that might not reflect denominational characteristics in other parts of the world. In Malawi Christianity and traditional religion are often combined (P44: 14/10/08). This means that the line between Christianity and tradition is often blurred. As Patterson points out 'unlike Western liberalism, African conceptions of politics and religion do not divide the sacred and the secular' (2011, p. 3). And as one informant revealed (see Box 5.1):

#### **Box 5.1 – P5 Interview with a Member of Parliament**

<p>But after Christianity, there has been another level of Christianity which is the, they call themselves the indigenous Christian churches. They are Christians but they have taken aspects of the Chewa tradition and said no no, we have we have our own way of looking at God's revelation but they emphasise a lot on the Bible and I am not an expert on that but I</p>
--

can tell you about the Chewa traditional religion. One God, monotheistic, that one is really highly developed and when you read it and you look at Christianity there is hardly much difference, but the way the Christians, the missionaries came, they had to demonise it, that this is primitive; it's not the right way of looking at religion but actually no, they believed in one God and called him different names but who doesn't call God different names? The Jews call him all kinds of names, the Christians call him all kinds of names, why should the Chewa not call it that, because God showed all his power in different forms. And they called ours ancestral spirit worship, no, they never worshipped the spirits. They looked at the spirits as intercessors to God, God was looked at as the supreme spirit. When you die you become a spirit, so you are nearer God so you can communicate better with God so you pray to God straight, directly, and then afterwards you call upon your ancestors to intercede for you, to pray for you. The Christians also do the same and now pray for Mary, what are they, are they alive, they are dead (laughter). So actually you can go through the tradition, the Chewa traditional religion quite similarly, I wish they had understood it and then say yes this is how you believe, it is quite correct, but the transformation of your belief into Jesus as the universal saviour, that would have gone very well with the Chewa. But they said stop, no, once you become a Christian, you stop everything. And that to my mind, and I am a Christian, my father was a Christian, but I think a lot of Malawians have really, are not what we say we are, because they can't take this out of us, they can't, we are still a Chewa. (P5: 18/12/2008)

Here we see a divide between those that combine African Traditional Religion (ATR) with Christianity and those that only practice Christian beliefs. The elite see themselves as the elite because they have rejected ATR in favour of Christianity as taught by the missionaries. This illustrates how a divide has emerged internally to Malawi and how this has in turn shaped the perceptions the elite have of the rural populations who they see as backward because they still practice traditional religion so to be enlightened is to reject tradition. ATR is difficult to define primarily because it is lived and not preached and followers are preoccupied with the practice of ATR rather than theory therefore there is no single simple and precise definition to describe it. Mbiti (1970) provides a useful summary of where to look for and find ATR. He suggests rituals, ceremonies and festivals; shrines, sacred places and religious objects; art and symbols; music and dance; proverbs, riddles and wise sayings; names of people and places; myths and legends and beliefs and customs. Bascom and Herskovits (1959, p. 3) argued that despite the intensity of Christian missionary efforts and the thousand years of Muslim proselytising which have marked parts of Africa, ATRs continued to manifest everywhere. This was seen in worship of African deities, the homage to ancestors, and the recourse to divination, magic, and other rituals.

Using broad categories of African Christian churches provided by Gifford (2004, p. 10) the estimated number of Christians categorized by churches in Malawi at the time (2001) with a population of 10.9 million is: Orthodox 4,400; Catholics 2.7 million; Old Mission Protestants (Mainlines) 2.37 million; New Mission Protestants (Faith-Mission and Pentecostals) 130,000; Old Independents (African Indigenous) 2 million; and New Independents (neo-Pentecostals and



Charismatics) 1.46 million (Barrett et al., 2001). As we can see from these figures Catholicism is the most popular type of Christianity with New Mission Protestants the least popular and a large percentage of the population still practicing ATR. In Africa, African Christians differ to Western Christians. African Christians are linked to spirituality whereas Western Christians believe in God's forgiveness. As this paragraph demonstrates there are many different types of Christianity in Malawi and within each type variations exist. For example, Pentecostals vary greatly and many congregations may have local autonomy from other churches but there can be considerable hierarchy within individual organisations (Patterson, 2011, p. 79).

However, as we have seen through my interviews there is an overlap between ATR and Christianity. The idea of 'divine punishment' is common to ATR and Christianity and resonates with 'transgressing taboos' (Lwanda, 2005, p. 120). Some Christians, although criticizing cultural practices for spreading HIV, accepted 'conservative' or formative aspects of ATR (Catholic Church, 1991, pp. 51-53). Lwanda (2005) makes the link between medicine and Christianity and ATR and posits the view that in rural and peri-urban areas disagreements between Christianity and western medicine and ATR and traditional medicine were solved by cultural dualities as opposed to hybridity or cultural subjugation (Lwanda, 2005, p. 83). He argues that:

Many core cultural beliefs, now embedded in village localities, were not significantly challenged by colonial or Christian assaults; they had been placed out of the colonial gaze. The invisibility often gave the impression of, and was mistaken for, indigenous practices dying out under the overwhelming and inhibitory nature of colonial governance. Dualism enabled many Maravai to survive colonialism without experiencing 'dissolution' or 'fragmentation' (mental illnesses resulting from cultural alienation or maladjustment) (Fanon, 1970, p. 7 and p. 77) a more common experience among educated elite who, unlike the more culturally secure villagers, had to confront the cultural dichotomy head on. (p. 84)

Patterson makes a similar point but related to the use of anti-retroviral drugs. She points out that whilst some churches are suspicious of ARVS God can be the only true healer. Some churches then combine the use of ARVs with spiritual healing (Patterson, 2011). However pastors may also use prayer, exorcism, fasting or traditional herbs to drive the virus from the believer's body (Becker et al., 2007, p. 11). This example shows how a tension exists between spiritual and biomedical approaches to treatment and how the lines are blurred.

District Interfaith AIDS Committees (DIACS) exist in Malawi and there are 32 in total, comprising 12 members from different churches at district levels. The DIAC nominates a chairperson, secretary and treasurer to run the committee. At the district level, activities for faith based

HIV/AIDS programmes take place which are run through the local churches of each faith group. The Malawi Interfaith AIDS Association (MIAA) has trained all DIACs and have linked them to the District Assembly. Religious leadership is generally male, although some of the evangelical Malawi churches are led by women but the wider social structures they promote are still patriarchal despite a female figurehead. The Protestant and Roman Catholic churches focus on behaviours – fidelity and abstinence, for instance—as means to prevent STIs; in other words, the focus is placed on the maintenance of a heterosexual status quo with emphasis placed on women as the homemakers and child rearers as the model most likely to see low infection rates. However, some critics think focusing on behaviour change alone, rather than changing its context, results in bad policy decisions (Barnett et al., 2005).

Others posit that it is naive since in many cases women are infected by their husbands. So in other words the focus placed on women conforming to their gender role is misplaced because it is the behaviour of husbands that often render women vulnerable to HIV/AIDS transmission.

A study by Trinitapoli (2009) examined religious teachings and influences on the Abstain, Be Faithful, use a Condom (ABC) approach of HIV prevention in Malawi. She presents an overview of the topics religious leaders in rural Malawi formally address in their weekly religious services. Over 88 percent of religious leaders reported preaching about morality (generally); and over 70 percent preaching about sexual morality; AIDS and illness (generally). Furthermore, 95 percent of religious leaders reported that they advise their members privately to stop promiscuity yet only 27 percent reported talking to members on an individual basis about the use of condoms (Trinitapoli, 2009, p. 203). Religious leaders generally tend to be male. Some evangelical churches in Malawi are led by women, but the wider social structures they foster are still patriarchal despite having a female leader (Rankin et al., 2006). Soothill's research examined women's empowerment in Ghana's Charismatic Churches (Soothill, 2010). During her fieldwork participating in the women's activities of three charismatic churches in Accra, she discovered that in contrast to Ghana's older mission-style churches (predominantly Catholic, Methodist, and Presbyterian), the charismatic churches embrace the concept of women's leadership and cast aside traditional barriers to women becoming pastors and church founders. Although the ratio of female to male pastors is still low and the men still dominate the movement in practice, the 'spiritual equality' of believers is a cornerstone of the charismatic discourse on gender (p. 84). Soothill goes on to say however that women in position of religious leadership has not reversed patriarchy.

Figure 5.2 – God, not condoms, can save you from AIDS



I collected newspaper articles on HIV/AIDS spanning 10 years during my fieldwork such as the one presented above. Many of them conveyed negative messages concerning HIV/AIDS and that condoms are 'useless things' and how everyone 'should kneel before God in order to be protected'. This viewpoint, from a biomedical and feminist viewpoint, is dangerous as it ignores the social reality of male sexual behaviour. The heavy emphasis in religious and public discourse on the importance of women as nurturers fails to acknowledge that the problem predominantly lies in the construction of masculinity that associates sexual prowess with a hyper-masculinity that in turn is desired (Gilmore, 1990). A concept of religious morality has clearly been employed in these advertisements. Such messages clearly deny that male promiscuity is both normalized but also legitimized by and through hegemonic constructions of male behaviour. Such religious beliefs ironically promote unprotected sex and have been considered to hamper HIV prevention programmes (Caldwell, 1999).

Gama (2000) reported that Malawi's Council of Churches condemn the distribution and use of condoms to prevent HIV transmission as immoral since the government's doing so is tantamount to supporting promiscuity. According to the Church in Malawi condoms are not 100% effective in preventing infection, noting that the only way to protect oneself is strict monogamy or abstinence. Church leaders make it clear that although non-governmental organisations (NGOs)

distribute condoms, they will not distribute or condone their use. This widespread antipathy to condom use has not helped discordant couples, nor has the occasional policy of requiring HIV blood tests before marriage and then refusing to marry discordant couples. A study by Kaler (2004) of the percentage distribution of themes in negative evaluations of condoms in Malawi showed that 16 percent (n=7) reported that using condoms is against God's will. Religion clearly influences people's behaviour and Chaves (2002) suggests three types of religious organisations are thought to influence the behaviour of individuals: congregations, denominational organisations, and religious non-profit organisations. However, there are more than three. Churches are often seen as civil society actors and in the 1900s donors and scholars were looking for agents of political change and socioeconomic development that were independent of the perceived corrupt and inefficient African state (Bratton, 1989; Harbeson, Rothchild & Chazan, 1994; Gifford, 1998; Patterson, 2011). Furthermore, the problems with structural adjustment policies led Africans to identify new alternatives to the state for services, such as religious organisations (Jenkins, 2007). According to the Gallup News Service (2007) religious organisations are the most trusted organisations in African civil society due to their links with communities, with 76 percent of respondents in nineteen countries in sub-Saharan Africa saying they had most confidence in these groups, followed by the military (61 percent) financial institutions (55 percent). They had least confidence in their governments (44 percent). Gallup further reported that channelling foreign aid through local religious organisations would bring more optimism to African citizens than channelling it directly through the government.

There has been an increase in donor interest and funding of religious groups in development and donors have paid more attention to religion since the United Nations Declaration on HIV/AIDS in 2001 at the General Assembly Special Session on HIV/AIDS. The Declaration mentioned in the previous chapter refers to 'religious factors' that are imperative for HIV prevention and that faith based organisations provide important leadership in the fight against AIDS (UNAIDS, 2001). Dominant donors have taken different approaches. For example, the USA under the Bush administration approached the issue from a conservative right's view and adopted the ABC approach which echoes the Church in Malawi; that abstinence and monogamy are the only way to reduce HIV/AIDS. Perhaps this is why USA does not put money in the basket funds in Malawi but established the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and adopted the ABC method as its primary prevention strategy against the sexual transmission of HIV, focusing on Abstinence for youth, including the delay of sexual debut and abstinence until marriage; Being tested for HIV and being faithful in marriage and monogamous relationships and Correct and

consistent use of condoms for those who practice high-risk behaviours. This is in contrast to the British government's approach and was one of the main differences between the UK and USA concerning funding HIV/AIDS programmes. DFID adopted the Sector Wide Approach (SWAp), which is supported by a group of development partners and comprises a mix of projects, pooled funding and sector budget support. There is no official definition of the SWAp but it usually adheres to the following:

- All significant funding agencies support a shared, sector-wide policy and strategy, which has clear sector targets and is focused on results;
- A medium-term expenditure framework (MTEF) or budget supports this policy;
- Government provides leadership in a sustained partnership;
- Shared processes and approaches for implementing and managing the sector strategy and work programme are agreed, including reviewing sectoral performance against jointly agreed milestones and targets; and
- There is a shared commitment to move to greater reliance on Government financial management and accountability systems. (Pearson, 2010, p. 13)

Since the establishment of the SWAp, DFID has increasingly provided support through Sector Budget Support (SBS) and General Budget Support (GBS) instruments as well as funding service delivery projects off-budget, but under the SWAp which are Banja La Mtsogolo (BLM), which provides family planning and sexual and reproductive health services in a Joint Financing Agreement with Government and other donors; and Voluntary Services Overseas (VSO) which manages a large volunteer programme (Pearson, 2010).

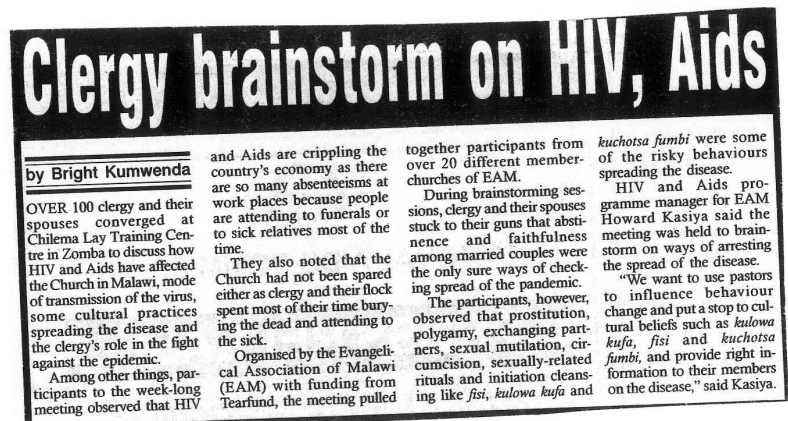
Catholic opposition helped to bring about democratization in Malawi, where the national bishops' pastoral letter of 1992, 'Living Our Faith,' distributed to parishes across the country, was the first public criticism levelled against the one-party rule of Hastings Kamuzu Banda, and a turning point in bringing him down. Opposing post-colonial authoritarian regimes the Church helped bring about democracy because of its political ideology of human rights and democracy. Philpott (2004) shows how the Catholic Church in Malawi spoke out against human rights abuses and poor governance in 1992. The church is therefore seen by local people as an important and positive force for change, making the views of its leadership highly influential. Engaging with religious leadership in reducing HIV/AIDS is therefore important, but so too is understanding the negative and detrimental way in which this conservative religious discourse on sexuality has fed into and legitimized constructions of gender that ultimately restrict women's freedoms and leave them vulnerable to violence, including rape.

In the following section I provide evidence from my interviews and documents to demonstrate that the church has a key role in portraying cultural practices as negative and blaming them for the spread of HIV. The church has been key therefore in distorting the impact harmful cultural practices have linking them directly to HIV/AIDS rather than understanding the negative impact they have on women's lives – specifically by increasing women's vulnerability to violence. This vulnerability to violence also exposes them to HIV/AIDS transmission.

**Figure 5.3 – Clergy brainstorm on HIV/AIDS**

— HIV/AIDS  
 — Church Org. (EAM)

28-29 M  
 P.O. Box  
 Lilongwe



As we can see from the above newspaper article, the NGO Tearfund, a UK Christian relief and development agency, funded a meeting organized by the Evangelical Association of Malawi to 'use pastors to influence behaviour change and put a stop to cultural practices such as *kulowa kufa*, *fisi* and *kuchotsa fumbi*'; the practices to which I refer throughout this study. Again, here I highlight the oversimplification in the analysis of the link between cultural practices and HIV/AIDS. The article reports that abstinence and faithfulness among married couples will stop the spread of

HIV, which contrasts with the article's conclusion and the argument that cultural practices need to be stopped; however, the cultural practices listed do not involve married couples.

The following is an extract from an interview with a senior politician (also see Box 4.2 where this politician's interview was referenced earlier) who talks in length about the role of Christians versus tradition (see Box 5.2).

### Box 5.2 – P5 Interview with a Member of Parliament

Aah, we aah, have been looking at the negative aspect of the cultural practices, and the government, the church, aah everybody international aah always writing about what is negative. He talks about a particular dance which is part of the initiation ceremony for the *fisi* practice said to spread HIV and he says "this great dance has caused a lot of problems to the early missionaries because they didn't understand it, but it has persisted, it has never been broken and over 150 years it is continuing" (P5: 18/12/08).

This is an example of how the missionaries have not been able to change the culture. He goes on:

From the Christian leaders aah, it's a hangover from the early missionary perception that traditional customs are unchristian and in order to become a Christian, you had to renounce your membership or your practice of these... actually non-Christians are called *akunja*, *akunja* meaning outsiders, those who are outside the grace of God, whatever it is, as if God only created a certain people (laughter). Aaaaah, when you do see one, aah, like try at the very first meeting to, to, to make, put your fact clearly that you are looking at it sympathetically, you respect what they ... whatever they will tell you, and if it is a secret and you don't want it to be defiled, I will respect it or whatever. Aaah then they will tell you a little bit more. But I have to be quite frank with you, you are not a chewa, they will never tell you everything, but at least enough for you to see the logic, aah and see why certain things are done in certain ways.

I am quite radical about it ... we cannot allow this to happen, if our girls die, what will happen to the community, they were very concerned. But if several times you bombard them with 'change your habits' this is not good, a chief is a chief, miyambo he is the custodian of (laughs) this is undermining his own power. They will, they will respect you because it is the government, but you have not won their hearts. Aaah, where we, one of the objectives is to try to explain the Chewa customs, traditions, religion, art, culture, aah dances to other Chewas as well as to other people. And we have, we hope that eventually we can have a radio station so that we can have our discussions freely without looking over our shoulders see whether our donors like it or not.

But there is a lot of misunderstanding, a lot of ignorance, a lot of very early condemnation of the issues by people who don't understand, who don't know anything. Lastly, I wanted to, I mentioned that there would be some issues of the positives, in this short paper it is not published, but it's just some of my thinking. I, I, from what I have told you about the responsibility to the community, that is very positive, very powerful for our concern, and therefore, following on to that, there are institutions with traditional, traditional institutions which have been set up which we can utilize, I mentioned may be one or two, I mentioned one, it is here. It is here. One is the marriage counsellors, when the family starts, the woman has, has a *nkhoswe* as her counsellor, her sponsor so to speak. For a life time. The man also has his, these are the people who were there in the marriage

negotiations. They start right at the beginning and if there are any problems, the family wants to discuss they call on these two people, one or two of these people. Now that's an institution which is almost, which is only working now at the actual wedding. When the wedding is there, they say who is the *nkhoswe*, when they go in church they say who is the *nkhoswe*, who is the *nkhoswe* for this woman, who dadadada! That's the end. But that is the institutions traditionally which was there to for the young couple to confide, to discuss issues, if there are any problems they would come, that's one. The other, institution is the traditional court, the chief, the *bwalo* where the elders meet regularly. Aah elders means both male and female in the Chewa although they sit separately. But they go to the *bwalo* under the big tree, that also is a consultative forum and many issues are discussed every case, legal case that is that comes there it is resolved at the *bwalo* where the chief sits with his counsellors as judges. So that *bwalo* system can be used. Then the initiation structures themselves, are very powerful educational and training institutions. You know what the boys and girls learn during initiation stays with them the rest of their lives, they never forget them.

And as an educationist myself, I was interested to know how do they teach (laughter) these boys and girls that they don't forget? Yaah, its songs, proverbs, aaa ee sayings, similes. Our cultures are very symbolic. So the explanation of symbols and what it means aah through songs, but also the instruction is almost one to one. And the demonstration, the physical demonstrations are very important. They will tell you the theories et cetera, but then they demonstrate by some act may be if you are talking about death, you would think that they have brought a dead person there, but actually he is not dead, but the way they present (laughter), the young people get the message that you know, it's not something that is light, it has to be respected because the spirit has left the body yes, but it's there. It is another form of existence. So it is very much interesting. I haven't done much work there but it's amazing that they have been very successful in putting ... and then there is the issue of personal training as well because, if it is a girl, they are taught how to cook, how to look after the children, hygiene, how to look after the house, and this is very important.

Secondly, a Christian influence has been deeply assumed that what is Christian is good, and what a Christian says is bad is bad. And many people of our group have become Christians, have grown up like Christians and really even the Chewa, many Chewas that I talk to, don't know about their culture, they are surprised when I give them some lectures on Chewas religion was all about, and they say, but aaah Chewa religion is good (laughter). So the whole history of cultural suppression had its toll and really even in the west when this disease came, they really didn't know how to tackle it. So really nobody had experience. I would really want to jump to the easy explanation and yaah you are supposed to be curious object of the study, and so aaah, I think that's why I said, I think we missed a point in tackling HIV/AIDS. We would have done a better job. We would have done a better job if we went to the chief, to the *namkungwi*, and explained and had a dialogue with them and told, no one wants their child dead. I am sure that we would have found a very good solution. My wife used to work for UNICEF (P5: 18/12/2008).

Despite this informant explaining about the influence of Christianity what is more interesting is how he makes it known to me that he is a member of the elite. He says as an educationist myself and then talks about his wife who used to work for UNICEF. By associating himself with his wife's position in a UN agency makes him an elite. Furthermore, as pointed out in the previous chapter, elites distance themselves from those communities that observe cultural practices and position



themselves in opposition to them as more enlightened – defined as a reflection of ATR and conversion to Christianity.

The following is an extract from an interview with a Freelance Journalist for a national newspaper. I read an article in a national newspaper concerning cultural practices and HIV/AIDS. I emailed him and we agreed to meet at a radio station in Lilongwe. It was only upon arrival when I signed in I learnt that he was a Reverend and that the radio station was Christian. Transworld Radio's mission is to assist the Church to fulfill the command of Jesus Christ to make disciples of all peoples, and to do so by using and making available mass media to proclaim the gospel of salvation to as many people as possible and instruct believers in biblical doctrine and daily Christ-like living. He told me that during the period of sixteen days against gender-based violence, he normally carries out some write ups focusing on specific areas on the theme that is being set aside that year. I said to him that in his newspaper article he talks about cultural practices. I asked him if he thinks the practices mentioned in his article really contribute to the transmission of HIV. He responded (see Box 5.3):

**Box 5.3 – P3 Interview with a Director**

I think they do because if you look at most of the cultural practices of our concern those cultural practices that either have a stature component or have a component where you know some grievous bodily harm has to be inflicted in order to invoke the power of that particular practice. I mean if you look at *fisi* for instance I mean, its aah surrounding the question of infertility and so in order to resolve that infertility such sexual practice must happen. *Chokolo*, which is wife inheritance, it's the same thing there has to be some sexual activity between the lady and the relation of the dead man, aa same thing with *kulowa kufa*, you find that again it involves ritual sex and so on. Aaah, actually I just pulled a document from my computer in which we will also see oppression, I think three years ago I attended a faith based leaders conference which was looking at some cultural practices which are fuelling the spread of HIV/AIDS in Malawi. I think this does look at quite a number of areas. If you look at these two the central slide which talk about sexual intercourse as ritual cleansing, sexual cleansing, cleansing a child initiation cleansing so you find that you know the sexual act has quite a very central role in aa in the cultural cleansing process. So aah one, one can't wish away these, one can't trivialize the role of you know, of sexual practices in our cultural practices. If you look at the last line there, sex as a coping mechanism and then where it says *Mwamuna ndi kabudula amathera moyenda, mwamuna sauzidwa*, it kind of justifies the fact that its natural for men to be promiscuous. But the husband, the man uses his common sense and common sense for him his wife alone is not sufficient. How loaded that particular statement *mamuna sauzidwa* may be. If you go to page three, there are 6 coping mechanisms. These are some of the practices one of them that I would like to talk about is *chisuweni*, the fourth one. *Nsuweni* means that if I have a cousin, *Msuweni* literally means cousin culturally there is freedom that you can flirt around because your cousin is not your sister and so there is that kind of social closeness between somebody and their cousins so you find that sexually it becomes very easy for people to sexually relate with their cousins. And then of course *Mitala* is polygamy, aaah, polygamy has got a role in the HIV/AIDS. The other talks about sex as a sign of hospitality, and, aah where you pay a visit to a village and then they give you a lady to actually entertain you over the night. So that's aaah the actual basis of some of those. *Kusamala mlendo* means taking care of visitors aah *nkhosa amamwa mkaka wa mberere zake...* to say that aah..... okay let me talk about the one which says *wamkachise amadya za mkachisi*. Its got some kind of religious connotation to say that if somebody is working in a temple, he has to eat, he has

to take their livelihood within the temple which they are working in and that sometimes is used culturally to say that for instance if I am the chief of the village then I can have access to any woman that I want to have access to, aaah and so on and so forth. So this does outline some of those that are quite central in our cultural set up. (P3: 17/12/2008)

He said that the conference he attended was organized by the Norwegian Church Aid where church leaders were brought together to speak about gender-based violence. I explained that the probability of the girl becoming infected in one sexual act is one in one thousand. He said: 'For the young virgin'. I said: 'Well for anyone. And if the person has an STI, then the probability of catching the virus... is every eight in one thousand'. He said: 'Oh! when you talk about that statistics you are talking about, for me it's the first time as well to encounter that'. (P3: 17/12/2008). This point demonstrates how a Director of a religious radio station and journalist was unaware of the disease's epidemiology despite his conveying messages in the newspaper that are not grounded in scientific evidence. It is also an example of how the church is able to powerfully communicate its message through the media. He then went on to say:

Yaah its clear that those types of messages have come up through quite well, I think the impression created in one way aaah aaah, every sexual encounter, potentially, yah potentially you know, can infect you with the virus. But then, aaa I think the issue is one where we do not want to say ... the messages stem from a technical point of view that if viewed from the information and the moment the public gets the information, aaaaaah the public are already threatened then they ... that defeats the whole process of behaviour change ....But to answer your question, it's a, in that scenario of aaah initiation, its chances are that aaah, from just a single sexual act, that doesn't transmit the virus. Perhaps that then calls for a longitudinal research aaah we need the information in Malawi so that we would be able to determine all these claims we are meeting regarding cultural practices that are fuelling the spread of AIDS. If eeeh aaah, can we make evidence based claims. (P3: 17/12/2008)

In his response he justifies why he did not know about the disease's probability of infection by arguing that it is better not to tell the public the truth about the disease otherwise this defeats the process of behaviour change. In other words, he is making points: i) don't tell the public the truth about the disease and ii) people will not change their behaviour if they know that the probability of infection is so low. In the quote above the respondent seems to be patronizing the 'other' as he refers to the public as separate from himself and defines them as uneducated. He then went on to talk about the sexualization of women:

One does see those types of linkages. Aaah some of it is aah in terms of some of the cultural practices, I think, whether they fuel HIV, the spread of HIV/AIDS, personally I think that its very clear that the very practice of them does usually subject a woman to inhumane treatment where the woman is treated more of as a sexual object as opposed to the fact that they should govern their own wellbeing. The observation that is being made in most forums that I have attended is that because we have been too quick to condemn cultural practices, you find that where we are celebrating that they are not being eradicated, they are simply going into hiding. (P3 17/12/08)

One respondent worked as a District Youth Officer in Balaka District but previously worked as a field facilitator for a faith based organisation called Family Life and AIDS Education Ministry that trained community volunteers on HIV/AIDS issues based on biblical principles. He said that people have to understand that ‘HIV cancellation is through spiritual conduct, if they avoid that they are going to prevent from contracting the virus and for them to do that they have to understand that God hates immorality’ (P15: 07/01/09). He said that he does not belong to any church as its interdenominational funded by Oikomonos Foundation from the Netherlands (the Oikomonos foundation is a Christian organisation working on development cooperation and works with local partner organisations in Bolivia, Ghana, Indonesia, India, Malawi, Nigeria and Zimbabwe) – a further example of international donors funding religious activities. He said (see Box 5.4):

#### **Box 5.4 – P15 Interview with a District Youth Officer**

We were teaching them that at least as a family, if they enjoy the family life they have to follow the big responsibility, God instituted the family so that the two, the husband and the wife should live happily, what is happening is that the two are not living happily because they have ignored what God has instituted, so we are trying to teach them that, and again if they had heard to what the Bible said about family life, they are also going to avoid contracting the virus that causes AIDS.

He then went on to explain about cultural practices:

R: There are a lot of cultural practices that are being practiced in Mulanje and Thyolo where we have been working, so we are also tackling that like *kuchosa fumbi*, *chokolo*, how many do you want? *kulowa fisi*... yeah there are many of them.

S: But what are you doing about these practices?

R: For example this *kuchosa fumbi* is practiced during initiation ceremonies, for example after initiation ceremonies they are advised to shake off their dust that is they should have sex. So sometimes we could go to where the initiation ceremonies were taking place and we could advise them that they should stop because it promotes the spread of HIV/AIDS. And again we could go to churches because some of these people who were involved in initiation ceremonies, the *anankungwi* initiation councilors were coming from the churches, so we could go through the churches and talk to them and say look at what the word of God is saying, advise them on this, and not only that, we could also advise the councilors that if they want to cut the foreskin, they should not use the same razor blade, at least each young man should have his razor blade so that they should avoid contracting the virus that causes HIV/AIDS.

He went on to explain that he trained volunteers from the surrounding communities about cultural practices so ‘they could go and teach others’. In return:

As a token of appreciation, I don’t know what I can call this, they could receive something like we were giving them bicycles which they were using to have their ceremonies in the communities and not only that, sometimes we could give them some soap, flour, salt, fertilizer, maize seeds, not as a payment for the work they were doing but....

I asked about the training that takes place:

S: Okay, do cultural practices come up?

R: Yeah it comes out automatically, we have a lesson on that and some of the cultural

practices that I have mentioned come out automatically

S: Why?

R: Some of them are being practiced here in Balaka, so when we take the young men and women for training, we ask them to give some cultural practices that are practiced in their respective areas and what they say it's what I have already said about Thyolo and Mulanje.

S: So what do you teach them about?

R: Cultural practices, firstly they have to understand what the cultural practices are all about and why are they practiced. This comes in the course of the discussion as a facilitator and the participant.

S: Say for example, I am a participator, what do you tell me about cultural practices?

R: I ask you what cultural practices are being practiced from where you are coming from, so you mention them, maybe you brainstorm about them and then you start to discuss are these good?, if they are bad, how are they bad?

S: So what do they say are good?

R: Of course there are some cultural practices that are good, not all are bad, but for those that are bad like the *Kusasa fumbi*, that one is very dangerous because it promotes the spread of HIV/AIDS, after the initiation ceremonies, they are told to have sex with the male youth or female youth and in the course of having sex may be the female youth has the virus, she is going to spread that virus to the male youth and if the male youth has the virus, he is going to spread that virus to the female youth.

S: So let's think about it, you say to young people, what are you trying to advise when they are having sex?

R: Yeah, if they might not have sex before, they might not spread the virus, but it's not only the issue of HIV/AIDS, there are issues like pregnancy, they can impregnate and on the STIs, we don't talk about HIV/AIDS alone, there are some infections like gonorrhoea, syphilis and others so we discuss about the dangers of such things. If you contract the virus that causes HIV/AIDS at one time or the other you will suffer from AIDS and it will jeopardize your health and as a result of this the future is doomed.

S: And that's the Ministry of Health (MoH) incorporating cultural practices in your training, what, where do they come from?

R: It's not the issues of incorporating they were already there.

S: You have talked about cultural practices, so is it already incorporated in your training manual or...

R: Yes it's already in our training manual, we have it and you can see it.

Here we see that although he mentions 'good' and 'bad' cultural practices he only tells me about the bad ones that those are very 'dangerous'. It is interesting that the Malawians themselves make the practices exotic as if I will be impressed to hear about them. We go on to talk about geographical areas where the training is conducted.

S: Do you go to all areas?

R: Yeah we go to all areas and there are youth groups in all areas. There are some areas where cultural practices are being practiced more than other areas like the areas where there are Yaos, this Kalembo side, Kachinga side, Amidu side and part of Nsamala.

S: Predominantly it's among the Yao?

R: Yes! Amongst the Yao.

S: But other tribes do it too?

R: Other tribes, off course they do it but not as the Yao do it.

S: What do you mean?

R: Yaos are doing it much much greater than the other tribes because the other tribes are mixing with other tribes, they have tried to reduce it, but these Yao people, they are difficult to change.

S: Why do you think it's that?

R: I do not know, may be because of the way they were brought up or we just established that these are very difficult to change and we have to follow that, this is what our ancestors, our father were doing so we have to do it. The other thing is that, these people they have problems with school, they do not go to school, you know education also influences once you know to change behaviour so amongst the Yao, you cannot find many people who have gone to school, you will find a 12, or 14 year old female youth is married and is carrying a baby on her back, why.. because of the cultural practices, if you tell them about school, they don't feel the need for them to go to school, maybe because of a lack of role models among themselves, there are no role models, they haven't seen somebody who has gone to school who has completed his or her studies and is working or doing fine because of school, for example, myself, I went to school and I am now working, if I was coming from a Yao area they could emulate my example that he is doing fine because he went to school, so such role models are not present amongst the Yaos. Those that could become role models are no longer there, they left a long time ago and they cannot go back to their respective areas to influence their relatives that you people this is what you are supposed to be doing, so you go to them, you tell them about the badness of those cultural practices but because there are no role models amongst themselves, it becomes difficult for them to change. And somebody amongst the Yaos said that, if you are coming here for your lessons, make sure that you are coming with a sharp axe.

S: Why?

R: They said that not many of us Yaos have gone to school so for us to understand some of the things you are talking about it becomes very difficult, so come with a sharp axe and cut all the roots so that we can change our behaviour, so there are a lot of work amongst the Yao.

S: What does the government do to try to make them to go to school?

R: There a lot of schools, they just start from standard one to standard five then they drop and get married.

S: How old do they reach standard five?

R: About eleven or twelve. So those that are doing fine among the Yaos, for example I am from Blantyre and I am working as a teacher I go and settle there, my children are also learning there they are the ones that are doing fine in their studies not the Yaos themselves (P15: 07/01/2009).

This interview extract (Box 5.4) shows how he is portraying himself as an elite and in this case he is blaming the Yao tribe.

One respondent worked for the Evangelical Association of Malawi (EAM). She explained:

It's an umbrella organisation of TransWorld Radio, Pentecostal and Evangelical Churches, now almost 82 churches and organisations. The Christian Health Association of Malawi is affiliated, EAM is its umbrella. Its core purpose is preaching the gospel but then it realized that there's a need for social services. HIV/AIDS is just one of the projects, with funding from DanChurch.

When beginning a project we normally conduct research, so we did that in about five districts. We learned about cultural practices, normally known as the *fisi*. *Fisi* for families that don't have children is common in the central region and in the south. Then we have the *fisi* in the Central region for ritual cleansing for girls reaching puberty, the parents look for a man to cleanse her, the girl is supposed to do that just because it's culture. And have it for ritual cleansing, especially in the south, when the husband has died (P55: 04/07/09)

I asked 'What do you do to try to change the cultural practices that are a perceived to be a problem?' She said 'We mobilize the traditional leaders, headmen. For the church it's not difficult,

our teaching is based on the Bible, in the Bible we have to wait until we get married to have sex. But for traditional leaders who are the custodians of the culture, we normally conduct trainings.’ I asked what do you tell them in the trainings?

The definition of AIDS, how it is spread, which cultural practices spread it. If possible we encourage their wives to attend. If it’s a she we encourage the husband to attend. We tell them how they can prevent infection, or if they are infected how they can prevent transmission. We tell them, the parents, that you take a man [for a *fisi*] but you don’t have him tested, you don’t know what he is. And then the girl gets married. But not to the *fisi* he is just gone. (P55: 04/07/09) Before the training ends we develop an action plan, that helps us in monitoring. If they are really doing what they wrote on their action plan’. Normally they say at the end of the training we didn’t know this but now that we know we are going to sensitize our community in an awareness campaign, we are going to involve the youths so there can be some songs on HIV/AIDS, so there can be dramas. It is easy to engage the youth’ (P55: 04/07/09)

She said the practices are immoral and that most of the communities where missionaries first came they were the first to stop them. She said that AIDS and cultural practices are parallel issues. ‘For us social workers we would love to identify the issues in whatever we are doing’. Then she talks about stigma in the church, that people who have AIDS are called sinners, ‘the church would say everyone who has the virus is a sinner. But EAM doesn’t want to say this, we don’t want to say *fisii* are immoral. We started working on AIDS prevention in 1999 and cultural practices in 2003 because as we were working with the religious leaders, issue of stigma came out. But the community was finding it difficult to accommodate those with the virus in the communities’. Then there were talks about hunger; that they give out maize. ‘That helped create stigma, since they had to identify as HIV positive to get the maize.’ This started to fight stigma. That’s when we started to approach the traditional leaders because they were stigmatizing, so they said you traditional leaders are also at fault you are spreading HIV. The question was posed “I would think they wouldn’t want you to come to their village?” ‘No No’, she said. We were going there humbly [she clasped her hands and looked down, respectfully]. We would first meet the religious leaders, and then they would meet with the chiefs’ (P55: 04/07/09).

Two of the people that I interviewed showed me the same presentation that was given by the Evangelical Association of Malawi at regional and national church leaders’ meetings. The presentation depicts 20 slides; the first one entitled ‘Evangelical Association of Malawi – Cultural Practices’. The second slide poses the question – what is fuelling the spread of HIV infection in Malawi? One slide then shows the factors that increase community vulnerability to HIV/AIDS and includes cultural and religious practices and lack of biblical sound teaching. The presentation goes on to identify different types of sexual acts which purportedly spread HIV including sexual intercourse for cleansing, sex as a coping mechanism, sex as a factor for hospitality, sex as a factor

of entertainment and sex as a treatment or cause of problem (i.e. health problems from not having sex and sex causing cancer).

An interview with the Coordinator for HIV/AIDS, Nutrition and Health at World Vision in Balaka explained 'We do advocacy. We also work hand in hand with community leaders, the chiefs, church leaders and faith leaders'. Sometimes we just hold a discussion with community leaders on cultural practices in the area and how that, those cultural practices contribute to HIV/AIDS. Sometimes we engage drama groups to come and just entertain people. We are educating people of the disadvantages of those cultural practices'. I asked if she found that community leaders are willing to change the practices? She said 'You just notice the change in behaviour. What they say. Issues of stigma and discrimination. They wouldn't mix with those people with HIV/AIDS. They would not talk openly. They are freely talking about it now. Normally talking about sexual practices is taboo. I asked if she had heard the community leaders talking? Firstly she said Yes. I said Are they saying they have changed them? She said 'No you actually notice them talking. A chief would say something encouraging. I said why do you think that? She said the reason I am saying it is I have actually seen community leaders talking about it (P43: 07/07/09).

The above extract is peppered with development buzzwords – 'advocacy, stigma and discrimination, change in behaviour'. Buzzwords are, what Williams (1976) called 'keywords': words that evoke, and come to carry, the cultural and political values of the time. Such words are frequently used in the language of mainstream development but it is often unclear what these words actually mean and what they do for development policy. It is therefore significant because the informant is using these words without referencing the meaning behind these. She is demonstrating use of development policy language but gives no concrete examples evidencing how behaviour change has actually taken place.

The Malawi Interfaith AIDS Association (MIAA) submitted a proposal to UNFPA entitled 'Combating HIV/AIDS through Elimination of Cultural and Religious Practices' and aligned its objectives with those of UNFPA. This is an example of how national organisations adopt the language of international donors to secure funding. In MIAA's proposal it stated:

Faith-based institutions and organisations could have a profound impact on the HIV/AIDS pandemic when they are properly and adequately equipped with the right skills and knowledge to facilitate their work. Religious institutions as trusted and respected institutions are better placed to play a significant role in the fight against HIV/AIDS. Faith-based institutions can effectively encourage and support loving, just and honest relationships and encourage members of the faith communities to adopt behaviours that renounce and repulse any traits of gender inequality, cultural and religious practice as well as stigma and discrimination that exacerbate HIV transmission by using religious and spiritual teachings in a positive way while at the same time

offer compassion and promote reconciliation. Many Malawians (over 95 percent) belong to most of the faith institutions in the country.

Despite the realization of this critical role that the faith-based institutions could play in the fight against the epidemic, most religious and traditional leaders still do not have the requisite knowledge and skills to wage the war. MIAA Secretariat is requesting financial support from UNFPA intends to strengthen the capacities of the religious and traditional leaders who are the custodian of culture and the congregants to effectively respond to the pandemic. It is expected that through this support faith and traditional leaders and the congregants themselves will cultivate amongst their congregants positive behaviours that also contribute to an effective fight against gender inequality and cultural and religious practices that facilitate HIV transmission. Using data from desk research and culturally sensitive approaches, the proposed project seeks to conduct some training programmes, social mobilization and advocacy sessions for both religious and traditional leaders and the congregants with the view of building their capacity to play an active and positive role in the fight against gender inequality, cultural and religious practice as well as stigma and discrimination. (n.d MIAA funding proposal)

MIAA told me that they intended to design a programme called Mpaka Liti. The programme would fight against gender inequalities and social injustices that are deeply rooted in the cultural and religious norms and tradition in Malawi. In this programme, communities and religious institutions will be challenged to realize that it was about time that things needed to change for the better. In addition, the leaders will spearhead a campaign to modify or completely eliminate the major cultural, religious and traditional practices that are driving the HIV transmission in the country. They would also:

‘Conduct training sessions for members of District Interfaith AIDS Committees in basic facts about the theology of HIV/AIDS. This will help to strengthen the capacity of the traditional and religious leaders to assess and analyse their own personal narratives in relation to the intersections between violence and HIV/AIDS) and conduct training sessions for religious leaders and other influential people within the faith institution. (P52: 05/06/09)

One informant working for World Vision in Balaka told me when I asked: ‘Do you talk about cultural practices and HIV/AIDS?’ He said:

There are many. We have a practice that we call *fisi* – where like I am married and my husband is dead then to drive the evil spirits away I have to sleep with another man. Then there is this belief that for you to be recognised as a man in the society you have to have multiple sexual partners. The other one is..ok..something is... If I am HIV + when you sleep with an albino the HIV will go away. Yah *Kusasa fumbi* - It’s the same as *fisi*. It’s where..and some of the beliefs or rather the cultures is like, yah, when I reach puberty, yah, I have to sleep with a man for me to be recognised as a woman. I ask ‘Is that part of the chinamwali?’ Yes it’s chinamwali. When you reach puberty they take you away for some counselling and the like. And at the end they give you a man to sleep with (P41: 28/04/2009).

As demonstrated in this chapter in an attempt to change people’s behaviours respondents repeatedly asserted that religious leaders need to be targeted. The following excerpt has been taken from a leaflet I was given when I visited MANERELA+’s office which is a further example of educating religious leaders.



### Box 5.5 – MANARELA+ leaflet excerpt

#### **MANERELA + Malawi Network of Religious Leaders Living with or personally affected by AIDS.**

Launched in 2004 by Reverend Canon Gideon Byamugisha. Purpose of MANERELA+ is to prevent and mitigate the impact of HIV/AIDS through the reduction of Stigma, Silence, Denial, Discrimination, Inaction and Misaction (SSDIM) at community and national level.

Specific objectives:

To promote safer and lawful sexual practices and behaviours through the SAVE model.

To improve networking and collaboration among the religious leaders living with or personally affected by HIV/AIDS and the key stakeholders.

The network works hand in hand with stakeholders and other institutions such as MANASO, MANET+, NAPHAM, MIAA, EAM, NAC, Action Aid, Ecumenical Counselling Centre, District interfaith AIDS Committee (DIAC), World Vision International, MAM.

Strategies. The network will fight SSDIM through advocacy, media theological debates or forums, training the religious leaders and other people living with HIV, adherence and peer counsellors training, national retreats, capacity building of the network, gender and human rights mainstreaming and promotion of networking and collaboration, development and distribution of relevant information, education and communication, materials and establishment of district and regional clusters of group therapy.

Working in Mzimba, Mzuzu, Salima, Mwanza, Dedza, Nkhotakota, Machinga and Mulanje.

Funding partners: Norwegian Church Aid; The Southern African AIDS Trust and Christian Aid.

I interviewed a Programme Officer working for the Norwegian Church Aid. She wrote her thesis on religious leaders and HIV/AIDS. When I first arrived in her office she gave me a copy of the study that the Evangelical Association of Malawi carried out on cultural and religious beliefs and practices. This was the same study the Reverend gave me when I interviewed him at Transworld Radio. It is interesting that out of 3 interviews three interviewees shared with me that same study. She told me Norwegian Church Aid works on a number of areas on HIV/AIDS. It is working with two partners focusing on HIV/AIDS in the Lower Shire, specifically Chikwawa and Nsanje. In Nsanje they are working with the Episcopal Conference of Malawi and the Chikwawa Health Commission, as she said: 'cultural practices are prevalent there in Chikwawa', so they are disseminating information on 'sensitisation and awareness'. I asked what do they actually do in terms of sensitisation and awareness? She said: 'The Chikwawa Health Commission produces IEC materials like T Shirts which say on the front 'Let us stop harmful cultural practices'. In Chikwawa working with the Catholic Commission for Justice and Peace through media programmes on the radio as well as trying to emphasise restricting cleansing rites such as *Chokolo*. Here we see the use of development buzzwords once again: sensitization and awareness. When I probe her she responds with more jargon, 'IEC'. In fact she assumes I understand what IEC means as she uses the acronym. By using these words she is demonstrating that she is educated and familiar with development policy. Coupled by her fluency in which she uses this language, and that she is a Programme Officer working for an international NGO based in the capital, she can be described as

a member of the Malawian national elite. (P56: 07/10/09). See literature review where I discuss the literature on elites and policy language.

I asked her if she thought these cultural practices contribute to the spread of HIV/AIDS? 'Yes in my opinion the effects spread HIV. Young boys and girls get infected. The man who sleeps with the girls, he slept with more than one girl. He sleeps with all girls.' I asked how are the boys infected? 'Circumcision. One razor blade is used. And also how to do sex with a woman after initiation'. I said that if we look at the evidence and statistics and the epidemiology of the disease then the probability of infection rate is 1 in 1,000 without any STIs. Her argument was that if we look at prevalence rates 1 in 10 people are being infected. She also said 'If we look at specific activities one of the areas being identified is harmful cultural practices. The evidence is the predisposing area'. (P56: 07/10/09)

Her other argument was that if you take groups of people living with HIV/AIDS one man said that he was the man who had to have sex with young girls and that is how he became infected. This argument doesn't actually weigh up since the man would be having sex with virgins and therefore would not get infected by the virgins. She said that again we need to look at statistics and existing documentation. She said that in urban areas we have antenatal clinics so there are more statistics for urban areas. I argued that in rural areas we also have the Behavioural Sentinel Surveillance data. She then argued that people from rural areas come to urban areas so that is how the disease is being spread around and that those from rural areas are bringing it to the urban areas. This is a further example of blaming the rural villager who visits urban areas and then spreads the disease to the urban elites. She said it is not just an issue of having sex but people having access to information. Information, she argued, is not available. We know this is not true as evidence shows that Malawians are aware of HIV/AIDS. She also says 'It is also an issue of poverty. In our culture people are being encouraged to get married early – this is a cultural practice'. She also talked about the issue of being sick where the same razor blade is used and this contributes to HIV/AIDS. What she says here shows how she is confusing many issues and is not clear how much of the actual epidemiology of HIV/AIDS she is aware of.

This next section looks at the role of religion and the sexual cultural practices themselves in order to understand why they are still observed despite the increased accessibility of biomedicine and education. The reason why I am addressing this issue is to support my argument – why are the cultural practices being observed – but also the way in which the church is trying to distance itself from the practices therefore presenting itself as more enlightened.

Research conducted by Van Gennep (1960) and subsequently Turner suggest that the meaning and significance of religion is entrenched and transmitted through rituals. For Turner (1967) 'ritual' applies to forms of religious behaviour associated with social transitions. According to Longwe (2007) initiation rites form an integral part of contemporary Chewa culture. She argues that apart from the sociological and cultural importance it is within the religious context that initiation rites have the most significant impact on Chewa society. Oduyoye (1992) holds the view that African rituals are psychological, spiritual, political and social. According to Turner (1967) the term 'ceremony' has a closer bearing on religious behaviour associated with social states, where politico-legal institutions also have greater importance. Ritual is described as transformative, ceremony as confirmatory.

Initiation ceremonies are often used for sex education because in Malawi the mother is not allowed to talk about sex to her daughter. Mbugua (2007) highlights this issue in her paper using field data from a study conducted in 1996 and 2003 which examines the socio-cultural and religious factors that prevent educated mothers in urban Kenya from teaching sex-education to their pre-adolescent and adolescent daughters. She concluded that socio-cultural and religious inhibitions prevent educated mothers in urban Kenya from giving meaningful sex-education to their pre-adolescent and adolescent daughters.

I now quote extensively from Longwe's book *Growing up – a Chewa Girls' Initiation* to give context on why a girl experiences initiation:

When a girl experiences her first menstruation she undergoes a ceremony called *chikule* performed for a smooth transition from childhood to adulthood. The belief among the Chewa is that menstrual blood is sacred and that it has mysterious powers of sustaining human life. Proper rituals must be performed and all taboos observed so that nothing endangers her life and that of the whole community so that she should not become sterile or suffer *mdulo*. Whoever notices the girl's first menses must inform the mother immediately who in turn informs the grandmother. The chief, as the owner of the *mbumba* and the one responsible for the girl's initiation is also informed through his *anankungwi* (instructresses).

The taboos to be observed during the girl's first menstruation are sexual abstinence for the parents until the end of her menses when the rituals described below are performed. The chief abstains only in the case of a girl who will be initiated at *mkangali* (the chief's initiation, as discussed below). All informants mentioned that if the parents break the sexual taboo the girl suffers from a disease called *mdulo* or *tsempho*. The symptoms of *mdulo* or *tsempho* are *kutupa masaya*, *kusololoka zala*, *kusanza magazi* or *kutuwa* (swollen cheeks, elongated fingers, vomiting blood or rough dry skin) and eventually the girl dies if not given the necessary herbs to cure the illness. In normal circumstances the girl is given food without salt and is instructed not to salt any food whenever she is menstruating. The grandmother's role is to take the girl into two or three

days seclusion for instruction concerning her menses. The girl is warned of the dangers of having sex during menstruation, and she is instructed on how to take care of the menses so that no one sees the blood, nor the menses linen, called *mwele* or *mthete*. She is instructed to respect her parents, the elderly people and especially the chief. At the end of her menses, the chief provided the necessary herbal medicine, called *khundabwi*, for the girl to eat in food or to drink with the parents (and the grandmother). Again the chief eats *khundabwi* only in the case of the special girl who will undergo mkangali. After taking the herbal medicine, all are free to resume their sexual activity.

Many informants mentioned that in the past, instead of the herbal medicine the girl was given a man to have sex with at night. Such a man was called *fisi* (hyena) because he came at night as a 'hyena to steal'. The warning for both the girl and the man was as one informant stated 'this must be kept as a secret and that it was just a one time ritual not to be repeated or continued'. Some informants said that this practice was the cause of polygamous families, for some men decided to marry the girl after the ritual act. In some cases it was the cause for premarital pregnancies among girls for some men continued to meet with the girl secretly. However, few informants insisted that the ritual is still practiced in spite of the HIV/AIDS pandemic. Their argument is that the family looks for someone whom they see as HIV/AIDS free, for they claim that the elderly women, just by looking someone in the eyes, are able to identify those who are sick. (Longwe, 2007, pp. 41-2)

*Fisi* may be given to a girl to purify her at the end of her first menses. In this case she is tested for pregnancy and not sexual purity (p. 60). However most of the instruction is to 'please' the husband (p. 65). Phiri argued that the importance of female initiation rites is demonstrated by the Chewa, who have four initiation ceremonies for women.

### **Christian's response to the chinamwali**

Research conducted by Turner and van Genep suggest that the meaning and significance of religion is entrenched and transmitted through rituals. According to Longwe (2007) initiation rites form an integral part of contemporary Chewa culture. Longwe argues that apart from the sociological and cultural importance it is within the religious context that initiation rites have most significant impact on Chewa society. *Fisi* may be given to a girl to purify her at the end of her first menses. In this case she is tested for pregnancy and not sexual purity (p. 60). Phiri argued that the importance of female initiation rites is demonstrated by the Chewa who have four initiation ceremonies for women and that most of the instruction is to 'please' the husband (p. 65). Longwe also talks about meetings with the Baptist church and a group of Malawian leaders talk about a national committee which had meetings to discuss a book that the Church wanted to write. The main argument was on their differences in some traditional customs, especially between rural and urban women (p. 78). Furthermore, female church members reported difficulties with what the church was saying, telling them that practices surrounding the life cycle rituals were unchristian and breaking away from some of these practices for fear of the consequences (p. 102). Sexual purity is not taught in traditional chewa society since girls can be introduced to sex on their first menses (p. 113).

In a document produced by the Evangelical Association of Malawi (EAM) entitled *EAM HIV/AIDS Programme: Baseline Survey Report*, 28 cultural practices were listed which purportedly spread HIV/AIDS, including the *fisi* practice. In the report it stated that:

The irony of these practices is that they are still being practiced with more than 84% record of Christianity, and where all the mainland churches have already had their centenary celebrations of their existence. During the focus group discussions with members of the church, it sounded as if issues of sexual immorality and witchcraft are deeply rooted and imbedded in culture such that the Christian faith cannot get rid of it or have it changed. It sounded as like; the Christian faith is far from transforming a culture. As if to confirm this, during the focus group discussions, the church members were emphasising that these practices can not be changed and people can never stop doing these practices. At one group discussion women lamented that such type of immoral practices are just part of our living, and being given a man for sexual intercourse, whether the woman or girl likes it or not is something that we as women have to live with. As women, the women continued, we are hired a man who is sometimes extremely dirty and filthy to have sexual intercourse with, in which case we have to do it because that is what is expected of us, or else, from the woman's own initiative, we take the trouble of bathing and cleaning this man before having sexual intercourse with him. Members of the church are practicing these traditions to the extent that some of the hired men and women are leaders of the church at different positions. (EAM Report, n.d., p. 12)

This paragraph reveals the use of moralizing language such as references to practices as 'immoral' or 'bad' without any attempt to clarify the cultural rationales for the rituals. Associated with this is the accusation that people are unwilling to 'change', and are portrayed as conservative and backward and that the church is unable to 'transform' the culture. It also reveals that women are powerless and are forced to have sex with men and cannot say no. Yet research suggests people are making several changes in their practices both everyday and 'cultural' as outlined in newspaper articles (Schatz, 2005; Smith & Watkins, 2005; Kalipeni & Ghosh, 2007). One respondent highlighted the importance of cultural issues in rural areas:

Aah you know cultural issues are regarded as very very important behaviour in a village setting. Aaah as a district first of all our aim is to *enlighten the community* on these cultural issues because they have been with these cultural issues since time immemorial. (P14: 07/01/2009)

This comment not only demonstrates how he makes the link between cultural issues and rural areas, but also this comment has religious connotations using the word enlighten. It also is an example of educating the other: we need to enlighten them.

The church adopted three stages of traditional rites – puberty, marriage and pregnancy. The traditional instructresses (anankungwi) were replaced with the Christian instructresses. These Christian instructresses worked under the supervision and training of the women missionaries (Longwe, 2007, p. 74). Missionaries adapted the initiation rites which were taught to the

instructresses. It was compulsory for church members' children to attend the Christian initiation rite. The Christianized puberty rite included the instruction on the 'sanctity of the body and the respect due to it, physical implications of puberty, behaviour towards men and her elders. As Phiri pointed out in her observations on the initiation of Chewa women of Malawi:

The public ceremony was held in the evening in a secluded 'well-lit' hall within the village, with all the initiates dressed in white. The programme for the evening was: opening prayer, singing of hymns, sharing of Word of God, some instructions to the girls, welcoming the girls into the group of women by shaking hands, hymn and prayer. (Phiri, 1998, p. 212)

Longwe also talks about meetings with the Baptist church and a group of Malawian leaders to discuss a book that the church wanted to write: 'the main argument was on their differences in some traditional customs, especially between rural and urban women' (Longwe, 2007, p.78). Furthermore female church members reported difficulties with what the church was saying, telling them that practices surrounding the life cycle rituals were unchristian and breaking away from some of these practices for fear of the consequences (p. 102). This point highlights the church's concern to distance itself from tradition positioning a more 'pure' form of Christianity as more enlightened. Sexual purity is not taught in traditional Chewa society since girls can be introduced to sex on their first menses (Longwe, 2007, p. 113) and are required not to be pregnant during the time of *chinamwali* whether married or not. *Chinamwali* is not just about sex education but has a deeper religious meaning – establishing fertility for the initiates (p. 113). According to Longwe biblical teaching on good morals:

Will help girls (and boys) to abstain from sex before marriage and to remain faithful during marriage. Jesus brings new life to the Chewa people. He gives added inward empowerment against sexual sin. Against this is a juxtaposition with tradition and trying to modernize a culture. The scriptures teach sexual purity until marriage and sexual faithfulness in marriage. Sexual purity also protects the girls from contracting the deadly disease of HIV/AIDS (Longwe 2007 p. 113).

She believes that if instructresses consistently carry out Christian *chinamwali* and give continuous instruction to the girls there should be no room for double initiations – secretly the traditional one first and later the church one: 'Let the initiates be taught how to live as adults and Christians in society' (p. 117).

One informant gave his opinion of the *chinamwali*:

Aah, because of this emphasis on fertility, aah now issues of sex through which they understood, is the way through which the children come, unlike there are some cultures in the pacific, they don't associate sex with reproduction (laughs), very funny, (laughs), but Chewas looked at the sexual act as part of the creation, reproduction, the continuation of God's power to increase

humanity and so it is sacred, it has to be regulated by *miyambo*, its eeh, *miyambo* is translated as customs, but the word customs does not really capture the meaning of *miyambo*. *Miyambo* will also include ethical code in it, and not just a custom, a habit no, aah it's a code, and ethics around the responsibilities to the community. Every *mwambo*, *mwambo* is singular, is for the betterment of the individual, within the community so during this, in this are you have to have all these regulations to ensure that the community increases. (P6: 18/12/08)

### **Where are the practices located?**

When asked what cultural practices take place many respondents mentioned the location and cited Nsanje, a district in Southern Malawi. The people of Nsanje are traditionally Sena and Mang'anja ethnic tribes. However, in a study carried out by Munthali and Zulu (2007) which analyses data from a national representative survey on the knowledge, attitudes and practices that put adolescents at risk of HIV infection or unintended pregnancies in Malawi where a total of 2,027 female and 2,101 male adolescents were interviewed. These data were supplemented with 102 in-depth interviews with adolescents; findings reveal that in-depth interviews (IDIs) conducted in Malawi with male and female in-school and out-of-school adolescents and married and unmarried adolescents aged 12-19 in October/November 2003. There were 48 interviews with males and 54 interviews with females. The study found that 75 percent of females reported attending an initiation ceremony after attaining puberty were from the Yao ethnic group, followed by 60 percent from the Lomwe tribe and 53 percent from the Mang'anja. These statistics are relevant as they demonstrate that the highest number of females participating in initiation ceremonies are from the Yao tribe, and 82 percent of females involved were Muslims (although the Yao tribe are primarily Muslims, not all Yao are Muslims). This demonstrates that contrary to most respondents' views regarding cultural practices taking place in Nsanje the majority of initiation practices take place amongst the Yao in Mangochi.

### **Conclusion**

This chapter has demonstrated how religious elites portray themselves enlightened compared to the backward largely non Christian rural people. They perceive cultural practices as negative because they think they spread the HIV virus. They also, like the political elites (and indeed they are often the same people) blame the villagers for spreading the virus. What is interesting in this chapter is how the religious elites volunteer information on sexual cultural practices and enjoy talking about them. By referring to the sexual cultural practices at length they distance themselves from the villagers who supposedly carry out these practices and conveniently apportion blame for HIV/AIDS away from them.

## **CHAPTER 6 The Construction of Policy: Donors, HIV/AIDS and Cultural Practices**

*The 15<sup>th</sup> International Conference on AIDS took place in Bangkok. Delegates welcomed an increase in funding to combat the disease but disagreed how to spend the money most effectively. Politics rather than science dominated the discussions. (The Economist, 17 July 2004)*

This chapter explores the dynamics of the policy development process. An analysis of the process is significant for this topic for the following reasons. My research findings demonstrate that policy on so called sexual cultural practices and HIV/AIDS in Malawi is not evidence-based and that policymakers are trying to modify or eradicate certain sexual cultural practices without any evidence to support the policy decision. This can clearly be seen in the interviews I present with individuals working for INGO and NGOs. Additionally, my data reveals that global policies are in fact influenced by the dominant narratives of blame projected by the Malawian religious and political elite rather than the medical epidemiology of HIV/AIDS. By focusing on narratives, I am able to show that the policy process is not characterized by rational policymaking but by people's views and interpretations which are in themselves bias and often politicised. First, I analyse the process of policy construction. Second, I look at the aid game in Malawi. Third, I look at how these narratives have been passed on through education. Fourth, I present data from interviews I conducted with UNAIDS to present stakeholders responses to the question *Does your organisation use evidence to inform policy and programmatic decisions on HIV/AIDS?* In my conclusion I reflect on the policymaking process and why policy and programmes on HIV prevention in Malawi are ineffective.

### **The process of policy construction**

I begin this section by examining the literature on policymaking processes, which proposes several different theoretical models. I analyse what authors have written to help develop my own analytical framework, presented in chapter one.

I have shown in chapter five how different types of knowledge exist in Malawi, for example African traditional beliefs, different denominations of Christianity and the biomedical rationalist secular worldview. What is clear through analysing policy documents surrounding HIV/AIDS is that policies are shaped by negative interpretations of cultural practices that have been constructed by Christian leaders and the Malawian elite.



In the 1990s we witnessed a great rush to produce global policies on HIV/AIDS (see chapter four on international frameworks on HIV/AIDS): it was acknowledged that the greatest impact of the HIV/AIDS pandemic had taken place in developing countries, particularly in sub-Saharan Africa. The international AIDS community produced policy documents in abundance raising and spending a millions of pounds on prevention and although the number of new infections had been falling (UNAIDS, 2010) there is not much evidence that policy (Ainsworth & Teokul, 2000) nor prevention programmes have been effective (Potts et al., 2008). As Chin argues, HIV prevention programmes have only received limited success (Chin, 2007). I present three examples to demonstrate how policy and prevention programmes are not working.

[T]here are remarkably few policy success stories on a national scale. Thailand is the clearest case: after an intense national campaign to raise condom use in commercial sex, the condom use rate for brothel-based sex workers reached more than 90%, STD cases declined precipitously, and HIV prevalence among army conscripts dropped by more than half. Infection rates among pregnant women have since declined, although are still high at 1-2%, and these accomplishments seem mostly sustained throughout the East Asian financial crisis. In Uganda, HIV prevalence has declined among pregnant women and young people who are delaying sexual activity. However, it is difficult to attribute either of these outcomes to public policy. The decline in prevalence may be due to heightened mortality among HIV-positive individuals or the natural evolution of human behaviour faced with a generation of high mortality associated with sexual behaviour. (Ainsworth & Teokul, 2000, p. 55)

Second, a mathematical modelling tool, known as the modes of transmission model, is used by decision-makers to target measures for preventing HIV infection. The model estimates the number of new HIV infections that will be acquired over the ensuing year by individuals in risk groups that have been identified in a given population using data on the size of the groups, the aggregate risk behaviour in each group, the current prevalence of HIV infection among the sexual or injecting drug partners of individuals in each group, and the probability of HIV transmission associated with different risk behaviours (Case et al., 2012). There is evidence from modelling that incidence tended to peak around the mid-late 1990s (Shelton, Halperin & Wilson, 2006), before much was done regarding HIV prevention. For example, in Malawi the models show incidence peaked in 1997 at 1.91 and by 2011 it was 0.45, but little donor money for AIDS had come into the country before 1997, and the NAC was not formed and active until well after 2000.

Third, money has kept Persons Living With AIDs alive via Anti Retroviral Therapy, and that might have some prevention impact by lowering viral load, but it is not yet known how much this has contributed to reducing incidence, and in the longer run it might not matter much if inconsistent adherence produces mutations in the virus that cancel these effects.

UNAIDS, a programme established in 1996 by six UN agencies to follow on from the work of the World Health Organisation's Global Programme on AIDS in 1987, was an attempt to coordinate efforts to curb the pandemic. The UN Millennium Declaration, signed by the majority of world leaders, put HIV/AIDS at the top of the international policy agenda. At the first-ever Special Session on HIV/AIDS of the United Nations General Assembly (UNGASS) in 2001, UN Member States strengthened the response to Millennium Development Goal 6 by unanimously endorsing the *Declaration of Commitment on HIV/AIDS*. This *Declaration* included time-bound pledges to generate measurable action and concrete progress in the AIDS response. At the five-year review of implementation of the *Declaration of Commitment* in 2006, UN Member States reaffirmed the pledges made at the 2001 Special Session. Also, in the *Political Declaration on HIV/AIDS*, they committed to taking action to move towards universal access to HIV prevention, treatment, care, and support by 2010 (UNAIDS, 2008).

Despite such efforts the reaction of policymakers in developing countries has been incredibly varied. Some have placed HIV/AIDS at the top of the policy agenda and established National AIDS Commissions. However, where National AIDS Commissions have been created the problem has not been fixed (Putzel, 2004). Studies refer to the success stories of Senegal and Uganda and claim that infection rates were reduced due to political leadership (Putzel, 2003; Moran, 2004; Putzel, 2006; Foley, 2010). South Africa, by contrast, witnessed some of the highest prevalence rates in the world due to the reluctance of politicians to act upon the evidence and respond to the disease. The National Party had 'little incentive to mobilize public resources to counter its impact' (Fourie, 2006, p. 52), particularly as the virus appeared primarily in marginalized groups, such as sex workers and white gay men.

The biomedical evidence tells us about the causes of the disease and how to stop it from spreading. It is accepted in global health policy circles that it is sexually transmitted and that it can be prevented by abstinence, mutual fidelity in a partnership that is concordant seronegative or consistent competent condom use. Yet politicians can only take effective action if they comprehend the epidemiological characteristics of the virus. So the questions emerging from my research are: 1. Why has the biomedical view failed to dominate the prevention discourses in Malawi? 2. Why has the international policy community strayed from this knowledge and adopted the narratives of blame constructed by the elite in Malawi?

In most developing countries HIV/AIDS is on the policy agenda. In Malawi my research has shown that policies and programmes on HIV/AIDS and traditional cultural practices are not informed by

evidence. This raises the alarming question, if this is the case in Malawi is it also true elsewhere? Stakeholders and policymakers think they have evidence, as my interviews presented above highlight, but in reality it is anecdotal or of poor quality. For example, data coming from misreporting, from advocacy documents such as those produced by development agencies or from focus groups and surveys that are small scale are then used to quantify large claims about the causes and reasons for Malawi's high transmission rate. There also seems to be an over emphasis on quantitative data and that numbers provide more 'evidence' than qualitative data. One respondent told me: 'DFID pushes numbers. Much more so than we did in the past' (P30: 11/03/09). Another respondent working for USAID informed me that a problem was that people do not accept qualitative, ethnographic studies as evidence (P32: 12/11/09). However, it is the qualitative analysis of local peoples' perceptions and knowledge around HIV/Aids and attitudes towards sexual behaviour that in fact give us a much more in-depth picture of how prevalent 'at risk' behaviour actually is and offer possible ways of challenging or breaking cycles of transmission.

Local NGOs are therefore asked to generate numbers, which they dutifully do, but the qualitative analysis that seeks to understand why people hold the views they do is rarely done. In other words, the data on transmission is stark, we can accept it is high, but understanding why it is so is left to the Malawian elite to interpret rather than a rigorous process of systematic ethnographic qualitative research. INGOs presented with the data turn to the elites and ask them to explain it; the narratives of blame have thereby been constructed and presented as the 'why' transmission is high. My interviews and analysis shows that the international community then accepts these interpretations which in turn take on a certain 'mythical truth' about transmission rates in Malawi. My data reveals that those national actors asked, for example by DFID, to come up with explanations for the high prevalence do so with vested interests – for example and as chapter four and five have shown, they are also driven by religious beliefs and/or by financial incentives. It is hardly surprising that the resulting HIV prevention programmes are ineffective in curbing transmission – they simply do not get to the root of the problem as defined through and by the biomedical evidence.

### **The development policy process**

#### **What is policy?**

There are confusingly many different definitions for the word policy. The Oxford English Dictionary (2007) describes policy as 'a course of action adopted or proposed by an organisation

or person'. Anderson (1984 p. 3) defines policy as a 'purposive course of action followed by an actor or set of actors'. 'Purposive' suggests that it is goal oriented which encompasses specific solutions to problems as well as frameworks for implementation. Buse et al. (2005, p. 6) describes health policy as embracing 'courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system'. Many scholars stress that policy is inherently political (Foucault, 1991), and in some countries, for example France and Spain, the word policy and politics are the same. Policy draws on concepts from several disciplines: economics, history, political science, public administration and sociology and emerged as a sub-discipline in the late 1960s, mainly in the United States.

Development policy has traditionally been seen as a state-led public policy (Hogwood & Gunn 1984; Grindle & Thomas, 1991). However, scholars have recognized a shift in the policymaking process, which now involves a larger group of actors (Buse et al., 2005). It is increasingly observed that the policy process landscape is changing and that public policy is not constrained to government. Different groups – governments, civil society organisations, coalitions, networks, NGOs, the private sector and religious groups as well as national and international media – are important players in policy development. Bilateral, multilateral agencies and NGOs have their own policies and partnerships between the public and private sector take place which also change the policy landscape. It is therefore not surprising that with so many different policies and partnerships that the policy process becomes confusing and muddled and as a result programmes are difficult to monitor and evaluate.

The following examples reveal how policy is made amongst different actors. When I asked the Director of DFID in Malawi 'Can you explain how policy is made within DFID at the country level?' she explained:

It depends on the issue. Sometimes we are leading. Sometimes we are following. DFID buys into the country led approach. It is about what is needed in the country and what the Government of Malawi wants to do on HIV. HIV is a massive problem. So here right now we are continuing with a policy that is already up and running. We continue to monitor a whole set of indicators. We have a key request to disburse £8 million pounds for the Sector Wide Approach. There are gaps regarding challenges and opportunities. Policy is ongoing – you need to check you are on track and you are not missing a trick. (P30: 11/03/2009)

This passage clearly highlights the extent to which DFID follows and adopts both the policies and explanations behind them already formulated at national level. She went on to say: 'One thing DFID has done a lot of is trying to solve problems' (P30: 11/03/2009). DFID sees itself as a trouble

shooter swooping in to sort out implementation challenges, it does not however seem to take the lead in the design of policy or even the collection of data by which policy may be evidenced.

When I asked the Country Director of World Vision how did they develop policy he said: 'We try to look at government country level policies – like HIV/AIDS. We interpret policies and work "hand in hand". We also work with different donors. We have received money from DFID for work in the past' (P28: 11/03/2009).

So again, World Vision is admitting here to not taking a lead role in the formulation of policy but rather works with national actors on the implantation of pre-agreed priorities accepting the evidence and narratives put forward by national stakeholders justifying a particular set of actions. Similarly one informant at USAID told me 'USAID's work depends on the policies of the government' (P31: 11/03/2009), so once again we see the role of the bi-lateral and multi lateral aid community to be one of supporting and funding implementation not questioning or challenging the wisdom of the national strategies themselves. A policy document entitled 'Malawi –German Health Programme, *Malawi-German cooperation in the health sector*', revealed:

The Malawian and the German governments cooperate closely in the sectors basic education, democratic decentralisation and health. Malawi-German cooperation with the health sector has a long history going back to the 1980s. Its ultimate goal is to improve the health status of the population. The German government supports the SWAp as a means of efficiently delivering the range of health services specified under the EHP. (no date, p. 5)

In my interviews with staff at UNAIDS it was clear that they were not happy with the operational structures of the Government of Malawi and specifically with the way in which the national AIDS strategy was put together and presented. Staff told me they felt it had been compiled in a rush with no adherence to participatory methodology that stresses the need for local views and experiences to be gathered systematically feeding into the policymaking process. In fact, on numerous occasions I heard staff describe the process as 'quick and dirty', they felt that involvement of the private sector in the policy process might have resulted in a much more robust and transparent process of programme design, instead it was not clear how the resulting programmes were put together, and no clear evidence for the narratives around high transmission available. What is interesting and also troubling is why did UNAIDS not question the narratives emerging from the process if they were unhappy with it and if participation was not happening. The UNAIDS staff member said:

The private sector has no participation in this process. It wasn't like the forum of active participation. Organisations such as MANET+ and NAPHAM had no consistent opinion and there

was no advocacy. The forum in which it was done did not influence active participation. It wasn't very well organized. (P59: 5/6/09)

This lack of public critical questioning of the policymaking process is apparent according to the INGOs and donors I interviewed and reveals clear apathy on their part. A reluctance to challenge the government, yet clearly privately acknowledged that the policies and frameworks were not robust. Part of this apathy may be due to contradictory views on the role of these agencies, for example according to UNAIDS its remit is as a facilitating agency however when I interviewed a UNAIDS staff member I was told 'UNAIDS prevention strategy has tried to *influence* the national prevention strategy' (UNAIDS consultancy 16/04/2009). This point of view completely contrasts to the view of the Programme Officer, UNAIDS who I also interviewed who said several times that UNAIDS role was to facilitate, not to influence (P25: 04/02/2009). This confusion provides an explanation as to why national policy processes remain unchallenged and why certain inaccurate narratives then become taken up without the evidence to support them, in an environment of such contradiction it is easy for forcefully presented views to dominate, the Malawian elite are nothing if not forceful.

Further explanation emerges through the fact that donors are not always in agreement with each other. So there is no united front between the donor community, this in itself is problematic as concerns are not shared. For example A DFID staff member informed me that:

There are issues we have with the Global Fund. Donors are disagreeing over basket funding. We have to negotiate with the Ministry of Finance. Different donors have more or less strict rules and then there are the Global Fund's rules. DFID believes in basket funds and SWAps (P30: 11/03/09)

The next section looks at the theoretical models of policymaking. This section is relevant as it explains the policymaking process which is fundamental to the thesis.

### **The schools of policymaking**

The concept of policy proposes a puzzling mix of frameworks and theories ranging from extremely prescriptive to descriptive (Hecló, 1972). Although there are many theories on how policy is made, understanding how the process works has been principally constrained with two opposing approaches to development policy. These can be summarised as follows. On the one hand there is a rational approach to policy, which was pioneered by Laswell in the 1950s (Laswell, 1956). This public policy model, also known as the linear or knowledge-driven model or *stages heuristic*, assumes that policy is a one-way process and that policymakers approach issues in a linear fashion whilst identifying different stages of the process. Significant features of the rational model

are a focus on agenda setting, policy formulation, decision-making, implementation and evaluation (Young & Quinn, 2002). Foltz describes the rational approach as decision making that can be carried out in an 'orderly fashion, starting with assessment of the problem, collection of data, synthesis, weighing of the alternatives, selecting objectives and actions and a system to evaluate performance and outcome' (Foltz 1996, p. 210). According to ODI, the rational model assumes a clear separation between fact (based on evidence, science and objective knowledge) and value (seen as a separate issue, dealt with in the political process) (ODI, 2006). The rational model is also seen as prescriptive and presents an 'ideal model' of how policy-making should happen, providing a way of ameliorating the effectiveness of policy-making through the identification of values and goals before making policy choices and opting for the best policy options based on information regarding the costs and consequence of each (Simon, 1957). This model was also seen as the solution to fixing political problems faced by public administrators. Gordon et al propose that the linear model is 'a normative model and a "dignified" myth which often shared by policy-makers themselves' (1993, p. 8, cited by, Shore & Wright 1997). As Mosse points out:

Now extensive literature argues that development's rational models achieve cognitive control and social regulation; they enhance state capacity and expand bureaucratic control (particularly over marginal areas and people); they reproduce hierarchies of knowledge (scientific over indigenous) and society (developer over 'to be developed') and they fragment, subjugate, silence or erase the local, all the while 'whisk[ing] these political effects out of sight' through technical discourses that naturalize poverty and objectify the poor and depoliticize development. (Mosse 2004 p. 4)

Nonetheless such approaches continue to be perpetuated as part of the policy development and planning techniques of international development agencies which have encouraged non governmental agencies and governments to use them. Yet this type of framework fails to recognise the gap between theory and practice and many scholars have attacked the rational approach. Sabatier (2007) criticizes this model as it presumes a linearity to the public policy process that does not exist in reality, it posits neat demarcations between stages that are obfuscated in practice, and suggests no propositions on causality. In a report for ODI, the UK's independent think tank on international development and humanitarian issues, Young and Mendizabal (2009) concludes that 'more evidence-based development policy may not be possible with traditional linear tools and approaches' (p. 3). In other words, the linear nature of such models is blocking the path for evidence-based policy. Linear tools used in development planning include the logical framework which is a management tool mainly used in the design, M&E of international development projects. Authors sum up problems with the Logframe Approach (LFA):

Unfortunately (for the logical framework approach at least) we are not working with such a self-contained system and there are so many factors involved which lie beyond the scope of the planned initiative that will change the way things work. Although the LFA makes some attempt to capture these through the consideration of the risks and assumptions, these are limited by the imagination and experience of those involved. As a result the LFA tends to be one-dimensional and fails to reflect the messy realities facing development actors. (Bakewell and Garbutt, 2005 p12).

Some scholars talk about the 'non-linearity' of policy where policy is often contested, reshaped or initiated from different points between macro and micro levels (Lipsky, 1980; Lindblom, 1980; Shore & Wright, 1997). On the other hand there is an *incrementalist* view which, as a criticism to the rational model of the policy process, the *incrementalist model* was put forward. The principle advocate of this model is Lindblom (1959, cited by Walt, 1994) who is concerned with the process of bargaining between different interest groups in the course of policymaking. This model also assumes incremental changes are made over time in order to decrease uncertainty, conflict, and complexity in processes of policy change and has descriptive overtones. It is incremental in that the process does not commence with objectives but with what exists and how one can proceed from this point.

However, literature on policy processes is now shifting away from the linear and incremental model and demonstrates such frameworks to be an inadequate reflection of policymaking in practice (Clay & Shaffer, 1984; Hajer, 1995; Keeley & Scoones, 1999). There is a third alternative to these models, and the view that I follow, which looks at the policy process consisting of power dynamics, relationships and vested interests of actors who are driven and constrained by the contexts within which they operate. My view gained from my professional experience working as a Consultant to governments and organisations on strategic planning and policy development resonates with recent literature, which emphasises the complex and messy processes by which policies are understood, formulated and implemented and the range of competing actors' interests involved (Keeley & Scoones, 2003). Clay and Shaffer's 1984 book, *Room for Manoeuvre*, describe 'the whole life of policy as a chaos of purposes and accidents. It is not at all a matter of the rational implementation of the so-called decisions through selected strategies' (cited by, Keeley & Scoones, 1999, p. 33). Walt et al. (1994) observe that rarely scholars look at the process of policymaking, the actors involved and the context in which those actors operate, but instead focus on content. Ramalingam et al. (2008) describe the process as non linear and complex with a multitude of factors involved. Keeley and Scoones (2000, p. 4) argue that this complexity 'may allow spaces for the assertion of alternative storylines and practices, which, in turn, can gradually result in substantial challenges or shifts in the knowledge and practices associated with previously



dominant discourses'. This can be seen in the Malawian context where the process is complex due to the amount of actors involved in policymaking.

Keeley and Scoones (1999; 2003) suggest that policy-making requires three broad *approaches*. One, policy emphasises political economy and interaction of state and civil society and different interest groups. Two, it examines histories and practices linked to shifting discourse and three, it gives primacy to roles and agency of individual actors. There is an integration of different but overlapping perspectives, rooted in different schools of thought and disciplines, which explore how actors make and shape policy narratives and interests whilst at the same time being constrained. McGee (2004) talks of the 'unpacking' of policy by looking at three different *concepts*: actors, knowledge and spaces. IDS (2006) adopt a similar conceptual framework to analyse the policy process but refer to three interconnected *themes*, namely discourse/narratives; actors/networks and politics/interests. It is important to note that the policy process does not take place in a void. Rather it takes place within a context in which history, culture, political economy, politics and power relations shape aspects of the context, the policy spaces and the way actors and knowledge interrelate to them (McGee, 2004, p. 23).

The role of NGOs in the policy process compared to district governments is often confusing as I discovered (Box 5.2). Save the Children was once the umbrella organisation in Balaka and was responsible for distributing funds. Then the Government changed the system and put the district government in charge of funding CBOs. Officials were sent from NAC headquarters in Lilongwe to provide training to CBOs on proposal writing to secure funds. What I then found was that the proposals submitted by the CBOs and FBOS after NAC officers had provided training on proposal writing the majority of CBOs were asking for funds to work on eradicating cultural practices. This has to be questioned as to why most CBOs that had different organisational objectives would be requesting funds for eradicating sexual cultural practices. For example, I obtained the proposals from Balaka District Council and it was clear from my analysis of them that the current trend at the time focused on the eradication of HCPs and CBOs knew that if they asked for money to work on cultural practices and behaviour change they would be more likely to secure it, whether or not they then used these funds on projects focused on eradicating HCPs is not clear, it is possible they diverted funding into their own commitments, through which perhaps a degree of meaningful impact was in fact achieved.

### Box 6.1 – P15 Interview with a District Youth Officer

S: Okay, let's continue with your work, how do you get funding from the Ministry of Health (MoH), do you get it directly?

R: We get funding from various NGOs, we have the Malawi Bridge project in Lilongwe, we have worked with them they have assisted us in many areas, we are also working with other NGOs like Concern Universal, Self Help Africa, formerly known as Self Help Development International, MACOHA, and there are a lot of NGOs, based in Balaka, they are working in Balaka and Ntcheu. The coordinator is based in Ntcheu; we combine the districts Balaka and Ntcheu. Save the Children, they phased out but we have worked with them, PSI, Blantyre Synod, Sue Lyder foundation, YONECO, Maphunziro foundation.

S: So they give you funding?

R: They don't directly give us funding but they conduct some activities for the youth so we take advantage of them because as government we have the programme and these people know what the government want to do with the youth. They realize that the government itself cannot manage to do all these activities; it is also depending on the NGOs.

S: How do they know what the government wants to do?

R: We have stakeholders meeting with them at least once or twice a year

S: With all the NGOs?

R: With all of them and during such meeting we disseminate what the youth policy is all about and its during this stakeholders meeting it's when the NGOs know what the youth policy is all about, say about the youth. So what they are doing it has to be in line with the youth policy.

S: So how does it work?

R: If they are not doing what is in line with the youth policy, we have to tell them that no, this is not what the youth policy says about the youth, this is what you are supposed to be doing.

S: So do they do their activities independently?

R: Of course they can do things independently but they have to follow what is in the youth policy

S: So does the youth policy mention about cultural practices?

R: Yes, it mentions about the cultural practices, I had a copy but somebody took it last week.

S: And the other NGOs, how do they know about trying to change cultural practices?

R: Let's go back to the youth... I mentioned about the cultural practices that enhance the spread of HIV/AIDS among the youth, there is a mention of that.

S: Okay, how do you work with the NGOs and how do you make sure that what the NGOs are doing is in line with the national policy?

R: When they are implementing their activities, they inform us that this is what we want to do with the youth and we go and see their project and we sometimes advise them on how they can go about it, sometimes they invite us, say, come and see what we are doing, or before they start the programme, they invite us to see what they are doing, but there are some who are implementing youth activities without informing our office, that is an offence, if we discover them, it's an offence.

S: What do you do?

R: We sue them and we tell them to come and brief us on what they are doing, if they continue doing that then we sometimes, we have what we call the district executive committee. This is the committee for all heads of government and NGOs, we have that in Zomba. In this committee all the activities that are happening in the district are briefed there so if an NGO is found doing what is not in line with government policy then it's taken to task. But people are careful; they know that if we do what is not in line with what the government wants to be done. So they are much more careful about that.

I spoke to a director of an NGO in Zomba he said his organisation focused on education but he said when speaking to senior managers in charge of NGOs if staff were not personally interested in education then they would not fund projects on this topic. This is an example not just of the institutions objectives but the staff that work for the institutions. If they have personal interests in a specific issue they will not fund projects that want to address other issues even though this issue says education is important and needed in that area. This example demonstrates that even

if an organisation has a strategy to implement staff working for the organisation have their own interests and can decide what will be funded. What then is the point of an organisation's strategic objectives if personal interests can get in the way?

CBOs in Malawi are often run by individuals who are motivated by a single set of community rooted issues, they will manipulate their own agenda in order to secure funds but ultimately are unwilling to side-track from their priority. Much money intended for HIV/AIDS was channelled through CBOs who were contracted to use it to eradicate HCPs, the lack of transparency in the process makes it difficult to know if this happened. For example, when I analysed 43 funding proposals submitted by CBOs to Balaka District Council for projects on harmful cultural practices and HIV/AIDS I found that although the project proposal stipulated they would be working on HIV/AIDS when I looked at the budget I discovered that the activities they wanted to fund were related to income generation which suggest these funds were being re-diverted for other projects which the CBO heads felt were of greater priority. These projects not only did not focus on HCP eradication but did not focus on HIV/AIDS either. The reality of this funding chain and the competing interests and priorities of each link is another key factor why donor money failed to have any dramatic impact in reversing transmission rates in Malawi.

The relationship between CBOs and INGOs in Malawi is fraught with tensions. INGOs are essentially donors who wield great power in determining how and which CBOs receives funding. As Lewis and Kanji pointedly describe:

For post-development critics such as Temple (1997), NGOs are viewed negatively as a continuation of colonial missionary traditions and as the handmaidens of the capitalist destruction of non-Western societies. Within this view, NGOs are modernizers and destroyers of local economies and communities which were once based on age-old systems of reciprocity, into which NGOs introduce undesirable Western values. (2009, p. 44)

Locally based CBOs in Malawi have found a way around the power hierarchy of the aid industry, they play the game to an extent, securing funding and then continue as they please, whether or not their efforts bring about positive development outcomes has not been closely explored as demonstrated above by my analysis of funding proposals submitted to Balaka District Council by CBOs.

CBO employees know how to play the donor game. But the 'big' donors who sit in their offices in the capital rarely meet the CBOs, at least not in the field, therefore have no idea what is actually

needed on the ground in the villages. When I interviewed the health specialist at DFID he had been in situ for four months and he could not talk about cultural practices even though DFID had funded a project on cultural practices and were funding national NGOs and the NAC who were distributing funds to CBOs to work on 'sensitizing religious and traditional leaders' about the eradication of cultural practices which were, according to the narrative, spreading the HIV virus. Although he could not talk about the things that were being funded he volunteered to talk about 'policy'. He said:

NGOs, CBOS and MOH and NAC have had a role in the grant making process which is a national agreement. We support other organisations and international NGOs; for example, the Malawi Economic Justice Network. We have the right focus to ensure vulnerable groups are properly taken into account (p4: 17/12/2008)

He then said he can get very absorbed in the process. He also said that DFID ensures that they (DFID) are aware of impact. Although DFID may be aware of impact through reporting procedures I discovered that there seems to be a disconnect between the donors and the CBOs that actually carry out the work, which seems to largely work to the advantage of local organisations who can carry on without fear of scrutiny with the agenda they themselves have set.

INGOs working in line with the government's national strategy put together training and capacity building workshops in order to help CBOs deliver and achieve on the goals of HIV/AIDS eradication (Webb, 2004). As an academic pointed out who worked at the College of Medicine:

Where is the evidence? When policy was developed people did not know how HIV was spread. The perception was that if you had sex with someone who is HIV positive then you would be infected. However 20 years later epidemiologists have discovered that there is 1 in 1,000 chance of contracting HIV (P50: 29/10/2008)

This reaffirms my point that evidence is not being used to implement policies and programmes on HIV/AIDS prevention in Malawi. Projects are funded because certain topics become the trend in the development field and the latest topic that donors want to prioritize. Yet if donors choose to increase funding for a particular issue they must decrease funding for other issues unless they can obtain additional resources (Feeny & McGillivray, 2004). This can be seen in the case of HIV/AIDS funding. Shiffman (2008) found that donor prioritization of HIV/AIDS treatment and prevention in developing countries displaced aid for other health issues. UNAIDS reported that:

It is an unfortunate reality that budgeting procedures too often may mean that new funds for HIV/AIDS can draw resources away from other activities, either at country level, or at donor level. Therefore, all parties need to commit themselves to the principle that additional funding for

HIV/AIDS is to be used for additional spending, otherwise displacement is inevitable to the detriment of overall development. (UNAIDS 2004 p. 145)

A study carried out in Malawi which looked at local people's needs revealed that villagers' main concern was not HIV/AIDS but water. Here we see a discrepancy between international policy and the reality on the ground, and how donors are not in tune with what is really needed (Dionne, 2011). Ironically, and from my observations and conversations with CBOs in Malawi, it is likely that HIV/AIDS money, at least some of it, is being used to meet these more immediately perceived needs.

What I have demonstrated so far in this chapter is that policy is confusing. Who is implementing what and from what direction? (See my analytical framework.) As I have evidenced in the light of my conversations I have presented in this chapter it is difficult to identify who is making the policy decisions in the development arena because there are so many actors involved in the process. The next section looks at actors' roles as actors are key to the policy making process.

### **Actors**

Some authors use the term actors to refer to people, others include collectivities such as organisations or government. Thus the term includes politicians, central government officials, local government officers, civil society organisations, NGOs, and technical experts. Increasingly, new actors enter the policy process, perhaps by invitation to demonstrate stakeholder participation by those who are holding power or for their own vested interests. Indeed, actors have vested interests; they are rooted in political and institutional cultures and they make use of agency. As demonstrated in chapter 3 actors are constantly entering or leaving the development arena and they may have a diversity of vested interests to pursue their own agendas, as well as representing an organisation; a pertinent point which is rarely documented by the international donor community (Kaler & Watkins, 2001; Luke & Watkins, 2002; Dorman, 2005; Marsland, 2006).

Actors have the potential to wield enormous power over policies and programmes as they produce their own interpretations of knowledge and thereby construct and influence policy. This can happen at the local, national or international level. The power of actors (agents) is often woven with the structures (organisations) to which they belong. To demonstrate this point one informant told me that if initiation ceremonies were eradicated then key actors involved in the process would lose their jobs such as the initiation counsellor and the hyena. For the actors involved it is an economic activity; the initiation counsellors can earn between 3000-5000 kwacha

(6-10 pounds) per initiation. Another informant remarked: 'If the cultural practices were removed there would no be research to conduct and then the researchers would lose their jobs' (P44: 14/10/08).

Actors are those who have some role in the policy process. As Brock et al. (2001, p. 3) highlights: 'an approach to policy processes that puts actors into the picture has much to offer in making sense of poverty policy processes'.

As my analytical framework demonstrates the policy process involves a complex web of interactions between a range of actors who are strategically positioned in the HIV/AIDS arena. The rise and fall of different policy emphases depends upon the ability of underpinning narratives to galvanise ideas and people around positions. Policy – built on successful (or otherwise) enrolment of actors – and the creation of networks that are able to make use of policy space emerging from contexts, circumstances and timing. Latour argues that development policy ideas are important less for what they say than for *who* they bring together; what alliances, coalitions, and consensuses they allow, both within and between organisations (Latour, 1996, pp. 42-3).

### **What is knowledge?**

There are different ways of understanding knowledge and therefore different types of knowledge. According to Keeley and Scoones: 'knowledge is produced discursively: it reflects and shapes particular institutional and political practices and ways of describing the world' (IDS, 2000, p. 3). When trying to gain knowledge the social sciences tend to oscillate between two opposing concepts: positivism and constructivism. These concepts are linked to assumptions about ontology, epistemology and the philosophy of science. In this positivist versus constructivist war one of the disputes is whether human behaviour is 'caused' by factors external to the individual or whether a person is a participating and, in principle, freely deciding member of a culture and society (Whimster, 2007). Whereas positivists can be seen as 'explainers' of reality by emphasising empiricist observation based on rational decisions, constructivists are more concerned with meaning and 'verstehen' (understanding). These 'paired oppositions' as Bourdieu (1998, p. 778) explains, 'construct reality...*they construct the instruments of construction of reality*: theories, conceptual schemes, questionnaires, data sets, statistical techniques, and so on'.

The social construction of policy is made up of narratives and discourses and is therefore not rational. Roe uses the term 'development narratives' and holds the view that narratives are

stories or arguments which have a beginning, a middle and an end and revolve around a sequence of events or positions in which something happens or from which something follows' (Roe, 2005, p. 314). Keeley and Scoones (2000) uphold that narratives are shaped by the policy process and also shape the way those involved in the policy process act. ODI indicate that narratives define a problem, explain how it comes about and show what needs to be done. Further validity is often gained despite the fact complex issues and processes are frequently simplified (ODI, 2006, p. 4).

Discourses, however, according to Hajer, are defined as 'a specific ensemble of ideas, concepts and categorisations which are produced, reproduced and transformed in a particular set of practices and through which meaning is given to physical and social realities' (Hajer, 1995, p. 44). For Roe (1991) discourses separate the way problems are thought about, connecting different issues often in highly programmatic, narrative, cause and effect form. These discourses and the institutional practices which they depend on are frequently so embedded that people are unaware of them and they form world-views (Keeley & Scoones, 2000). As Gasper and Apthorpe (1996) indicate, 'discourse' is understood and used in a range of different ways in the policy process literature.

Foucault (1979), who argues for the strategic reversibility of discourse, suggests:

There is not, on the one side, a discourse of power and opposite it, another discourse that runs counter to it. Discourses are tactical elements or blocks operating in the field of force relations; there can exist different and even contradictory discourses within the same strategy; they can, on the contrary, circulate without changing their form from one strategy to another, opposing strategy. (1979 p. 101–102)

This is an important point as it relates to my research in that discourses on HIV/AIDS and cultural practices are being used to accuse those living in rural areas as being backwards and spreading the disease and that these practices need to be eradicated thereby creating employment opportunities for themselves.

### **Networks**

The HIV/AIDS prevention community in Malawi is a network of professionals. Such networks are able to create knowledge and formulate policies. The HIV/AIDS prevention network I examined comprises NGOs, INGOs, local and national government, universities and bi and multilateral donors. There have been many different definitions to describe these networks. Castell (1996) describes them as a network society. Haas' (1992) notion of the 'epistemic community' is particularly useful for conceptualising the HIV/AIDS prevention community in Malawi; Haas

describes an epistemic community as 'a network of professionals with recognised expertise and competence in a particular domain or issue-area' (Haas, 1992, p. 3). He posits that epistemic communities are groups of professionals, often from a variety of different disciplines, which produce policy-relevant knowledge about complex technical issues (Haas, 1992, p16). Such communities embody a belief system around an issue which contain four knowledge elements: [1] a shared set of normative and principled beliefs, which provide a value-based rationale for the social action of community members; [2] shared causal beliefs which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes; [3] shared notions of validity – that is, inter-subjective, internally defined criteria for weighing and validating knowledge in the domain of their expertise; and [4] a common policy enterprise – that is, a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence (Haas, 1992, p3).

It is important to understand which actors set the debates and influence policy. A senior DFID staff member informed me: 'I have two health advisers. You met with John and are trying to hook up with Sandra. They are part of a network of professionals' (P30: 11/03/2009) and evaluators of the curriculum books included staff from USAID, UNFPA and the Ministry of Education. Staff from the UN agencies were described as 'expert judges'. These examples illustrate how those working for bi and multilateral donors are given elevated titles such as 'experts' and 'professionals' thus demonstrating their apparent expertise amongst the donor community. Yet their expert knowledge does not extend to understanding the local contexts which the policy endorsed intends to change. In other words, they have not spent any time gathering local contextual knowledge of HIV/AIDS.

Knowledge is constructed in policy and human beings are not blank sheets, hence knowledge is filtered through preconceived ideas and values. Thus it is not an accumulation of facts but involves ways of construing the world. Scientific evidence can be sought to justify a particular policy position however actors are able to cherry pick points to justify their arguments. As a result policy processes include some perspectives and exclude others, often of the poor and marginalised. Policymakers can also frame scientific enquiry as I have demonstrated in this thesis. Science has been framed in the context of sexual cultural practices spreading HIV/AIDS. A combination of science and policy then plays down scientific uncertainties. Knowledge has been



used in international development policy however it is important to ask how has the knowledge been gathered? Often in development knowledge has been gathered by top-down methods and controlled by national or international elites. Local events are then being re-interpreted or reconstructed within international frameworks. Narratives about HIV policy become normalised. Discourses about harmful cultural practices in Malawi circulate so that people assume the practice is contributing to the spread of HIV but to what extent no one actually knows. One example illustrates my argument. I interviewed a Programme Officer working for UNAIDS and she said:

We've talked about the cultural practices, we have people talking about it but we don't really have evidence about what is happening in each district, but we've been told and informed by the communities, the leaders within the communities, that yes it is happening. You know, the government people, the NGOs that are working there, they are saying 'yes they are happening'. But we really want to have substantial information for us to be able to say 'yes it's an issue and we need to do something about it. (P25: 02/04/09)

This is an example of how evidence is not being used to support policy decisions. Keeley and Scoones (2000) point out that analysis of the policy process requires an examination of how discourses are created and supported through institutions of science, government and administration and to find out where they are contested, where they are open to incremental change and where alternative discourses are emerging and finding expression in the policy process. The concept of 'space' is used in literature on policy change (Brock & McGee, 2002) and citizen participation (Jones, 2002). Conceptualizing policy arenas as 'spaces' where different discourses and actors interact builds on the influential work of Grindle and Thomas (1991). They describe policy spaces as interventions or events which create new opportunities and reconfigure relationships between actors or bring in new ones. This can be seen in the case of Malawi where stakeholders come and go: new ones enter the HIV/AIDS prevention arena where others leave and move on to different jobs in the development field. Hajer talk about 'new spaces of politics' where there are 'concrete challenges to the practices of policymaking and politics coming from below' (2003, p. 8). In their view, policy has become more deliberative: less top-down, involving networks, and more interpretative, taking on board people's narratives, their understandings, values and beliefs revealed through language and behaviour. This is the view that I also hold which is policy is made on the basis of people's beliefs and not on scientific evidence. Spaces can be categorised in a number of ways. Jones identifies two dimensions: the level and the place and the forms of power maintained within them (Jones, 2009). Gaventa (2006) argues that the ways in which spaces are created also play a pivotal role: spaces can be closed, made by a set of actors behind closed doors; invited, where efforts are made to widen participation with citizens groups

invited to participate; or, claimed, where less powerful actors create spaces or claim them against the power holder, often emerging out of common concerns or identifications.

Drawing on the conceptual work by Cornwall (2002) and Jones (2002), McGee identifies five dimensions that make up a policy space: history, access, mechanics, dynamics and learning dimensions. She argues that these are pivotal factors for consideration by policy actors considering engagement or analysts trying to comprehend what drives certain episodes or outcomes of policy processes (McGee, 2004, p. 18). Another typology categorises spaces according to their functions in the policy process: conceptual spaces (where new ideas are introduced), bureaucratic spaces (formal policymaking led by civil servants), invited spaces (where new ideas are introduced), bureaucratic spaces (formal policymaking led by civil servants), invited spaces (such as consultations), popular spaces (such as protests and social movements), practical spaces (providing opportunities for 'witnessing' by policymakers), and political/electoral spaces (elections) (KNOTS, 2006, cited by, Jones, 2009). These frameworks on policy spaces have helped my argument as what can be seen in the case of Malawi is certain stakeholders are invited to certain spaces (e.g., meetings) but not others (see UNAIDS example provided earlier regarding participation of the private sector) to develop policy.

One study by Wachira et al. (2011) presents findings on the impact of the PRSP process on Malawi's National HIV/AIDS Strategic Framework (NSF). In 2007, a survey was carried out which sought respondents' retrospective perceptions of NSF resource levels, participation, inclusion, and governance before, during, and after Malawi's PRSP process (2000–2004). Malawian government ministries, United Nations agencies, members of the Country Coordination Mechanism, NAC and NAC grantees were interviewed (n=125, 90 percent response rate). The authors of the article also assessed principle health sector and economic indicators and budget allocations for HIV/AIDS. Results of the survey suggested that the PRSP process supported accountability for NSF resources but that the process may have marginalized key stakeholders, potentially undercutting the implementation of HIV/AIDS Action Plans. In section two I will now present the case of Malawi using the analytical framework in Figure 1.3 in order to analyse the policy process.

### **The aid game**

Donors' choice of a particular form of aid (relief, bilateral or multilateral development, policy-based or project-based assistance) reflects their global policy objectives and their analysis of

how aid contributes to the development process. As development theories change and circumstances in affected countries alter, so donors have increased or decreased the proportion of their aid channelled through the state in recipient countries - the greater the international legitimacy of a recipient country's government, the more bilateral and developmental the channels of assistance are likely to be (Crewe & Young, 2002). Donors' choice of aid instrument is also affected by the degree to which they wish to engage with the recipient state (Macrae, 2001).

Donors are increasingly moving away from providing financial support to UN agencies in favour of NGOs working through field offices in country. For example, DFID provides funding to more than 100 UK civil society organisations as well as organisations in developing countries. The 'aid chain' (Bebbington, 2005) can then be very long which makes it more difficult to monitor and evaluate the impact of the funded programmes. It also makes it harder to uncover how policy and funding decisions were/are made. This can be seen in the case of Malawi. Three examples of the aid chain are: 1. DFID in Malawi funds the NAC, the NAC distributes funds to the district governments and the district governments distribute funds to community based organisations. 2. DFID UK distributes the money to an NGO in London, the NGO in London distributes the funds to a national HIV/AIDS NGO in Malawi, the National HIV/AIDS NGO distributes it to hundreds of CBOS in the country. These examples support my argument that donors are supporting projects at many different levels of the aid chain and therefore it makes it difficult for donors to know exactly what projects they are funding. Although DFID may know what it is funding through the process of reporting I did not see any evidence that a National HIV/AIDS NGO reports to DFID on every single project a CBO is implementing but instead provides a summary of activities the NGO has funded. For example, I interviewed a Programme Officer working for UNAIDS she gave an example of how UNAIDS gives funds directly to nationally present NGOs to complement the interventions that UNAIDS is implementing. She said:

We are giving money to four NGOs in 4 districts (Chitipa, Nsanje, Ntcheu and Mangochi) to help build their capacity and implement some of their activities in relation to harmful cultural practices and HIV/AIDS. We did an expression of interest, some NGOs applied; we wanted to see if indeed if in those districts they are indeed implementing activities on HIV/AIDS and cultural practices. So, those ones have been selected but they have not been informed yet; I, myself, don't even know who they are. But we are giving them funds from this year. We have proposed that, with the Flemish, that we need the mapping of the whole country district by district, of what are the cultural practices in those areas. This is the only intervention, because what we are trying to look at with them is that this (mapping) should precede the intervention to address cultural practices. (P25: 04/02/09)

This example demonstrates how decisions are being made to influence policy; that four districts were randomly selected to see if cultural practices take place. This example supports my argument concerning how cultural practices are being blamed for the spread of HIV. It also highlights that in this instance the link between HIV/Aids and HCPs has been accepted, the donor is requesting data on the prevalence and nature of HCP but is clearly not questioning the link. I believe that this multi chain reality adds to the distortion and enables particular narratives to emerge unchallenged and unevidenced. The interview above certainly reveals that this narrative has been accepted by donors. The examples that follow also demonstrate that donors have funded work on sexual cultural practices because they believe them to be a significant factor in spreading HIV/AIDS. Several studies, reports and educational materials have been funded by international donors to identify sexual practices and their link to HIV/AIDS rather than how they supported structural gender inequalities and violence. The following section will present these examples.

One study entitled *A Literature Review to support the Situational Analysis for the National Behaviour Change Interventions Strategy on HIV/AIDS and Sexual and Reproductive Health* Coombes (2001) was conducted by the Liverpool Associates in Tropical Health Ltd with funding from the DFID in the UK. The study's findings, which are relevant to this research, came under the topic 'ceremonies and rituals'. It was stated that cultural practices continue to play an integral part in HIV and STI transmission (p. 93). However, the study did not name specific cultural practices neither did it refer to epidemiological data regarding HIV transmission. So once again we see a link between HIV/AIDS and HCP accepted without clear evidence beyond a narrative provided by the Malawian elite. A second study also funded by DFID in entitled *A review of Cultural beliefs and practices influencing sexual and reproductive health and health seeking behaviour, in Malawi* (McConville et al., 2003) makes a similar automatic link between HIV/AIDS and HCPs. The following extract is taken from the introduction:

The aim of this brief review was to provide a summary of cultural beliefs and practices in Malawi that may serve as risk factors to sexual and reproductive health (SRH). It is simply the *first step* in a process intended to consider deep-rooted cultural issues in the planning and programming of multi-sectoral activities which are focused on mainstreaming HIV/AIDS and improving SRH. The need for this first step arose because of the lack of accessible data. The DFID supported MoHP Safe Motherhood Programme (SMP) in the southern region is acknowledged for prompting this review by highlighting the links between beliefs, practices and SRH through a needs-based planning process. The audience for this first step is intended to be those involved in developing the Government of Malawi Sexual and Reproductive Health Programme (SRHP), HIV/AIDS organisations, and those in other sectors working towards a cross-sectoral approach. (Matinga et al., 2003, p. 1)

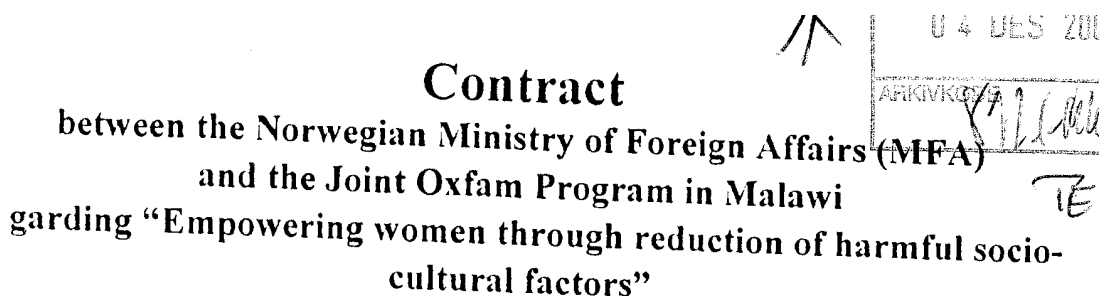
This is an example of how DFID as a donor has invested money specifically to look at cultural practices because they believe them to be linked to HIV/AIDS. This report also mentions the *fisi* practice of particular interest to me:

'Hyena' (*fisi*) During the ceremony a man (often an older man) undertakes sexual acts with all the girls). His identity is a secret, but he is known as the 'hyena' (i.e. the hyena that comes out at night. SMP research in Mangochi District also notes that the *fisi* may insert a piece of wood into the girl, mimicking the sexual act (SMP 2000), a point reiterated by Chirwa (CSR) who believes that much of the sexual activity is symbolic only. (McConville et al., 2003, p. 28)

These examples also demonstrate how DFID is funding work on sexual cultural practices despite the fact sexual cultural practices are not mentioned in DFID Malawi's country strategy paper. What again is not elaborated in this document is the way in which these practices generate a gendered ideology that renders girls inferior to men leaving them vulnerable to violence and oppression. The 'symbolic' impact of these practices referred to in this passage clearly indicates the deep-rooted and often sub-conscious impact these practices have in shaping attitudes and behaviours towards women. DFID however fail to pick up on this choosing instead to focus on an imagined link between harmful cultural practices and HIV/AIDS.

The following is an example of a contract between the Norwegian Ministry of Foreign Affairs and Oxfam. Here we see the adoption of language which is more nuanced. The use of the term harmful cultural practices is not used but instead harmful socio cultural factors that risk causing HIV.

Figure 6.1 – Contract between Oxfam and Norwegian Ministry of Foreign Affairs



The Goal of the Project is “to empower women through reduction of socio-cultural factors that predispose women to gender based violence, HIV and AIDS, and marginalise their participation in decision-making processes”.

*The socio-cultural factors this project aims to address include early and forced marriages, practice of risky, traditional after-initiation-ceremonies such as sexual cleansing (kusasa fumbi), promotion of early sexual debuts and promiscuity. The initiation ceremonies themselves tend to institutionalize the subordination status of women, as girls are taught that their role is to please and serve men, and these will therefore be addressed. Other socio-cultural factors that impact girls and women negatively are regulation of sex during certain times of their lives, wife inheritance, spouse swapping, property dispossession of women and children, forced ritual sex and gender based violence.*

One anthropologist at the College of Medicine told me to go to NAC as ‘they have commissioned most studies on sexual cultural practices including funding the work of NGOs’ (P51: 13/11/2008). When interviewing a Research Officer at NAC (P46: 14/10/2008) he described four research reports to support his view and to provide evidence that cultural practices increase vulnerability to HIV/AIDS. What is interesting is to see who funds these studies. Those mentioned were a study conducted by the College of Medicine in Blantyre (2005) funded by the NAC. This study was conducted among three ethnic groups of Malawi (the Yao of Balaka, the Chewa of Mchinji and the Sena of Nsanje) and mapped cultural practices and assessed the influence of these on sexual and reproductive health (SRH) outcomes and HIV transmission. The data analysed in this report was collected using qualitative research methods. The evidence presented in this report was a result of 179 interviews conducted in the three sites. These included key informant interviews with traditional leaders, religious leaders, community elders, parents of new initiates, traditional healers, traditional birth attendants, traditional sex counsellors and religious sex counsellors. In-depth interviews were also conducted with married men and women, new traditional and faith-based initiates, recently married men and women, widows, widow inheritors, widowers, *fisiis*, individuals who refused to be cleansed, widows who refused to be inherited, inherited women and participants in ceremonial dances. Study sites were selected villages in Njolomole in Ntcheu, Makanjira in Mangochi and Ndamera in Nsanje. Selection of these sites was

purposive and the research process was guided by advice from the District Commissioners and Traditional Authorities. This report did present biomedical evidence and presented the argument that HIV is difficult to contract. It also stated that:

It follows from the low transmission probabilities of HIV that the most dangerous cultural practices are heterosexual relationships in which sex is frequent, the partner is likely to be infected, and sex is likely to be unprotected. Conversely, the least dangerous are those in which sex is infrequent, the partner likely to be uninfected, and sex is likely to be protected. Other cultural practices such as traditional healing and circumcision are likely to be risky where the same and unsterilized instrument is used. (2005, p. 10)

The above paragraph is interesting because it shows how despite the fact the report presents the epidemiological evidence it was still seemed necessary to carry out an in-depth study on cultural practices and HIV/AIDS.

A report by the Human Rights Commission of Malawi, funded by the Norwegian Agency for Development Cooperation (NORAD) through UNDP and UNICEF, entitled Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi was also cited. This report made the link between HIV/AIDS and cultural practices by focusing on the human rights narrative and by holding the view that cultural practices are a violation of women's rights. He listed two further studies described as The Priorities in Local AIDS Control Efforts (PLACE) which is a rapid assessment method for identifying areas likely to have sexual partnership formation patterns capable of spreading and maintaining HIV infection. One was entitled 'An Assessment of Risk Practices and Sites where such Practices take place in the urban areas of Lilongwe and Blantyre Districts' (Kadzandira et al., 2006) and funded by the US Centres for Disease Control and Prevention. This study included a section referred to 'factors that could be facilitating HIV transmissions in the cities of Lilongwe and Blantyre as reported by other patrons'. The factors listed were ignorance/not valuing condom use; poverty/unemployment/more orphans; promiscuity/high sexual partnerships; lack of sensitization; too much drinking/smoking joints; high cash flow and social life; high population/mobility; peer pressure and other factors.

A second PLACE study also funded by the Centres for Disease Control and Prevention was conducted in July 2006 'to identify sites, events or locations where risky behaviours take place i.e. where people meet new sexual partners and to assess the reach of HIV prevention interventions in these places' (2006, p. vii). This study took place in Nsanje and the passage

below highlights that HCP have been placed into the category of risky sexual behaviour, yet again the medical evidence does not support this:

The prevalence of HIV/AIDS in Nsanje has remained very high (>30% among sentinel surveillance women) and it is for this reason that NAC with funding from the Centres for Disease Control and Prevention (CDC) commissioned the PLACE study in the district so as to generate information that would help in designing prevention interventions. On sexual practices, sexual cleansing to protect widows/widowers, their families and village clans or their property is still being practiced and there are well structured groups who are hired to perform the function at a fee. (2006, p. 1)

This passage also highlights how people focus on Nsanje as a region. This region has been identified as problematic because of the high HIV prevalence rates therefore a link is made between high observation of harmful cultural practices and assumed high transmission rates. This link is not borne out in the national level statistics on prevalence. During this interview I was also told that policy development begins from such studies mentioned above then a research dissemination meeting takes place followed by a planning meeting to take forward the policy recommendations outlined in the research reports. This statement by the NAC staff member demonstrates how perceptions of sexual cultural practices filter upwards and help shape international development policy. These examples demonstrate that these reports act as evidence convincing policymakers that they are right to pour money into HIV/AIDS programmes which focus on the eradication of HCPs because the donors cite these reports and evidence them.

In an interview conducted in Balaka with a district youth officer I was told that cultural practices are addressed in the gender policy and to implement the gender policy a project was designed called women-girls HIV/AIDS which was funded by the Global Fund (P14: 07/01/2009). It then transpired that the policy was developed in Lilongwe and that a UN taskforce came to Malawi and decided the project was important as a key way of bringing HIV/AIDS transmission rates down rather than as a way of improving the position of women. Although the district was implementing the project staff are not informed of the size of the budget but they were given a motorcycle and ten bicycles for peer educators 'who are communicating to the community on issues of gender and HIV/AIDS' (P14: 07/01/2009) by training peer educators and area development committees. This provides an example of the nature of training, for example the training focused around the need for communities to no longer observe those practices thought to increase HIV/AIDS. The reasoning was not based on the negative impact these practices have on the empowerment of girls but on their supposed link to HIV transmission.



In Malawi's national gender-based violence strategy (2002-2006) it states:

Special thanks are due to GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit) for funding a consultant and organising a workshop to solicit the views of stakeholders. Awareness and education programmes on GBV to eliminate harmful cultural practices will directly contribute to reducing risk for girls and women to become infected with HIV/AIDS. Key activities are mainstreaming gender-based violence issues alongside HIV/AIDS in staff training programmes and workplaces.. (2002, p. 3)

This shows how the German technical agency is funding work in Malawi to eliminate harmful cultural practices. I interviewed a Programme Officer working for UNAIDS who clearly linked cultural practices and HIV/AIDS. She informed me that the Flemish government is providing funding for a study on cultural practices. She said that UNAIDS then gives the funds to the Government of Malawi to implement the HIV/AIDS programme and to work on cultural practices. The Programme Officer informed me that cultural practices 'are major things that are issues within the communities'. She said that 'the Flemish will be interested to know what is the status in terms of culture within the country' (P25: 04/02/09). This example shows how an international donor is funding research on cultural practices and HIV/AIDS.

When I interviewed a staff member at USAID she told me that the final evaluation of a BRIDGE project was being conducted which addressed cultural practices. BRIDGE is an NGO working on BCI In Malawi which USAID funded and provided technical support. Aims of the evaluation were to assess progress in mitigating the impact of HIV/AIDS in Malawi and identify lessons learned and make recommendations for USAID/Malawi to explore in designing future programmes (USAID, 2008). The report refers to 'unhealthy cultural practices'. She said that in terms of initiation rites the Traditional Authority still continued with the ceremony but changed it in light of HIV/AIDS. Others also reported how the practice was changed in light of HIV/AIDS for example condoms are used or the act is only symbolic. This highlights the extent to which the primary concern was the risk that harmful cultural practices present to HIV/AIDS rather than the way in which these practices feed into and help maintain patriarchal values. The fact the practices remain even in symbolic form, and that the donor is not concerned to see them eradicated highlights the level of their ignorance in terms of how these practices exacerbate violence towards women. When interviewing the country director, GTZ, I asked if she thought cultural practices contribute to the spread of HIV, she explained:

Yes of course but you don't see them if you live in Lilongwe or Blantyre. Before I came here as country director I used to come to Malawi and visited very, very remote areas to monitor and

evaluate programmes. It's a completely different world. Witchcraft takes place and traditional culturally-bound things. (P37: 18/03/2009)

This comment shows that she thinks cultural practices only take place in remote areas thus reinforcing the views of the Malawian elite I presented in chapter four who try and distance themselves from the high transmission rates by blaming 'the backward culture' of rural communities. However, this is not the case as witchcraft and other forms of African Traditional including traditional healing and medicine also take place in urban areas (Englund, 2002). This interview highlights the way that this perception of a backward rural other has influenced and shaped the views of at least some members of the international donor community. She goes on to talk about cultural practices:

Cultural practices can be disasters for example if you can't get pregnant. Not in Lilongwe or Blantyre but if you cannot get pregnant you would go to a traditional healer. Some of the traditional leaders would contribute to the spread of the disease and would bring in someone to have sex with the woman. (P37: 18/03/2009)

As pointed out in chapter 3 where I presented the epidemiology of HIV/AIDS this is medically inaccurate. These are examples of how international donors are funding work on cultural practices. Again we see how donors are funding projects to reduce harmful cultural practices because of the primary link to HIV/AIDS not because they represent forms of gender-based violence. So how do these distorted perceptions become so dominant in the international donor community?

### **Donors must get out more**

Donors cover a huge range of organisations; some spend huge amounts of time in the field (e.g., INGOs with country offices), other never visit (e.g., Big Lottery Fund), while others are in between (e.g., DFID staff). However based on my findings a fundamental aspect is the lack of evidence and the fact that donors that are based in the capital of Malawi do not get out into the field often enough means they have a lack of insight into local conditions. Therefore certain donors will accept the views of what goes on in rural communities provided by the Malawian elite whose own agenda was outlined in chapter four. For example when I interviewed the HIV/AIDS cluster leader for USAID he said he would like to go out and visit projects more. A DFID officer told me he could not answer any of my questions about sexual cultural practices and had no knowledge about them and said he 'rarely went to the field'. He told me to talk to his Malawian counterpart as he said 'she knows more than me [about cultural practices]'. He also told me he could not talk about cultural practices but could talk

about policy. He then went on to say that ‘we ensure that we are aware of impact. We think the HIV/AIDS programme is pretty good. Some of it is remarkable’ (P4: 17/12/2008). He also stated that he agreed with the links made between HIV/AIDS and HCP, so despite his willingness to acknowledge he does not go into the field and has no direct understanding – the view on prevalence he puts forward is essentially the narrative of blame constructed by the Malawian elite.

During my consultancy with UNAIDS I asked the question ‘How many AIDS-related missions were undertaken by your agency in the last 12 months (either from your headquarters or instigated from the country office)?’ The following are some responses:

#### **Box 6.2 – Response to UNAIDS question**

“Five in the last six months. So ten. It is our plan to improve this. We are weak on these kinds of missions. We attend conferences and workshops but not real, real missions.”

UNAIDS Office, 16/04/09

“Six.”

United States Group [USG] Country Coordinator for US Government AIDS Programme  
PEPFAR 29/04/2009

“We keep a log for incoming missions and they come and support those areas that we itemised. Missions are not instigated by HQ or head office.”

Request from Ministry. WHO 29/03/2009

“We have district based staff so we make visits twice every month.”

Thomas Kisimbi, Country Director, Clinton Foundation 17/04/2009

“Finances, one per month \_\_\_\_\_ one per quarter.”

Director MBCA

“We have contributed a lot and received recognition from NAC to see the work we are doing. We have visited thousands of organisations are visited. Irish Aid also funds some of our work. Not specifically speak about HIV/AIDS but different components Irish Aid mission. Great interest in our work. Help to guide us in terms of what are the best practices out there. Cross cutting issues about gender rights tremendous added value to our work. So I would not be able to quantify the exact number of times”.

Concern Universal 20/04/2009

“Yes the National AIDS Commission comes once a year but then they came three times to look at the construction work taking place for the new lecture theatres”.

College of Medicine 22/04/2009

“Five in country mission in March from HQ but in the last twelve months we have had two in country missions.”

EU office, 16/04/2009

“Two Irish Aid delegates and the Irish Ambassador have visited the programmes in Nsanje district.”

GOAL MALAWI

“No visits.”

Former HIV and AIDS Coordinator,  
GTZ, 12 /05/2009

“So many times. NAC, DFID, Scottish Executive and BRIDGE”.

MANASO 20/04/2009

“2 times” Mwanza district 30/04/2009

“6 times” Toveraine 30/04/2009

### **How narratives have been passed on through education**

The narratives of blame also feed into the education system via the curriculum. Curriculum-based education books are used by teachers in schools in Malawi to teach students about developing life skills. UNFPA, Norwegian Agency for Development and Co-operation (NORAD) and Swedish International Development Agency (SIDA) funded the development of these text books. I analysed a complete set (2002, 2004, 2008). In 2002 cultural practices were referred to and described as both helpful and harmful. This book referred less to HIV/AIDS. In 2004-2008 however more references were made to harmful practices and HIV/AIDS. Pertinent issues featured in these books were cultural practices and HIV/AIDS, gender and HIV/AIDS and human rights and HIV/AIDS.

In the senior secondary life skills education student’s book (Fabiano, 2002) cultural practices are reported to encourage the spread of HIV/AIDS. An activity section on ‘harmful cultural practices’ asks students to:

- Brainstorm cultural practices
- Work in groups to identify cultural practices which are harmful and those which are not harmful
- Report your findings to class for discussion
- Discuss in groups practical solutions to each of the harmful cultural practices
- Report your findings to class for discussion

Cultural practices referred to as harmful include *fisi* (hyena), male circumcision, female circumcision, tattooing for beautification or administration of charms, widow inheritance (*chokolo*) and death cleansing (*kuchotsa kufa*). The *fisi* is described as a man from the village who is given the role of sleeping with young girls as part of their initiation into womanhood (Mthanga et al., 2002). What is unclear is why these practices were identified as harmful as

there is no explanation as to why they are deemed harmful. Through the curriculum this narrative of blame is being introduced to children shaping the way they see this issue. The text books are funded by international donors who see this approach as an important way of challenging HIV/AIDS as it directly focuses on changing behaviour and attitudes.

### **Box 6.3 – Questions for students on cultural practice and HIV/AIDS**

Review questions

1. Give three examples of cultural practices that facilitate the spread of HIV/AIDS.
2. Give three examples of cultural practices that help in the prevention of HIV transmission
3. Explain how each of the examples you have given in 1) facilitates the spread of HIV/AIDS.
4. Write an essay on the impact of HIV/AIDS in your community
5. Suggest ways of alleviating the impact of HIV/AIDS on the community.

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Review questions

- 1a) Give three examples of negative effects of foreign culture and technology on indigenous cultural and traditional practices
- b) Explain the importance of critical thinking before adopting foreign culture and technology.
2. Explain the importance of critical thinking before adopting foreign culture and technology.
3. Write an essay on the impact of HIV/AIDS on the nation and the world.
4. Suggest ways of alleviating the impact of HIV/AIDS on the nation and the world.

The exercises in curriculum-based books mentioned above demonstrate how misconceptions concerning sexual cultural practices and HIV/AIDS are embedded in people's views at an early age. Research shows that well-designed and well-implemented HIV prevention programmes can significantly reduce sexual risk behaviours among young people and schools should be key to supporting effective HIV prevention among youth. However teaching young people about harmful cultural practices will not lead to a reduction in risky sexual behaviour. As I have outlined the damaging impact of HCP is far more nuanced than immediately rendering girls vulnerable to HIV transmission.

In an interview with a civil servant at the Health Education Unit, Lilongwe (P45: 14/10/2008) I met him at his office in October 2008. He told me that the Salvation Army did work to develop materials on cultural practices and HIV/AIDS. He said the *fisi* practice and *kusasa fumbi* exist. He said in the course of learning adult language, adult techniques they get a woman for a boy and a man for girls. He said they are scared that if they don't do it they will experience drying of skin – coarse skin. He said children practice sex but if they have sex with someone who is infected they get infected. He said that the Health Education Unit is producing a manual and is waiting for funds from headquarters to translate into Chichewa and Chitumbuka. The manual describes how to get into communities and address cultural practices and how to approach

traditional leaders and convince them to change the practices. The manual includes sections on: types of relationships; relationship with HIV; Approach; What is it? Cultural practices; What can they do? And what are the dangers? He said the manual will be used by ‘change agents’ in other words, anyone involved in the issues. He said evidence is difficult to come by and what is needed is a control – a community that hasn’t made changes and a community that has. He said evidence for this manual was obtained from interviewing Initiated girls and initiated boys in Mulanje. The Health Education Unit used the information from this research to develop materials.

A PowerPoint presentation I was given by the Seventh-day Adventist Church concerning a Clinic & Community Service Initiative of Adventist health services which spoke about an integrated clinic and community HIV/AIDS/STI prevention project was funded by USAID through the Umoyo network. The programme’s objectives included creating awareness on the dangers of harmful cultural practices and advocating for the modification of harmful cultural practices. The presentation also listed positive and negative cultural practices as follows:

**Box 6.4 – PowerPoint presentation by the Seventh-day Adventist Church**

<ul style="list-style-type: none"> <li>• Positive</li> <li>1. Lobola</li> <li>2. Kumeta</li> <li>3. Chinamwali</li> <li>4. Chikamwini / Chitengwa</li> <li>5. Wife inheritance to a certain extent</li> </ul>	<ul style="list-style-type: none"> <li>• Negative</li> <li>1. Fisi</li> <li>2. Polygamy</li> <li>3. Magolowazi</li> <li>4. Property grabbing</li> <li>5. Post menopausal cessation of intercourse</li> <li>6. Use of herbs to dry out &amp; tighten of vagina</li> </ul>
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The presentation then outlines the roles played by the Adventist health services and the community:

**Box 6.4 – Cont.**

<ul style="list-style-type: none"> <li>• Adventist Health Services</li> <li>1. Facilitate focus group discussion on cultural practices that promote the spread of HIV virus</li> <li>2. Train Community based HIV counsellors.</li> <li>3. Introduce VCT services in two of the nine Supervision areas</li> </ul>	<ul style="list-style-type: none"> <li>• Community</li> <li>1. <b>Review cultural practices in relation with HIV/AIDS.</b></li> <li>2. <b>Modify cultural practices that promotes the spread of HIV virus.</b></li> </ul>
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### Where is the evidence?

This section presents data from the consultancy I conducted with UNAIDS. The question asked to stakeholders involved in HIV/AIDS was *Does your organisation use evidence to inform policy and programmatic decisions on HIV/AIDS?*

#### Box 6.4 – Data from UNAIDS consultancy

Yes	Please provide examples
No	Do you have plans to improve on this in the future? Please give examples

Director of Planning, Ministry of Health 20/04/2009  
 This is one area that is still a challenge. We are supposed to do this. Monitoring and Evaluation (M&E) is one area where we need to do a little bit more work. In the districts at the health level, for example in rural health centres we have M&E officers. We don't have specialised information so we are grappling with non- trained statisticians. They know the policy requires a certain quality of information and timeliness of providing that information and also ownership of that information. Like HIV/AIDS, TC has vertical silos that have their people. The programme wants to correct Malawi Integrated Health Survey (MIHS) one guy needs to sit down and address it is an issue for example MIHS timeliness and quality of reporting for evidence based planning. We are using programme information to request the government department to create positions for m and e graduates. This has not yet happened but the request has been made.

Director, MBCA 22/04/1999  
 Yes it is based on evidence – what is working well with some of our partners. During m and e visits and biannual review meetings. New members study visits looking at best practices.

Alliance One 20/04/2009  
 Increase in number of employees with STI's necessitated the company to scale up condom use awareness for those that cannot abstain or stick to one partner. Our clinic registered for ART programme having looked at statistics of employees whose health status was deteriorating as a result of being HIV positive. Referring employees for ART to other health facilities e.g The Light House was proving problematic due to the large number of people looking for the same service.

Concern Universal implementing partner 20/04/2009  
 We do work internally for advocacy at the national level but we have not played an advocacy role to influence policy at the national level. We are trying to influence the extended NAF in terms of what should be some of the priorities we should be focusing on. Within the room 3 organisations from a perspective. Such things are areas that we have tried to influence.

Doctor, College of Medicine 22/04/2009  
 I suppose we have to say. What constitutes evidence? There is awareness in university of Malawi. HIV is having an impact both in and outside, members of staff. I cannot remember exactly what the source was how many members of staff died as a result of HIV/AIDS. We need to have an HIV/AIDS policy. Distant memory no formal report or assessment done to inform policy most policies are made with elements of general knowledge. What other institutions may have. Research in my view the gold standard of evidence is the randomised control trial. Observational studies, audits. Type of evidence I have articulated we see what is happening in other parts of the world. Great knowledge.

ESCOM 20/04/09 This one yah what happens is through these M&Es through these surveys. Our HIV/AIDS policy developed in 2001; reviewed in 2006. Provisions of nutritional supplements Living with HIV/AIDS. Incorporate into programme. Employees. As of now providing ARVs into clinic. After revision. Use evidence. After collecting data go through the responses from questionnaires – steering committee

– we haven't reached out through the north. Let's do this, coming up with the results. Do presentation with executive mgt outcome of the survey communicate to my employees. Newsletter produced to all employees. Human resources. Member of staff can access.  
Questions about HIV/AIDS. The rest don't know.

GOAL HIV/AIDS M&E Manager 27/04/2009

GOAL Malawi conducts KAPB surveys to determine what issues are there on the ground that need to be addressed. For example, in the past year, GOAL Malawi discovered that stigma and discrimination still exists in the communities and then developed specific interventions to reduce stigma and discrimination and also carry out advocacy campaigns.

MANASO 24/04/2009

Yes a number of activities are actually informed by what is coming from our constituencies. Information from them helps us come up with new programmes. Technical support that we provide to the members workshop set up only thirty members. When we saw that people were under-utilising that. We had to ask them why they weren't implementing what they had learnt. 1. Had not understood. 1. Language barrier. Changed our strategy on site technical support all group members would be present. Ten to fifteen members remind each other. Needs driven. Workshops when the needs are similar. Do have national workshops

MANET+ PROG OFFICER 24/04/2009

Yes. We have done that. Research on stigma and discrimination that has informed the policy. Part of the policy development process. Also one of the challenges we are facing. Donors not much willing to support, research and m and e just looking at implementation. Stigma response. No nationwide study. Evidence base. For us you will see the irony not only reporting to NAC. In terms of the donors that require support. Results. To follow up on how we can deal with the challenges that we face. Not equated with resources. Development partners not ready to support us on results.

Of course HIVOS supporting in terms of m and e. not expect results on the ground. Want the evidence. Want to hear voices. Results on the ground hear a story. Home based care. Dutch humanist comic relief interested in results. Can share USAID. Not just interested in outputs, success stories. What change have you brought. Voices must be reflected. This is what is not in comparison. There is a lot of money come through NAC programmes. Most of work is advocacy. Difficult to measure. Many partners influencing us. Difficult. Combined interventions. Difficult for one organisation to take success. Good to look at the result. That requires resource. Proportion of monitoring. For NAC come up with a three year proposal. Make much sense. Previous implementation. That is the situation on the ground. Come up with another three year strategy. More or less ready just to get what we are presenting. To some extent not ready to face what we are doing. Why is that we are not making significance strides in behaviour change. That awareness not translated into behaviour change. Over what period. Really moved down. Looked at same methodology. Maybe have shifted the goalposts.

Ministry of Education, 28/04/2009

Yes the evidence analysing the capacity of teachers living +. Issues to be discussed there. Report is here. Take to management to react towards problems identified.

Ministry of Local Government , "no" 29/04/2009

Mzimba district council 29/04/2009

Yes district HIV/AIDS has affected us all. Something that when we are implementing has to be mainstreamed. For example if we look at BCI in the district most of them like going to South Africa leaving spouses behind. Wife stays does other things. Created situation need to sensitise the communities to let them know it is more serious. Presenting them to the behaviours. Base all activities if we find if that is a problem. HTC week. If people go for htc if they found positive this area going towards levels we need to act urgently.

Mzudza 20/04/2009

Yes we do that. Chairman at the ministry level.



Toveraine 29/04/2009

For our programme we go to the field and assess. Quality Assessment sponsored by Umoyo network. Activities based on what we did during that survey.

Any evidence to inform policy decisions? Trocaire conducted an HIV/AIDS scoping study and a gender study. HIV highly subscribed. Trocaire does not have skills or capacity to fill important gap (P27 09/03/2010).

This section demonstrates that evidence to inform policies and programmes on HIV/AIDS is weak.

### **Conclusion**

This chapter has looked at the complexities of the donor funding process and how inaccuracies come in to play and how things become distorted; I have evidenced that distortion and looked at how different narratives merge which then hinder the effectiveness of prevention programmes. Policies and programmes are affected as they are not supported by epidemiological evidence. This is why it has been important to talk about the policy process. If the policy process was dealt with in a different way and evidence was used to support the policy decision then perhaps HIV prevention programmes in Malawi would be more effective. I have also highlighted the extent to which the primary concern has been the risk that harmful cultural practices present to HIV/AIDS rather than the way in which these practices feed into and help maintain patriarchal values. The fact the practices remain even in symbolic form, and that the donor is not concerned to see them eradicated, highlights the level of their ignorance in terms of gender equality and violence towards women.

## Chapter 7 Conclusion

The focus of this study was to examine how policies and programmes on HIV/AIDS prevention and the sexual cultural practice of *fisi* have come to be linked. My thesis reveals how policies have been constructed based on inaccurate imaginings of both the sexual behaviour of rural people, who have been primarily blamed for the spread of HIV, and the Malawian elites' and international donors' poor understanding of the bio-medical evidence surrounding HIV transmission during one heterosexual act. I have shown this by using the example of the *fisi* practice; a practice that involves a man having sex with girls during initiation. Although there are many sexual cultural practices taking place in Malawi, I focused on this practice, as whilst I was in Malawi working as Programme Manager for a sexual and reproductive health NGO, it was this practice that was recounted to me at length by women working for a Community Based Organisation.

According to work on sexual cultural practices they act as a mechanism rendering women inferior to men, and it is this inferiority that renders them vulnerable to violence (Mkamanga 2000; Kamlongera (2007). For example Anderson (2012) in her study on women's bodies in Malawi, argues that most women who participate in sexual cultural practices are unable to refuse, as within wider society there is an understanding of a universal 'masculine sex-right' where men have the right to make decisions over what can be done with a female body, which makes women vulnerable to violence. Bradley (2011) argues that culture, tradition and religion are not in themselves the problems, but rather in certain contexts it is the way they feed into and help to perpetuate misogynistic values that produces and sustains abusive and violent practices against women. Further, Kistner (2003) argues that masculinity has emerged as one of the key factors at the interface between gender-based violence and HIV/AIDS. Thus we can see that the practice of such sexual acts can lead to women's susceptibility to violence.

This thesis has drawn attention to the fact that the probability of infection from one heterosexual act, such as the *fisi* practice, is very low: as reflected in the epidemiological evidence provided in this research (Gray et al 2001, Powers et al 2008). In light of this, the thrust of the thesis is the exposure of current misconceptions among development practitioners and policy makers in Malawi concerning HIV/AIDS: this misconception is grounded in the view that certain cultural practices are fuelling the HIV pandemic in Malawi. This research has predominately focused on revealing how very little if any bio-medical evidence is being used to inform current policies and programmes on HIV/AIDS in Malawi.

Instead a handful of HCPs have been targeted as the problem, which has led to a focus on eradicating those sexual cultural practices deemed dangerous. There is no evidence that the sexual practice of *fisi* has a higher transmission rate than other sexual practices that are common within Malawi. While a *fisi* may be more likely to be HIV positive than the average male, it is the case that intercourse with a *fisi* is usually a single act of intercourse and is far from an everyday occurrence: since intercourse within marriage is much more frequent and the use of condoms in marriage is infrequent (Chimbiri, 2007), regular marital relations are thus more likely to lead to infection than intercourse with a *fisi*. For HIV prevention purposes, it would be far more useful to focus on more frequent practices, such as transmission within marriages or stable couples.

In the health sector, the concept of evidence-based policy has gained ground, and the *Journal of Evidence Based Health Policy and Management* launched to address this issue. Yet as I have demonstrated a lack of capacity to make use of existing data in policy development and programmes imply that inefficiencies in the development process have not been properly identified and addressed. Most HIV/AIDS prevention programmes in Africa have also arguably had limited impact because the research behind them focused primarily on risk groups, behavioural change models, and flawed understandings of cultural practices and economic conditions (Packard & Epstein, 1991; Waterston, 1997; Kalipeni et al., 2004). In other words, the explanations given for high rates did not rely enough on biomedical facts but rather on constructed categories of 'at risk' groups which once interrogated, as I have done in relation to Malawi, can be seen to be inaccurate.

In this conclusion I bring together the various threads of my argument. First, I summarise the findings and discussion of this research in relation to the themes identified and the analytical frame employed in this study. Second, I present my three key arguments. Third, I contextualize my study in terms of where we are today with HIV/AIDS and gender-based violence both at the global level and within Malawi. Fourth, I demonstrate how this study contributes to academic debates. Finally, I present recommendations.

### **Summary of key findings**

In chapter one, due to the inter-disciplinary nature of this study, I show how a number of theories influenced by argument. First, using the approaches used within the anthropology of development I provide a critique of HIV/AIDS policy making in Malawi. Second, and in order to

understand how policy was constructed based on misconceptions, I draw on elite and policy-making theories to demonstrate how the policy process in Malawi is being mediated by the agendas of elites as opposed to bio-medical facts. Third, I use postcolonial theory to highlight how the elites in Malawi are interpreting for themselves the colonial narrative that is founded on a binary opposition; civilised (the elites) and the uncivilised (the rural uneducated population) (Galtung, 1971). This then enables them to distance themselves from those living in rural areas, allowing them to maintain a position of power and access to the resources flowing in from the aid community. Fourth, as this study is guided by a feminist perspective, I argue that patriarchy and male dominance in sexual relationships need to be examined in Malawi.

In chapter two literature within the field of anthropology of development was reviewed, with particular emphasis placed on the work of Mosse (2011) and Crewe and Harrison (1998). Both demonstrate that many actors are involved in the policy process, which is not linear or straight forward, which makes it hard to unravel by whom these policies are constructed. These scholars demonstrate the usefulness of ethnography as a way of understanding the threads that interlock in the formation of policies and thereby have helped me identify how misconceptions have seeped into the process in relation to HIV/AIDS prevention in Malawi. They critically analyse the complex relationships of power between global multilateral organisations, donors, governments of resource-poor countries, and local communities, and their impact on development projects. They also demonstrate how to critically engage with development practice by combining academic development work with academic writing and reflection therefore they have insights due to their positioning. Their approaches have been instrumental in developing my own analytical framework, as my research looks at how different elites working within the field of HIV/AIDS are able to construct policies based on vested agendas and interests whilst at the same time questioning my own position as a researcher.

In chapter two the work of Chin (2006) is also particularly relevant to the central argument of my thesis, that is Malawian elites working on HIV and AIDS perpetuate the myth that the *fisi* practice contributes significantly to the spread of HIV in Malawi. I argue that Malawian elites perpetuate this myth to maintain their professional status and to secure external funding from donors for projects on HIV prevention. Chin (2006) argues that UNAIDS and AIDS activists accept certain myths about HIV epidemiology to keep the disease on the political agenda and, by implication, ensure funding and jobs.

In chapter three I demonstrate the powerful and influential role that international donors (bilateral and multilateral agencies and INGOS) play in constructing HIV/AIDS policies and programmes in Malawi. Additionally this chapter emphasizes that aid conditionality can lead to failure by demonstrating how funding is often donor led. For example if donors disagree with policies being implemented in the country to which they are supplying aid, whether it is the way money is being spent or the type of policies the government implements, then they will withdraw funds. See chapter 3 where I provide an example of the British Government suspending aid because it was unhappy with the President of Malawi's autocratic management style (The Guardian, 2011). The paradox of such policies in practice is that they reduce the ability of nation states to be self-sufficient and instead put them in a dependency relationship with international donors as demonstrated by the example of Malawi, where donors' decisions to withhold funds had a detrimental effect on Malawi's economy and healthcare system (see page 49).

In this chapter I also review literature on HIV epidemiology. Epidemiological studies estimate the risk of HIV-1 transmission and show that the average rate of HIV transmission is 1 in 1000. These findings demonstrate that HIV is not easily transmitted particularly during a one-off sexual act for the first time. This is relevant to my study because the *fisi* practice occurs as a one-off heterosexual act and therefore it is statistically unlikely that this practice contributes significantly to the spread of HIV. This practice has only been evidenced in a very small number of rural communities. Further, no randomised clinical trials have been carried out in Malawi to provide evidence that the *fisi* practice is contributing to the spread of HIV. This is an example of evidence of a lack of evidence. In this chapter I also argue that the single traditional practice of *fisi* is being utilised as a scapegoat for the spread of AIDS in Malawi to deliberately detract attention away from everyday sexual practices in urban areas of Malawi such as extra-marital relations and multiple sexual partners.. As reflected in the evidence below HIV prevalence is in fact higher in urban areas where the *fisi* practice does not take place.

HIV prevalence rates in Malawi demonstrate prevalence is greater in the south (20-22 percent) than the north (8 percent) and centre (7 percent); and greater in the urban than rural areas, (MDHS, 2004). Data shows that urban residents have a significantly higher risk of HIV infection than rural residents. While 18 percent of urban women are HIV positive, the corresponding proportion for rural women is 13 percent. For men, the urban-rural difference in HIV

prevalence is even greater; urban men are nearly twice as likely to be infected as rural men (16 and 9 percent, respectively) (MDHS, 2004 p.231).

This is very significant because harmful cultural practices are reported to be largely rural practices but yet infection rates lower in these contexts. This highlights the inaccuracy in the elites' narrative blaming rural harmful cultural practices for high prevalence rates. The problem is conversely higher in urban areas where the elites live. Further, HIV prevalence rates are higher amongst women age 30-34 (18 percent) compared to 3.7 percent of women age 15-19. In addition no data was collected for women under 15. The fact that data was not collected and yet this is the demographic that is partaking in initiation ceremonies supports my argument that those blaming the sexual cultural practice of *fisi* for the spread of HIV lack evidence to support their case. In terms of education and wealth, the HIV prevalence rate is highest amongst women with a secondary education and above (15.1 percent) compared to those women with no education (13.6 percent). In terms of income those women with the highest rates of HIV were in the top wealth quintile. The emphasis of AIDS policies should therefore in fact be attributed more to contemporary patriarchal constructions of gender and power than a one-off highly un-evidenced traditional sexual practice.

I also examine how the advent of HIV/AIDS has provoked a reinterpretation of the impact of certain sexual cultural practices, which have now been labeled 'risky' or harmful. Some studies carried out have used culture as an explanation for high-risk behavior, which can lead to HIV infection (Rushton & Boegart, 1989; Rushing, 1995; Caldwell, Caldwell & Quiggin 1989). However, this research shows that targeting specific population groups as opposed to addressing gender inequalities and issues of sexual power to a general population can be ineffective and misleading. This thesis does not argue that the cultural practices such as the *fisi* practice are not harmful and violent towards women but that these are not adversely contributing to the spread of HIV. Incorrect messages regarding HIV transmission rates are relayed which inhibit effective programme implementation.

Chapter four begins by reviewing national and international policies on gender-based violence, harmful cultural practices and HIV/AIDS to highlight how these policies have been constructed around harmful cultural practices. I then review literature on elites and I use this to inform my own argument that policy processes are driven by the Malawian elites as opposed to the argument made by Laswell (1956) that policy implementation is a linear, rational process.

These policies are being constructed around narratives of blame, which portray rural communities as backwards and the parties responsible for spreading HIV. This chapter concludes that the elites use these narratives as an 'imagined fact' in terms of how they contribute to high prevalence rates.

In chapter five I argue that elite Christian religious morality has played an active role in portraying indigenous cultural practices as negative and blaming them for the spread of HIV/AIDS. In this chapter I also demonstrate how Christian elites portray themselves and their theology as enlightened in comparison to the largely non-Christian rural population. Thus casting indigenous cultural practices as responsible for the spread of AIDS within Malawi with the agenda to undermine forms of non-Christian culture and validate a Christian lifestyle as unproblematic in terms of HIV/AIDS.

In chapter six I examine theories of policy implementation, arguing against scholars such as Laswell's (1956) presentation, that policy implementation is a linear, rational process. Instead agreeing with Lipsky (1980); Lindblom (1980), Shore and Wright (1997) and Sabatier (2007) who postulate that policy processes are less of a linear sequence but more of a political process underpinned by a complex mesh of interactions and ramifications between a wide range of stakeholders who are driven and constrained by competing interests and the context in which they operate.

I have argued that there are a wide range of stakeholders involved in policy implementation in Malawi. This research places significant emphasis on bilateral and multilateral agencies, international NGOs, national NGOs including faith based organisations and the state at the national and district levels that have vested interests. Therefore I argue the evidence produced to apply policies is not objective evidence but narratives shaped by elites' agendas and interests. As a result policies are pushed in a direction, which do not benefit the population of Malawi in terms of HIV prevention, but instead perpetuate these groups' standings and beliefs.

### **The three main arguments**

In this study I argue that a complex interplay of causes has led to the construction of the narrative that the sexual cultural practice of *fisi* is contributing significantly to the spread of HIV and AIDS. I argue this complex interplay can be best understood through three sets of

arguments. Although these three sets of arguments are presented separately here, in practice these are interlocking.

The first and main argument is that the 'narrative of blame' is maintained by the national elites in Malawi to ensure that HIV is kept on the development policy agenda within the institutions in which they work thus attracting donor funding and retaining elites' professional status. I place emphasis on understanding policy construction as a process mediated by those involved in the policy process and argue that one reason why national elites are able to influence the policy agenda on HIV is due to the narrative they have constructed that has been sold to the donors. Thus they have a vested interest in maintaining their position as this is what motivated them to construct the narrative to start with. I argue that national elites working on HIV prevention in Malawi need to sustain certain agendas to maintain their own status and positions. Therefore, by maintaining the narrative that the sexual cultural practice of *fisi* is spreading HIV can ensure policy and programmes directed to reduce HIV transmission continue.

The second argument identified in this study is that AIDS is being presented by national, urban elites as a rural disease because the sexual cultural practice of *fisi* is reported to take place in rural areas. Therefore the narrative told by the elites is that the disease is being spread by people living in rural areas who are mainly illiterate and do not speak English. This narrative distances the urban elite from the disease as well as detracting attention from urban male and female promiscuity. As I highlight in this study, this 'othering' is a result of those elites working in HIV prevention providing explanations to 'problems' that satisfy donors and therefore ensure continued funding. Therefore, the urban elites who perceive themselves as civilised distance themselves from rural people who they conveniently position as uncivilised. I argue that elites in Malawi maintain their positions through playing into the concepts of modernity held by the donors that relies upon a binary that divides the modern from the un-modern. Thus, the Malawian elites are making themselves look like the modern, unproblematic group that donors should engage with in Malawian society.

The third argument identified is that the Malawian elites base their category of uncivilised by pointing to those practising African Traditional Religion designating them as backwards, thus by having converted to Christianity the elites perceive themselves as modern and progressive. What this demonstrates is that the elites in Malawi are perpetuating a narrative that asserts



their superiority by placing the blame for transmission on those who practice African Traditional Religion, thereby establishing their modernity in comparison. Within this context, Christian leaders also play a role in projecting the narrative of blame as an ideological tool to promote a Christian lifestyle against traditional forms of African religion.

### **Contribution to academic debates**

This research makes three important contributions to academic debates. Firstly, by using a number of theories taken from anthropology of development, elite theory, policy-making, postcolonial theory, feminist theory and epidemiological theory I have contributed to academic debates about policy, policy actors and policy-making within a developing country context. I have done this by arguing that policy is not rational and made through a logical series of stages in which policy makers serve elected decision makers, but instead that policy making is complex and messy and steered by groups of national elites and powerful political discourses within these contexts. This contributes to academic debates by demonstrating that such agendas and discourses need to be considered when making future policy.

I have argued that although findings from epidemiological studies have shown that the probability of infection by one heterosexual act is 1 in 1000, I demonstrate that epidemiological evidence is ignored by policy makers in Malawi. The gap between research and policy therefore needs to be bridged by disseminating research findings to policy makers so that when development programmes are designed they are based on evidence. Therefore for policy to be effective in Malawi it needs to be informed by objective, empirical research on the population as a whole. For example, epidemiological evidence is particularly useful when preventing and controlling disease in populations and guiding health and health care policy and planning. Therefore such evidence can enrich health policies and plans to improve the health of a population.

The second contribution I make is a methodological one, enabling an understanding of how policy translates into practice across levels from the global arena down to the community level. The analytical framework and approach I proposed intended to facilitate analysis in evaluative and formative studies of—and policies and programmes on—HIV/AIDS, to generate meaningful evidence to inform policy. Therefore this study is not just applicable to Malawi but may be used in any developing country setting. It is an original contribution to research as it focuses on narratives told by actors working in organisations, which focus on HIV/AIDS, whilst also tracing the impact of these narratives on the production of policies and programmes,

rather than on geographically bounded local communities. My analytical framework has built on theoretical propositions and empirical research in development studies, particularly the work of Mosse (2013) and Crewe and Harrison (1998). I show that narratives on HIV/AIDS and cultural practices are an obstacle to the development process. I argue these narratives become the dominant themes in the construction of policies. As a result, other key themes such as gendered power relationships are ignored or overlooked. Thus these narratives become the rationalised measures on which these policies are judged.

Thirdly, this study demonstrates a contribution to ethnographic research as it has shown how ethnography can be used to help construct policy and practice, which responds to the complexity of peoples' lives. Using this ethnographic approach has enabled me to highlight why progress is slow in terms of improving gender relations and has emphasised how these narratives of blame are used as a smokescreen to pursue government and donor interests.

#### **Where are we today in terms of Gender Based Violence, HIV/AIDS and cultural practices?**

This research comes at a time when never before has gender-based violence been so widely discussed as it is today. We only have to look at the Delhi gang rape and subsequent death of Nirbhayana; the shooting of the sixteen year old Pakistani girl, Malala Yousafzai, by the Taliban for advocating for women's education; and, closer to home, the abuse of schoolgirls taken from the streets and care homes to be drugged, raped and sold into prostitution by a paedophilia ring in England. These horrific acts of violence, carried out on women and girls because they were female, have drawn worldwide attention to women's rights and gender equality.

To contextualize such events at the international level, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) is calling for a further stand-alone goal on gender equality to be included in any development framework that addresses gender-based violence, post MDGS 2015 (UN Women, 2013). Three components are recommended to be included to reach the proposed goal on gender equality, women's rights and women's empowerment: these are freedom from violence, capabilities and resources and voice, leadership and participation. Interestingly the paper refers to harmful traditional practices and cites the following as 'harmful': female infanticide, prenatal sex selection, child marriage, dowry-related violence, female genital mutilation/cutting, so-called 'honour' crimes, and maltreatment of widows (UN Women, 2013, p. 23). In the same paragraph the link is made between violence against women and increased risk of HIV, which suggests these practices are

contributing to women's vulnerability to HIV infection. On the same page the proposed indicators to prevent and respond to violence against women and girls include rates of female genital mutilation and other traditional harmful practices. The rationale for measuring the prevalence of female genital mutilation/cutting and other so called harmful traditional practices and the prevalence of child marriage is, according to the paper, in line with the Secretary-General's *In-Depth Study on All Forms of Violence Against Women* (UN General Assembly, 2006). In these documents it is assumed that the risk is from the practice itself, however the practices feed into and maintain an environment in which women are vulnerable to sexual violence and this is what increases their risk to HIV/AIDS, therefore this document fails to make this more nuanced argument. Further, as is clear from the Malawian case measuring reduction in the conduct of harmful cultural practices is difficult. As I have shown it is unknown to what extent such practices actually take place due to the secrecy surrounding them therefore this indicator would be virtually impossible to measure.

In this research I was not able to look at the ways in which HIV/AIDS impact on women but I know it to be considerable as when I was in Malawi I heard from women in rural areas how their husbands were dying of AIDS and how they were struggling to cope day to day. There remains a clear urgency therefore to tackle HIV/AIDS, which in various ways disproportionately impacts on women.

As I have also shown, the Malawian elites refer frequently to sexual cultural practices and describe them at length. In my view this is how these 'narratives of blame' filter upward into international organisations and in turn become international policy. Why is it, then, that Malawians want to talk about these cultural practices? My evidence has demonstrated it is because they want the donors to think that they (the donors) do not know anything about Malawian culture and so to talk about culture keeps them in jobs as the 'experts' in what actually happens in the country. So for example, the national level politicians have a perception of international donors and the funding on which they depend and want to secure. They have constructed in this story specific narratives of blame that support their objective of ensuring a constant flow of aid money into the government.

The newspaper article in Figure 7.1 tells the story of the Gender Minister who speaking at an event to commemorate 16 days of activism against gender-based violence advising women to hurt the hyena. She is reported to have said 'Hit them (those hyenas) hard in their private

parts and I can assure you it hurts’ (Nyasa Times, 2011). Of course advising women to carry out violent acts towards men is not particularly helpful and will not help improve women’s lives in fact it could leave them more vulnerable to abuse. But it is examples such at this one that is featured in the Malawi media that can be read by international donors and thereby influence international policy and programmes.

**Figure 7.1 – Gender Minister wants women to hurt ‘hyenas’**

National

## Gender Minister wants women to hurt ‘hyenas’

By Nyasa Times Correspondent November 29, 2011 · 41 Comments [Email This Post](#)

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Malawi Minister of Gender, Child and Community Development, Rene Kachere has told women who are forced sleep with relatives of their deceased husbands in traditional cleansing ceremonies where the men performing cleansing acts are known as Fisi (hyenas) to resist the rituals and if need be use physical violence to hurt the ‘hyenas’.

Kachere was speaking during the launch of activities to mark the commemoration of 16 days of Activism Against Gender Based Violence at Mponela 2 Primary school in Dowa district on Sunday.


“Hit them (those hyenas) hard in their private parts and I can assure you it hurts,” Kachere advised.

She said if the women are then accused of violence they must say, in their defence, “inetu ndimamenya fisi (It is a hyena that I was hitting)”.

The commemoration of 16 Days of Activism Against Gender Based Violence is an annual worldwide campaign which starts on November 25 day on November 25, ending on December 10 which is the World Human Rights Day.

This year’s commemoration is being held under the theme “From peace in homes to peace in the world”.

The launch in Mponela was characterized with various performances including traditional dances, drama, poetry recitals, live band performance, testimonies from victims of domestic violence and speeches by various dignitaries among them Ministry of Gender officials, traditional leaders, District Commissioner for Dowa district, a representative of the UNFPA and the Chair for NGO Gender Coordinating Network, Emma Kaliya.



Kachere: Hurt them where it pains most

Five years later the legislation drafted by the Law Commission has yet to be passed. This supports the comment made by a Lawyer at the Commission who told me the legislation was ‘legislation for the urban elite’. He also said that even if the legislation were passed it would never be implemented. Even if it were implemented one fundamental problem with implementation would be women reporting incidences and accessing information as the majority of women in Malawi who live in rural areas are illiterate and would probably not be aware of their rights. It is also still unknown how prevalent these practices are and what proportion of the population is involved. All those I interviewed had never seen a sexual

cultural practice take place but the practices were still perceived as negative and are seen as a 'problem'.

## **Recommendations**

As a consultant working for UNAIDS Box 7.1 presents recommendations I made to the NAC and UNAIDS based on the data gathered from face to face interviews and completed surveys.

### **Box 7.1 Recommendations made in UNAIDS CHAT report**

#### **Planning, alignment and harmonisation**

- For enhanced and sustainable HIV/AIDS response and in recognition of the epidemic as a crosscutting and development issue, all sectors of society should mainstream and address HIV/AIDS in their plans and programmes. Collaboration and sharing of experiences among stakeholders, including government, development partners, NGOs, religious organisations, private institutions, traditional institutions and communities are key principles in the design, implementation and monitoring of multi-sectoral and multi-disciplinary programmes.
- An effective national response to the epidemic requires that there is good governance, transparency and accountability at all levels in the management of the national response, especially in resource allocation and utilisation.
- Donor and development partners could improve on reporting results to the National Response in order to strengthen the NAF and avoid duplication.
- There is a desire for stronger multi-sectoral collaboration in Malawi without a further proliferation of initiatives. Discussions with other important sectors such as decentralization, education, energy and the private sector are needed and conclusions shared at the national level. One forum for sharing information on progress towards a multi-sectoral response could be the annual review.
- Mainstreaming needs to be better conceptualised to improve effectiveness of efforts to engage more ministries in the response, and more commitment is needed from sectors and local authorities.
- The limited capacity of the health sector remains a barrier to scaling up the largest part of biomedical prevention and care services. Health systems strengthening needs to be a major component of the response.
- Decentralisation of the response to district level, and strengthening community systems are hampered by limited institutional, human and technical capacity, thus affecting planning, implementation, tracking and reporting progress on service delivery. Alignment can also be improved with key partners at the district level to ensure implementation of the 'Three Ones' principles.
- NAC should work towards building the capacity of partners, particularly CSOs at the district level that do not receive NAC funding, to ensure that organisations' plans are aligned with the NAF.

#### **Monitoring and Evaluation (M&E)**

- It is essential that the national response to HIV/AIDS be based on sound, current, empirically based research. Interventions need to be more evidence based, better evaluated on impact and cost-effectiveness, and better targeted, especially in the areas of prevention and impact mitigation. Research and surveillance efforts generate ample strategic information, but it is not effectively disseminated and not often used for evidenced-based policy development and intervention design.
- Health Management Information System (HMIS) in MoH needs to be strengthened in order to collate data and evidence, which is crucial to evidence-based decision making. Research institutions therefore have an important role to play.
- M&E data, reports and research need to be shared at the district level. Furthermore, research, surveillance and M&E data available at the district and community levels should be presented in a way that is understandable and that allows findings to be built into prevention activities.
- M&E plans at the government level still need to be harmonised to avoid use of different reporting systems. Furthermore M&E plans within different sectors need to be harmonised. For example government departments should ensure M&E plans are harmonised with those of their partners.
- Research is needed to identify total number of partners participating in the national HIV/AIDS response in Malawi including identifying roles, programmes and activities.
- Funding needs to be provided to carry out research other than operational research. Funding to carry out clinical trials is needed. Most of the knowledge based on clinical trials is done elsewhere.

#### **Reporting, funding and financing**

- Allocation of resources between and within core strategies needs to be more rational. The (cost) effectiveness and sustainability of interventions needs to be improved.
- Adequate financial resources should be available to build infrastructure and implement HIV preventions activities at national, Local Authority and community levels.
- Reporting mechanisms could be improved in order to capture all relevant and available data. The current NAC reporting template is limiting input and a section on 'other comments' would be welcome.
- Ensure availability of dedicated and trained staff at all levels to lead and implement the HIV prevention response at all levels. A commitment to training as many people as possible in the country is needed to ensure the pool of technical experts is increasing.
- Funding needs to be provided to the private sector to ensure a multi-sectoral response to HIV/AIDS.
- More transparency is required regarding reporting mechanisms. Accountability regarding budgetary information also needs to be improved.

#### **Administration, support, coordination and communication**

- The timing of financial disbursements to partners should be improved to ensure effective implementation of planned activities.
- More feedback from key policy holders regarding submission of reports and workplans is needed to assure transparent, accurate and timely information flows between both the policy holder and the implementing partner.
- Ensure better communication and information sharing and communicate the principles

of the 'Three Ones' more deliberately and effectively, particularly at district level.

- Implementing partners working on similar programmes should have their own forum to share best practices. For example organisations such as MANASO, MANET+, MBCA and NAPHAM should be working in partnership in order to avoid duplication of efforts.
- CSOs should be better represented in the national response.
- Networking among implementing partners would help information sharing but policy holders should also strive to provide necessary information that would enable implementing partners make informed decisions and move forward.
- Coordinating bodies that are represented on technical working groups and steering committees at the national level need to ensure information is being shared with their members at the district level.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.

The following recommendations are based on the research I conducted for this thesis building on those made above. What this research has enabled me to do is develop my critical thinking on this issue and revisit my original recommendations made for UNAIDS highlighting the need for a much more rigorous evidence based grounding.

- Policies and programmes developed on HIV/AIDS at the international and national level need to be informed by rigorous evidence, collected through critical, reflexive methodologies.
- To advance HIV/AIDS policies and programmes, stakeholders will need to embed policies in epidemiological evidence and pay greater attention to how the wider political contexts at national and international levels impact on the policy and implementation processes.
- Stakeholders need to better articulate the link between harmful cultural practices, gender-based violence and women's health.
- Donors need to ensure they visit rural areas so that they understand the culture of the country and respond to local concerns and priorities.
- Donors need to apply a more theoretical perspective to project planning and implementation that mainstreams gender as they key lens through which gender-based violence and HIV/AIDS should be viewed.
- In terms of methodology a participatory grass roots approach to development is necessary to ensure data accurately reflects the grassroots.
- All programmes should ensure a baseline survey is conducted as well as a mid term review and a final evaluation to determine impact and adjust if necessary.

- Quantification of the risk of HIV infection after sexual intercourse is difficult to measure therefore more quantitative studies are also needed regarding the risk of HIV infection after sexual intercourse to inform policy.
- Research has the potential to impact and therefore it needs to be accessible to non-academics. Researchers need to educate policymakers, by carrying out research that focuses on the ordinary cultural practices, such as extra-marital relationships instead of the taken-for-granted understandings of the rural Malawians.
- A closer relationship is needed between practitioners and qualitative researchers who have longitudinal and in-depth knowledge of the country and its changes.



## BIBLIOGRAPHY

Abramsky, T., Devries, K., Kiss, L., Francisco, L., Nakuti, J., Musuya, T. et al. (2012). A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the SASA! Study): study protocol for a cluster randomised controlled trial. *Trials*, 13:96.

Ahearn, L. (2001). *Invitations to love: literacy, love letters, and social change in Nepal*. Michigan: University of Michigan Press.

Ainsworth, M. & Teokul, W. (2000). Breaking the silence: setting realistic priorities for AIDS control in developing countries. *The Lancet*, 356, 55-60.

Anderson, J. E. (1984). *Public-policy making: An introduction* (3rd ed.). Boston, MA: Houghton Mifflin.

Anglewicz, P., & Kohler, H.P. (2009). Overestimating HIV Infection: The Construction and Accuracy of Subjective Probabilities of HIV Infection in Rural Malawi. *Demography Research* 20 (6), 65-96.

Bakewell, O. & Garbutt, A. (2005). The use and abuse of the logical framework approach: *Stockholm: Swedish International Development Cooperation Agency (Sida)*.

Barnett, T. & Parkhurst, J. (2005). HIV/AIDS: sex, abstinence, and behaviour change. *The Lancet Infectious Diseases*, 5(9), 590–593.

Barrett, D.B., Kurian, G.T., & Johnson, T.M. (Eds.) (2001). *World Christian encyclopedia: a comparative survey of churches and religions in the modern world*. New York: Oxford University Press.

Bascom, W. R. & Herskovits, M. J. (1970). *Continuity and change in African cultures*. Chicago: The University of Chicago Press.

Bassegy, M. O. (1999). *Western education and political domination in Africa: A study in critical and dialogical pedagogy*. Westport, CT: Bergin and Garvey.

Bebbington A. (2005). Donor-NGO relations and representations of livelihood in non-governmental aid chains. *World Development*, 33(6), 937-950.

Beck, U. (1995). *Ecological politics in an age of risk*. Cambridge: Polity Press.

Beck, U. (2000) *Brave new world of work*. Cambridge: Polity Press.

Becker, F. & Geissler, P. W. (2007). Searching for pathways in a landscape of death: religion and AIDS in East Africa. *Journal of Religion in Africa*, 37, 1-15.

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Studies in Family Planning*, 32(3), 189-213.

Boily, M.-C., Baggaley, R. F., Wang, L., Masse, B., White, R. G., Hayes, R. J. et al. (2009). Heterosexual risk of HIV-1 infection per sexual act: systematic review and meta-analysis of observational studies. *The Lancet Infectious Diseases*, 9(2), 118–129.

- Bottomore, T.B. (1993). *Elites and society* (2nd ed.) New York: Routledge.
- Bourdieu, P. (1988). Vive la crise! For heterodoxy in social science, *Theory and Society*, 17(5), 773-787.
- Boyle, P. (2002). Population Geography: Transnational Women on the Move, *Progress in Human Geography*, 26(4), 531-543.
- Bretton Woods. (2004). Retrieved January 14 2012  
<http://www.brettonwoodsproject.org/art.shtml?x=42231>
- Brock, K., Cornwall, A., & Gaventa, J. (2001). Power, knowledge and political spaces in the framing of poverty policy. Sussex, UK: Institute of Development Studies.
- Brock, K., & McGee R. (Eds.). (2002). *Knowing Poverty: Critical Reflections on Participatory Research and Policy*. Earthscan, London.
- Burgess, R. G. (Eds.) (1994). *Analyzing qualitative data*. Oxfordshire: Routledge.
- Buse, K., Mays, N., & Walt, G. (2005). *Making health policy*. London: Open University Press.
- Caldwell, J. C., Anarfi, J., Awusabo-Asare, K., Ntozi, J., Oruboloye, I. O., Marck, J. et al. (Eds.) (1999). *Resistances to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*. Canberra: Australian National University.
- Caldwell, J. C., Caldwell, P. & Quiggin, P. (1989). The social context of AIDS in sub-Saharan Africa. *Population and Development Review*, 15(2), 185-234.
- Case, K. K., Ghys, P. D., Gouws, E., Eaton, J. W., Borquez, A., Stover, J., et al. (2012). Understanding the modes of transmission model of new HIV infection and its use in prevention planning. *Bulletin of the World Health Organisation*, 90(11), 831-838A.
- Cabello, D., Sekulova, F., & Schmidt, D. (2008). World Bank conditionalities: poor deal for poor countries. *A SEED Report*.
- Cammack, D., McLeod D., & Menocal, A. R., with Christiansen, K. (2006). Donors and the 'Fragile States' Agenda: A Survey of Current Thinking and Practice. London: ODI.
- Cammack, D., Golooba-Mutebi, F., Kanyongolo, F. & O'Neil, T. (2007). Neopatrimonial Politics, Decentralisation and Local Government: Uganda and Malawi in 2006. London: ODI.
- Castells, M. (1996). *The rise of the network society*. Oxford, UK: Blackwell.
- Chabal, P., & Daloz, J. (1999). *Africa works: Disorder as political instrument*. Bloomington: Indiana University Press.
- Chandra, K. (2006). What is Ethnic Identity and Does it Matter? *Annual Review of Political Science*, 9, 397-424.
- Chaves, M. (2002). Religious organisations: data resources and research opportunities. *American Behavioral Scientist* 45(10), 1523-1549.

Chimbiri, A. (2007). The condom is an 'intruder' in marriage: evidence from rural Malawi. *Social Science & Medicine*, 64(5), 1102–1115.

Chimombo, S. (2006). *The hyena wears darkness*. Zomba: WASI Publications.

Chin, J. (2007). *The AIDS pandemic: the collision of epidemiology with political correctness*. Oxford: Radcliffe Publishing.

Chizimba, R. et al (2004) The Development and Implementation of the National Behaviour Change Interventions Strategy for HIV/AIDS/SRH in Malawi: An evidence-based approach to planning strategic behaviour change interventions. National AIDS Commission, Malawi.

Clay, E. & Shaffer, B. (Eds.) (1994). *Room for manoeuvre: an exploration of public policy in agriculture and rural development*. London: Heinemann.

Clifford, J. & Marcus, E (Eds.) (1986). *Writing culture: the poetics and politics of ethnography*. Berkeley: University of Californian Press.

Cohen, M.S. & Pilcher, C.D. (2005). Amplified HIV transmission and new approaches to HIV prevention. *The Journal of Infectious Diseases*, 191, 1391-1393.

Cohen, D. & Reid, E. (1996). The vulnerability of women: is this a useful construct for policy and programming. Issues paper No.28 UNDP, HIV and Development Programme. UNDP: New York.

College of Medicine (2005) *Cultural practices related to sexual and reproductive health outcomes and HIV transmission*. Blantyre: College of Medicine.

Coombes, Y. (2001). A literature review to support the situational analysis for the national behaviour change interventions strategy on HIV/AIDS and sexual and reproductive health. London: DFID.

Conroy, A., Blackie, M., Whiteside, A., Malewezi, J. & Sachs, J., (2006). *Poverty, AIDS and hunger: breaking the poverty Trap in Malawi* Hampshire: Palgrave Macmillan.

Corbin, J. M. & Strauss, A. L. (2008). *Basics of qualitative research: techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles: SAGE Publications.

Cornwall, A. (2002). Making spaces, changing places: situating participation in development. Sussex, UK: Institute of Development Studies.

Court, J. & Cotterrell, L. (2006). *What political and institutional context issues matter for bridging research and policy? A literature review and discussion of data collection approaches*. London: ODI.

Crewe, E. & Harrison E. (1998). *Whose development? An ethnography of aid*. London: Zed.

Crewe, E. & Young, J. (2003). *Bridging research and policy: context, evidence and links*. London: ODI.

De Waal, A. (1997). *Famine crimes: politics and the disaster relief industry in Africa*. Oxford:

James Currey.

Dean, M. (1999). Risk, calculable and incalculable. In D. Lupton (Ed.) *Risk and sociocultural theory: new directions and perspectives* (pp. 131-159). Cambridge: Cambridge University Press.

De Lay, P. & De Cock, K. (2007). UNAIDS rejects claims of exaggeration and bias. *Nature*, 448, 251.

De Lay, P., Greener, R. & Izazola, J. (2007). Are we spending too much on HIV? *British Medical Journal*, 334, 345.

Dey, I. (1999). *Grounding grounded theory: guidelines for qualitative inquiry*. San Diego: Academic Press.

Dionne, K. Y. (2011). Local demand for a global intervention: policy priorities in the time of AIDS. *World Development*, 40(12), 2468-2477.

Dionne, K. Y., Gerland, P., & Watkins, S. C. (2013). Aids exceptionalism: another constituency heard from. *AIDS and Behavior*, 17(3), 825-831.

Donnelly, J. (2011). Battles with donors cloud Malawi's HIV prevention plan. *The Lancet*, 378(9787), 215-216.

Dorman, S. (2005). Studying democratization in Africa: a case study of human rights NGOs in Zimbabwe. In T. Kelsall & J. Igoe (Eds.), *Between a rock and a hard place: African NGOs, donors and the state* (pp. 33-59). Durham, NC: Carolina Academic Press.

Easton, D. (1965). *A framework for political analysis*. Englewood Cliffs: Prentice-Hall.

Englund, H. (2002). The dead hand of human rights: contrasting Christianities in post-transition Malawi. *The Journal of Modern African Studies*, 38(4), 579-603.

Englund, H. (2006). *Prisoners of freedom: human rights and the African poor*. Berkeley, CA: University of California Press.

Englund, H. (2007). The dangers of disease specific aid programmes. *British Medical Journal*, 335:565.

Escobar, A. (1988). Power and visibility: development and the intervention and management of the third world. *Cultural Anthropology*, 3(4), 428-443.

Escobar, A. (1995). *Encountering Development: The Making and Unmaking of the Third World*. Princeton, New Jersey: Princeton University Press.

Evangelical Association of Malawi (EAM). (n.d.) HIV/AIDS Programme: Baseline Survey Report. Blantyre: EAM.

Fanon, F. (1970). *Black skin, white masks*. St Albans: Paladin.

Feeny, S. & McGillivray, M. (2004). Modelling inter-temporal aid allocation: a new application with an emphasis on Papua New Guinea. *Oxford Development Studies*, 32(1), 101-18.

- Ferguson, A. E. (1994). Gendered science: a critique of agricultural development. *American Anthropologist*, 96(3), 540-552.
- Foley, E. E. & Nguer, R. (2010). Courting success in HIV/AIDS prevention: the challenges of addressing a concentrated epidemic in Senegal. *African Journal of AIDS Research*, 9(4), 325.
- Foltz, A. (1994). Donor funding for health reform in Africa: is non-project assistance the right prescription? *Health Policy and Planning*, 9(4), 371-384.
- Foltz, A. & Foltz, W. (1991). The politics of health reform in Chad. In D. Perkins & M. Roemer (Eds.), *Reforming economic systems in developing countries* Boston: Harvard University Press.
- Foucault, M. (1979). *The history of sexuality, vol. I: an introduction*. New York: Random House.
- Foucault, M. (1991). *Discipline and punish: the birth of the prison*. London: Penguin.
- Fourie, P. (2006). *The political management of HIV/AIDS in South Africa: one burden too many?* Basingstoke, UK: Palgrave MacMillan.
- Fuchs, S. (1993). Three sociological epistemologies. *Sociological Perspectives*, 36(1), 23-44.
- Gallup News Service. (2007). *Africans' Confidence in Institutions -- Which Country Stands Out?* News Release. Retrieved October 20 2013, from <http://www.gallup.com/poll/26176/africans-confidence-institutions-which-country-stands-out.aspx>
- Galtung, J. (1971). A structural theory of imperialism. *Journal of Peace Research*, 8(2), 81-117.
- Gasper, D. & Apthorpe, R. (1996). Discourse analysis and policy discourse. *The European Journal of Development Research*, 8, 1-15.
- Gaventa, J. (2006). Finding the spaces for change: a power analysis. *IDS Bulletin*, 37(6), 23-33.
- Geertz, C. (1973). *The interpretation of cultures*. New York: Basic.
- Geisler, G. (1997). Women are women or how to please your husband: initiation ceremonies and the politics of 'Tradition' in Southern Africa. *African Anthropology* 14(1), 92-128.
- Geo-Jaja, M. A. & Mangum, G. (2001). Structural adjustment as an inadvertent enemy of human development in Africa. *Journal of Black Studies*, 32(1), 30-49.
- Gifford, P. (1998). *African Christianity: its public role*. Bloomington: Indiana University Press.
- Gifford, I. (2004). *Ghana's new Christianity: Pentecostalism in a globalising African economy*. London: Hurst & Company.
- Gilmore, D. D. (1990). *Manhood in the making: cultural concepts of masculinity*. New Haven & London: Yale University Press.
- Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine.

- Government of Malawi (2003). *National HIV/AIDS Policy*, Lilongwe: Malawi.
- Government of Malawi (2007). *Malawi and the millennium development goals*, Lilongwe: Malawi.
- Government of Malawi (2009). Report of the committee on HIV/AIDS on regional seminars for Members of Parliament on HIV/AIDS issues. National Assembly 40th Session Report, January 2009. Lilongwe, Malawi.
- Government of Malawi (2012). *Global AIDS response progress report*. Malawi Country Report for 2010 and 2011.
- Gramsci, A. (1971). *Selections from the prison notebooks*. London: Lawrence & Wishart.
- Grant, A. D. & De Cock, K. M. (2001). HIV infection and AIDS in the developing world. In M. W. Adler (Ed.), *ABC of AIDS* (5th ed.) (pp. 59-64). London: BMJ Books.
- Gray, R. H., Wawer, M. J., Brookmayer, R., Sewankambo, N. K., Serwadda, D., Wabwire-Mangen, D. et al. (2001). Probability of HIV transmission per coital act in monogamous, heterosexual, HIV discordant Couples in Rakai, Uganda. *The Lancet*, 357(9263), 1149-1153.
- Gray, R.H. & Wawer, M.J. (2012). Probability of Heterosexual HIV-1 Transmission per Coital Act in Sub-Saharan Africa *Journal of Infectious Diseases*, 205 (3), 351-352.
- Grindle, M. & Thomas, J. (1991). *Public choices and policy change: the political economy of reform in developing countries*. Baltimore: John Hopkins University Press.
- Guba, E. G. & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). California: Sage Publications.
- Gupta, G. R. (2002). How men's power over women fuels the HIV epidemic: it limits women's ability to control sexual interactions. *British Medical Journal*, 324(7331), 183-184.
- Gupta, G. R. & Weiss, E. (1993). Women's lives and sex: implications for AIDS prevention. *Culture, Medicine and Psychiatry*, 17(4), 399-412.
- Gustafson, P. E. (1998). Gender differences in risk perception: theoretical and methodological perspectives. *Risk Analysis*, 18(6), 805-11.
- Haas, P. M. (1992). Epistemic communities and international policy coordination: introduction. *International Organisation*, 46(1), 1-35.
- Hajer, M. A. (1995). *The politics of environmental discourse*. Oxford: Oxford University Press.
- Hajer, M. A. (2003). A frame in the fields: policymaking and the reinvention of politics. In M. A. Hajer & H. Wagenaar (Eds.), *Deliberative policy analysis: understanding governance in the network society* (pp. 88-112). Cambridge: Cambridge University Press.
- Hammersley, M. & Atkinson, P. (1995). *Ethnography: principles in practice*. New York: Routledge.

- Harbeson, J., Rothchild, D., & Chazan, N. (Eds.) (1994). *Civil society and the state in Africa*. Boulder, CO: Lynne Rienner Publishers.
- Hargreaves, J. R. & Glynn, J.R. (2002). Educational attainment and HIV-1 infection in developing countries: a systematic review. *Tropical Medicine and International Health*, 7(6), 489-98.
- Hattori, M. K., & Nii-Amoo Doodoo, F. (2007). Cohabitation, marriage, and 'sexual monogamy' in Nairobi's slums. *Social Science & Medicine*, 64(5), 1067–1078.
- Hecló, H. (1972). Policy analysis. *British Journal of Political Science*, 2(1), 83-108.
- Herrera, R. (1996). Understanding the language of politics: A study of elites and masses. *Political Science Quarterly*, 111(4), 619–637.
- Higley, J. & Burton, M. (2006). *The Elite Foundations of Liberal Democracy*. Lanham: Rowman and Littlefield.
- Hobart, M. (1993). *An anthropological critique of development: the growth of ignorance*. London: Routledge.
- Hogwood, B. W. & Gunn, L. A. (1984). *Policy analysis for the real world*. Oxford: Oxford University Press.
- Holland, J. & Campbell, J. (Eds.) (2005). *Methods in development research: combining qualitative and quantitative approaches*. Rugby, Warwickshire: ITDG Publishing.
- Hossain, N. and Moore, M. (2002). Arguing for the Poor: Elites and Poverty in Developing Countries, IDS Working Paper, no. 148, Institute of Development Studies: Brighton.
- Institute of Development Studies. (2006). *Understanding policy processes: a review of IDS research on the environment*. Sussex, UK: IDS.
- IRIN. (2011). MALAWI: UK aid cuts hit health care. Retrieved June 6, 2011, from <http://www.irinnews.org/report/92877/malawi-uk-aid-cuts-hit-health-care>.
- Jenkins P. (2007). *The next Christendom: the coming of global Christianity*. New York: Oxford University Press.
- Jenkins, R. (2002). *Pierre Bourdieu*. New York: Routledge.
- Jones, E. & Gaventa, J. (2002). *Concepts of citizenship: a review*. Sussex, UK: IDS.
- Jones, N., Datta, A., & Jones, H. (2009). *Knowledge, policy and power: six dimensions of the knowledge-development policy interface*. Overseas Development Institute (ODI).
- Kadzandira, J. M. & Zisiyana, C. (2006). *Assessment of risk practices and sites where such practices take place in the urban areas of Lilongwe and Blantyre districts*. Zomba: Centre for Social Research.
- Kaler, A. (2004). AIDS-talk in everyday life: the presence of HIV/AIDS in men's informal conversation in Southern Malawi. *Social Science and Medicine*, 59(2), 285-297.
- Kaler, A. & Watkins, S. (2001). Disobedient distributors: street-level bureaucrats and would-be

patrons in community based family planning programs in rural Kenya. *Studies in Family Planning*, 32(3), 254-269.

Kalipeni, E. Garrard, C. (Eds.) (2004). *HIV/AIDS in Africa: beyond epidemiology*. Oxford, UK & Cambridge, USA: Blackwell.

Kalipeni, E. & Ghosh, J. (2007). Concern and practice among men about HIV/AIDS in low socioeconomic areas of Lilongwe, Malawi. *Social Science & Medicine*, 64(5), 1116-1127.

Kamlongera, A. (2007). What becomes of 'her'? a look at the Malawian Fisi culture and its effects on young girls, *Agenda: Empowering women for gender equity*, 21(74), 81-87.

Kaplan, A. & Lasswell, H. D. (1950). *Power and Society*. New Haven: Yale University Press.

Keely, J. & Scoones, I. (1999). *Understanding environmental policy process: a review*. Sussex, UK: IDS.

Keely, J. & Scoones, I. (2000). *Environmental policymaking in Zimbabwe: discourses, science and politics*. Sussex, UK: IDS.

Keely, J. & Scoones, I. (2003). *Understanding environmental policy processes: cases from Africa*. London: Earthscan.

Kenny, C. & Summer, A. (2011). *More money or more development: what have the MDGs achieved?* Washington DC: Centre for Global Development.

Kitching, G. (1982). *Development and Underdevelopment in Historical Perspective*. New York: Methuen.

Kleinman, A. (2004). Culture and depression. *New England Journal of Medicine*, 351, 951-952.

Kornfield, R. & Namate, D. (1997). *Cultural practices related to HIV/AIDS risk behaviour: community survey in Phalombe, Malawi* (No. 10). Support to AIDS and Family Health (STAFH) Project, 612-238.

Lange, S., Wallevik, H. & Kiondo, A. (2000). 'Civil Society in Tanzania', Christian Michelsen Institute.

Lasswell H.D. (1956). *The decision process*. College Park, MD: University of Maryland Press.

Lasswell, H.D. (1936). *Politics: Who gets what, when, how*. Cleveland: Meridian.

Latour, B. (1996). *Aramis, or the love of technology*. Trans. C. Porter. Cambridge, MA & London: Harvard University Press.

Lewis, S. & Donovan, P. (2007). Time for a change? *Nature*, 447, 531-532.

Lewis, D. & Kanji, N. (2009). *Non Governmental Organizations and Development*. Oxon: Routledge.

Leynaert, B., Downs A.M. & de Vincenzi, I. (1998). Heterosexual transmission of human immunodeficiency virus: variability of infectivity throughout the course of infection. *European*



- Study Group on Heterosexual Transmission of HIV. *American Journal of Epidemiology*, 148, 88-96.
- Lindblom, C. E. (1959). The science of 'muddling through'. *Public Administration Review*, 19(2), 79-88.
- Lindblom, C. E. (1980). *The policy-making process*. Englewood Cliffs, NJ: Prentice Hall.
- Lipsky, M. (1979). *Street-level bureaucracy: dilemmas of the individual in public service*. New York: Russell Sage.
- Ludden, D. (1992). India's development regime. In N. B. Dirks (Ed.), *Colonialism and culture* (pp. 247-287). Ann Arbor, MI: University of Michigan Press.
- Lloyd, P.C. (1967). *Africa in social change: Changing traditional societies in the modern world*. Baltimore: Penguin Books.
- Lloyd, P.C. (1966). *The new elites of tropical Africa*. London: Oxford University Press.
- Luke, N. & Watkins, S. C. (2002). Reactions of developing-country elites to international population policy. *Population and Development Review*, 28(4), 707-733.
- Lwanda, J. (2005). *Politics, culture and medicine in Malawi*. Zomba: Kachere.
- Macrae, J. (2001). *Aiding recovery: the crisis of aid in chronic political emergencies*. London: Zed Books.
- Malawi Demographic and Health Survey (2004). Maryland: NSO and ORC Macro.
- Malawi Demographic and Health Survey (2010). Maryland: NSO and ORC Macro.
- Malawi Human Rights Commission (2006). *Cultural practices and their impact on the enjoyment of human rights, particularly the rights of women and children in Malawi*. MHRC: Malawi.
- Malawi Law Commission (2008). *Report of the Law Commission on the development of HIV and AID legislation*. Lilongwe: Malawi.
- Maleta, K. & Munthali, A. (2007). *Impact assessment of the national HIV/AIDS response in Malawi*. Lilongwe: Malawi.
- Manning, R. (2009). *Using indicators to encourage development: learning lessons from the millennium development goals* (No. 2009 : 01). Danish Institute for International Studies.
- Marsland, R. (2006). Community participation the Tanzanian way: conceptual contiguity or power struggle? *Oxford Development Studies*, 34(1), 65-79.
- Marx, K. & Engels, F. (1962). *Selected Works*, Vol II, Foreign Languages Publishing House: Moscow.

- Matiki, A. J. (2001). The social significance of English in Malawi. *World Englishes*, 20(2), 201-218.
- Matinga, P., & McConville, F. (2003). *A review of cultural beliefs and practices influencing sexual and reproductive health and health-seeking behaviour, in Malawi*. Department for International Development Malawi: DFID.
- Mbeki, M. (2009). *Architects of poverty: Why Africa's capitalism needs changing*. Johannesburg: Pan Macmillan/Picador Africa.
- Mbiti, J. S. (1970). *Concepts of God in Africa*. London: SPCK.
- Mbugua, N. (2007). Factors inhibiting educated mothers in Kenya from giving meaningful sex education to their daughters. *Social Science & Medicine*, 64(5), 1079-1089.
- McGee, R. (2004). Unpacking policy: actors, knowledge and spaces. In K. Brock, R. McGee, & J. Gaventa (Eds.), *Unpacking policy: actors, knowledge and spaces in poverty reduction* (pp. 1-26). Kampala: Fountain Press.
- Merry, S. E. (2006). *Human rights and gender violence*. Chicago: Chicago University Press.
- Merriam S.B., Johnson-Bailey J., Lee M-Y., Kee Y., Ntseane G. & Muhamad M. (2001). Power and positionality: negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education* 20(5), 405-416.
- Mertens, D. M. (2005). *Research methods in education and psychology: integrating diversity with quantitative and qualitative approaches* (2nd ed.). Thousand Oaks: Sage.
- Mills, C.W. (1956). *The power elite*. New Jersey: Oxford University Press.
- Mkamanga E. (2000). *Suffering in Silence-Malawi women's 30-year dance with Dr Banda*, Scotland, Dudu Nsomba Publications.
- Morfit, S. (2008). *Dangerous development: the global response to AIDS in Africa*. Unpublished Master's Paper, Department of Sociology, University of California, Berkeley.
- Mosca, G. (1896). 1939. *The Ruling Class (Elementi di scienza politica)*. New York: McGraw-Hill.
- Mosse, D. (2004). Is good policy unimplementable? Reflections on the ethnography of aid policy and practice. *Development and Change*, 35(4), 639-671.
- Mosse, D. (2005). *Cultivating development: an ethnography of aid policy and practice*. London & Ann Arbor, MI: Pluto Press.
- Mosse, D. (2008). International policy, development expertise, and anthropology.' *Focaal*, 52, 119-126.
- Mosse, D. (2008). The anthropology of international institutions (Conference Report). *Anthropology Today*, 24(5), 24.

- Mosse, D. (2011). Introduction: The Anthropology of Expertise and Professionals in International Development in Mosse, D. (Ed.) *Adventures in Aidland*. Oxford: Berghahn.
- Msowoya, A. B. B. (2008). *Powerpoint presentation: overview of the proposed HIV/AIDS legislation*. Blantyre, Malawi.
- Mthanga, A.S., Maluwa-Banda D. (Dr), Chiziwa, S.E., & Mphande, D. K. (Rev Dr) (2002). *Senior secondary life skills education, student's book 3 and 4*. Blantyre: Macmillan.
- Munthali, A. C., Chimbiri, A., & Zulu, E. (2004). *Adolescent sexual and reproductive health in Malawi: a synthesis of the research evidence*. New York: The Alan Guttmacher Institute.
- Munthali A. C., Moore, A., Konyani, S., & Zakeyo, B. (2006). *Qualitative evidence of adolescents' sexual and reproductive health experiences in selected districts of Malawi.*, New York: The Alan Guttmacher Guttmacher Institute.
- Munthali, A. C. & Zulu, E. M. (2007). The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive behaviour in Malawi. *African Journal for Reproductive Health*, 11(3), 150-167.
- Musopole, A. (2006). *Spirituality, sexuality and HIV/AIDS in Malawi*. Malawi: Kachere Series.
- Myroniuk, T. W. (2011). Global discourses and experiential speculation: secondary and tertiary graduate Malawians dissect the HIV/AIDS epidemic. *Journal of the International AIDS Society*, 14(1), 47.
- Nanda, S. (1987). *Cultural anthropology*. Belmont, CA: Wadsworth.
- National AIDS Commission (NAC) [Malawi] (2004). *HIV and AIDS Monitoring and Evaluation Report 2004*. Lilongwe, Malawi: National AIDS Commission.
- National Statistics Office and ORC Macro (2005). *Malawi Demographic and Health Survey 2004*. Calverton, Maryland.
- Ngũgĩ wa Thiong'o (1986). *Decolonizing the mind: The politics of language in African literature*. London: Heinemann Educational Books.
- NSO (2008). *Multiple indicator cluster survey*. Zomba: National Statistical Office.
- Nyasa Times. Retrieved 29/11/2011 <http://www.nyasatimes.com/2011/11/29/gender-minister-wants-women-to-hurt-hyenas/>
- Oduyoye, M. A. & Kanyoro, R. A. (Eds.) (1992). *The will to arise: women, tradition and the church in Africa*. Cluster Publications.
- OECD-DAC (2007) *Geographical Distribution of Financial Flows to Developing Countries 20032007*, Paris: OECD.
- Oppenheim-Mason, K. (1992). Culture and Fertility Transition; Thoughts on Theories of Fertility Decline. *Genus*, 40, 1-14.
- Oppong, J. R. & Kalipeni, E. (2004). Perceptions and misperceptions of AIDS in Africa. In E. Kalipeni, S. Craddock, J. R. Oppong, & J. Ghosh (Eds.), *HIV/AIDS in Africa: beyond epidemiology*

(pp. 47-57). Malden, MA: Blackwell.

Ornett, A. & Hewitt, T. (2006). *Elites and Institutions*. Literature Review. Birmingham, Governance and Social Development Resource Centre: University of Birmingham.

Packard, R. M. & Epstein, P. (1991). Epidemiologists, social scientists, and the structure of medical research on AIDS in Africa. *Social Science & Medicine*, 33(7), 771-794.

Page, S. (2009). *Country harmonization and alignment report for Malawi*.

Palella, F. J., Delaney, K. M., Moorman, A. C., Loveless, M. O., Fuhrer, J., Satten, G. A., et al. (1998). HIV outpatient study investigators. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. *The New England Journal of Medicine*, 338(13), 853-860.

Pareto, V. (1916 [1935]). *Mind and society* [Trattato di Sociologia Generale]. New York: Harcourt, Brace and Company.

Patterson, A. (2011). *The church and AIDS in Africa: the politics of ambiguity*. Boulder, CO: First Forum Press.

Pearson, M. (2010). *DFID Malawi impact evaluation of the SWAp*: DFID.

Philpot, D. (2004). The Catholic wave. *Journal of Democracy*, 15(2), 32-46.

Phiri, I. A. (1998). The initiation of Chewa women of Malawi: a Presbyterian women's perspective'. In J. L. Cox (Ed.), *Rites of passage in contemporary Africa: interaction between Christian and African traditional religions*. Cardiff: Cardiff Academic Press.

Pilcher, C.D., Tien, H.C., Eron, Jr J.J., (2004). Quest Study, Duke-UNC-Emory Acute HIV Consortium. Brief but efficient: acute HIV infection and the sexual transmission of HIV. *Journal of Infectious Diseases*, 189, 1785-92.

Pinkerton, S.D. (2008). Probability of HIV transmission during acute infection in Rakai, Uganda. *AIDS and Behaviour*, 12, 677-684.

Poku, N. K. & Whiteside, A. (2004). Introduction: Africa's HIV/AIDS crisis. In N. K. Poku & A. Whiteside (Eds.), *The Political Economy of AIDS in Africa* (pp. xvii-xxii). Hampshire, UK: Ashgate Publishing.

Poku, N. K. (2005). *AIDS in Africa: how the poor are dying*. Cambridge, UK: Polity Press.

Potts, M., Halperin, D. T., Kirby, D., Swidler, A., Marseille, E., Klausner, J. D., et al. (2008). Reassessing HIV Prevention. *Science*, 320(5877), 749-750.

Powers, K.A., Poole, C., Pettifor A.E., Cohen, M.S. (2008) Rethinking the heterosexual infectivity of HIV-1: a systematic review and meta-analysis. *The Lancet Infectious Diseases*; (8) 553-63.

Putzel, J. (2003). *Institutionalising an emergency response: HIV/AIDS and governance in Uganda and Segal*. London school of economics and political science (LSE). Crisisstate research centre (CSRC).

- Putzel, J. (2004) The global fight against AIDS: how adequate are the National Commissions. *Journal of international development*, 16(8), 1129-1140.
- Putzel, J. (2006). A history of state action: the politics of AIDS in Uganda and Senegal'. In P. Denis & C. Becker (Eds.), *The HIV/AIDS epidemic in sub-Saharan Africa in a historical perspective* (pp. 171-184). Senegalese Network.
- Quarles van Ufford, P. & Saleminck, O. (2006). *After the fall: cosmopolitanism and the paradoxical politics of global inclusion and authenticity*. Paper prepared for the panel on cosmopolitanism and development. Association of Social Anthropologists Diamond Jubilee Conference. Keele, UK.
- Ramalingam, B., Jones, H., Reba, T., & Young, J. (2008). *Exploring the science of complexity: ideas and implications for development and humanitarian efforts*. London: ODI.
- Rankin, S. H., Lindgren, T., Rankin, W. W., & Ng'Oma, J. (2006). Donkey work: women, religion, and HIV/AIDS in Malawi. *Health Care for Women International*, 26(1), 4-16.
- Reid, E. & Bailey, M. (1992). Young women: silence, susceptibility and the HIV epidemic, Issues Paper No.12, New York: UNDP HIV and Development Programme.
- Reinicke, J., Schmidt, P., & Ajzen, I. (1996). Application of the theory of planned behaviour to adolescents' condom use: a panel study. *Journal of Applied Psychology*, 26(9), 749-772.
- Riddell, J. B. (1992). Things fall apart again: structural adjustment programmes in sub-Saharan Africa. *The Journal of Modern African Studies*, 30(1) 53-68.
- Roe, E. (1991). Development narratives, or making the best of blueprint development. *World development*, 19(4), 287-300.
- Roe, E. (2005). Development narratives, or making the best of blueprint development. In M. Edelman & A. Haugerud (Eds.), *The anthropology of development and globalization: from classical political economy to contemporary neoliberalism* (pp. 313-322). Oxford, UK & Malden, MA: Blackwell.
- Rushing, W. A. (1995). *The AIDS epidemic: social dimensions of an infectious disease*. Boulder, Colorado: Westview Press.
- Rushton, J. P. & Bogaert, A. F. (1989). Population differences in susceptibility to AIDS: an evolutionary analysis. *Social Science & Medicine*, 28(12), 1211-1220.
- Sabatier, P. A. (2007). 'The Need for Better Theories' In P. Sabatier (Ed.) *Theories of the Policy Process*. Westview Press, Boulder.
- Sadasivam, B. (1997). The impact of structural adjustment on women: a governance and human rights agenda. *Human Rights Quarterly*, 19(3), 630-665.
- SAfAIDS (2008). *Inter-linkages between culture, gender based violence, HIV and AIDS and women's rights training manual*. Zimbabwe: SAfAIDS.

- Sahlins, M. (1963). Poor Man, Rich Man, Big-man, Chief: Political Types in Melanesia and Polynesia. *Comparative Studies in Society and History*, (5) 285-303.
- Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students*. London: Pearson Education.
- Schatz, E. (2005). 'Take your mat and go!': Rural Malawian women's strategies in the HIV/AIDS era. *Culture, Health and Sexuality*, 7(5), 479-492.
- Schoepf, B. G. (1992). AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire. In R. Bolton & M. Singer (Eds.), *Rethinking AIDS prevention: cultural approaches* (pp. 87-106). Reading: Gordon and Breach Science Publishers.
- Schoffeleers, J. M. (1968). *Symbolic and social aspects of spirit worship among the Mang'anja*. Unpublished PhD Thesis, Oxford.
- Schoffeleers, J. M. (2008). *Mang'anja traditional religion: spirit and practices in Malawi's Lower Shire Valley*. Leiden: Mlambe Foundation.
- Scott, J. (1998). *Seeing like a state: how certain schemes to improve the human condition have failed*. New Haven, CT & London: Yale University Press.
- Semu, L. & Binauli, L. C. (1997). Women's status in Malawi: a case for gendered development. In *Bwalo: A Forum for Social Development* (Vol. 1, pp. 85-103).
- Sen, A. (1999) *Development as freedom*. Oxford: Oxford University Press.
- Shankman, P. (2009). *The trashing of Margaret Mead: anatomy of an anthropological controversy*. Wisconsin: The University of Wisconsin Press.
- Shiffman, J. (2008). Has donor prioritization of HIV/AIDS displaced aid for other health issues? *Health Policy and Planning*, 23(2), 95-100.
- Shore, S. & Wright, S. (Eds.) (1997). *Anthropology of policy: critical perspectives on governance and power*. London & New York: Routledge.
- Silvermann, D. (1993) *Interpreting qualitative data*. London: Sage.
- Simon, H. A. (1957). 'A behavioral model of rational choice'. In H. A. Simon, *Models of man, social and rational: mathematical essays on rational human behavior in a social setting*. New York: Wiley.
- Smith, K. P. & Watkins, S. C. (2005). Perceptions of risk and strategies for prevention: responses to HIV/AIDS in rural Malawi. *Social Science & Medicine*, 60(3), 649-660.
- Soothill, J. E. (2011). The problem with 'women's empowerment': female religiosity in Ghana's charismatic churches. *Studies in World Christianity*, 16(1), 82-99.
- Stiglitz, J. (2000). What I learned at the world economic crisis. *Globalization and the poor: exploitation or equalizer*, 195-204.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.) Newbury Park, CA: Sage.

- Sutton, R. (1999). *The Policy Process: An Overview*. London: ODI.
- Svanikier, J.O. (2007). Political Elite Circulation: Implications for Leadership Diversity and Democratic Regime Stability in Ghana, *Comparative Sociology* 6, 114–135.
- Swidler, A. & Watkins, S. (2009) “Teach a Man to Fish”: The Sustainability Doctrine and Its Social Consequences *World Development* 37(7) 1182–1196.
- Taufik, L. & Watkins, S. (2007). Sex in Geneva, sex in Lilongwe, and sex in Balaka. *Social Science & Medicine*, 64(5), 1090-1101.
- The Guardian (2011) Britain expels Malawi ambassador in retaliation after envoy is ordered out. Retrieved June 14, 2011, from <http://www.theguardian.com/world/2011/apr/27/britain-malawi-ambassador-expelled?INTCMP=SRCH>
- Thomas, F. (2006). Stigma, fatigue and social breakdown: exploring the impacts of HIV/AIDS on patient and carer well-being in the Caprivi Region, Namibia. *Social Science & Medicine*, 63(12), 3174-3187.
- Tran, M. (2011). Britain suspends aid to Malawi. Retrieved July 14, 2011, from <http://www.guardian.co.uk/global-development/2011/jul/14/britain-suspends-aid-to-malawi>
- Trinitapoli, J. (2009). The Malawi religion project: data collection and selected analyses. *Demographic Research*, 21(10), 255-288.
- Turner, V. W. (1967[1962]) 'Betwixt and between: the liminal period in *rites de passage*.' In V. W. Turner, *The forest of symbols: aspects of Ndembu ritual* (pp. 93-111). Ithaca: Cornell UP, 1967.
- Tylor, E. (1871). *Primitive culture*. London: John Murray.
- UN (1993) Declaration on the Elimination of Violence against Women A/RES/48/104 85th plenary meeting 20 December 1993.
- UN (1994). Report of the international conference on population and development. Cairo, 5-13 September.
- UN (1996). Report on the fourth world conference on women. New York: UN.
- UN (2006). Human Development Report New York: UN.
- UN (2010). Human Development Report New York: UN.
- UN (2011). One Plan Annual Report: United Nations Country Team. Malawi Lilongwe: UN
- UNAIDS (2001) United Nations Declaration on HIV/AIDS at the General Assembly Special Session on HIV/AIDS.
- UNAIDS (2004). Report on the global AIDS epidemic: executive summary. Geneva, Switzerland: UNAIDS.

- UNAIDS (2006). 2006 report on the global AIDS epidemic. Geneva, Switzerland: UNAIDS
- UNAIDS (2007). Practical guidelines for intensifying HIV prevention, towards universal access. Geneva, Switzerland: UNAIDS.
- UNAIDS (2007). Country harmonization and alignment tool. Geneva, Switzerland: UNAIDS.
- UNAIDS (2008). *2008 report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS
- UNAIDS (2010). *UNAIDS report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS
- UN Commission on Human Rights (2003). Commission on Human Rights Resolution 2003/45: elimination of violence against women. Retrieved 06 November, 2013, from the Refworld website: <http://www.refworld.org/docid/43f3133b0.html>
- UNESCO (2001). *A cultural approach to HIV/AIDS prevention and care*. UNESCO Inter-regional conference, 2-4 October 2000. Nairobi, Kenya.
- UN (2000). Resolution A/RES/54/133 adopted by the General Assembly: traditional or customary practices affecting the health of women and girls. Retrieved November 06 2013, from <http://www1.uneca.org/Portals/ngm/Documents/Conventions%20and%20Resolutions/Resolution%20on%20traditional.pdf>
- UNFPA (2013) Gender Equality. Retrieved October 13, 2013, from <http://www.unfpa.org/gender/violence.htm>
- UN Women (2013) A transformative stand-alone goal on achieving gender equality, women's rights and women's empowerment: Imperatives and key components. New York: UN Women.
- USAID (2008). *Bridge project final evaluation*. Washington, USA.
- Van Gennep, A. (1908). The rites of passage *Trans.* (1960) M. B. Vizedom & G. L. Caffee. London: Routledge & Kegan Paul.
- Van de Walle, N. (2003). Presidentialism and clientelism: Africa's emerging party systems, *Journal of Modern African Studies*, 41(2) 297-321.
- Wachira, C., & Ruger, J. P. (2011). National poverty reduction strategies and HIV/AIDS governance in Malawi: a preliminary study of shared health governance. *Social Science & Medicine*, 72(12), 1956-1964.
- Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), 353-370.
- Waterston, A. (1997). Anthropological research and the politics of HIV prevention: towards a critique of policy and priorities in the age of AIDS. *Social Science & Medicine*, 44(9), 1381-1391.
- Watkins, K. (2011). The millennium development goals: three proposals for renewing the vision and reshaping the future. Retrieved October 10 2013, from <http://www.scribd.com/doc/2442520/Millennium-Development-Goals>.



Watkins, S. (2003). *Navigating AIDS in rural Malawi*. Paper presented at the Annual Meeting of the Population Association of America, Minneapolis, MN, 1-3 May.

Wawer, M.J., Gray, R.H., Sewankambo, N.K., Serwadda, D., Li, X., Laeyendecker, O., Kiwanuka, N., Kigozi, G., Kiddugavu, M., Lutalo, T., Nalugoda, F., Wabwire-Mangen, F., Meehan, M.P. & Quinn, T.C. (2005) Rates of HIV-1 transmission per coital act, by stage of HIV-1 infection, in Rakai, Uganda. *Journal of Infectious Diseases*, 191,1403-1409.

Webb, D. (2004). Legitimate actors? The future role for NGOs against HIV/AIDS in sub-Saharan Africa. In N. K. Poku & A. Whiteside (Eds.), *The political economy of AIDS in Africa* (pp.19-32). Hampshire, UK: Ashgate Publishing.

Whimster, S. (2007). *Understanding Weber*. New York: Routledge.

Williams, R. (1976). *Keywords*. London: Picador.

Wilson, D.P., Law, M.J., Grulich, A.E., Cooper, D.A., & Kaldor, J.M. (2008). Relation between HIV viral load and infectiousness: a model-based analysis. *Lancet*, 372, 314-320.

World Bank (2011). *Global monitoring report 2011: improving the odds of achieving the MDGs*. Washington DC: World Bank.

World Bank (2013). *Malawi Overview* Retrieved October 06,2013, from <http://www.worldbank.org/en/country/malawi/overview>

Wroe, D. (2012). Donors, dependency, and political crisis in Malawi. *African Affairs* 111(442), 135-144.

Young, E. & Mendizabal, (2009). ODI briefing paper. London: ODI.

Young, E. & Quinn, L. (2002). *Writing effective public policy papers: a guide to policy advisors in Central and Eastern Europe*. Budapest: LGI.

## APPENDIX 1 Ethical Approval



Samantha Page  
PhD Student  
School of Languages and Area Studies  
University of Portsmouth

**REC reference number: 13/14:05**  
**Please quote this number on all correspondence.**

5th December 2013

Dear Samantha,

**Full Title of Study:** HIV and AIDS, Cultural Practices in Malawi: Implications for HIV and AIDS Policies and Prevention Programmes

Further to our recent correspondence, it has been confirmed that your ethical review was carried out by Swansea University, and was issued a favourable opinion. The Ethics Committee of the University of Portsmouth accepts the decision of this review and you thus have approval for your study.

Kind regards,

FHSS FREC Chair  
**David Carpenter**

## FORM UPR16

### Research Ethics Review Checklist

Please complete and return the form to Research Section, Quality Management Division, Academic Registry, University House, with your thesis, prior to examination

<b>Postgraduate Research Student (PGRS) Information</b>		<b>Student ID:</b>	UP15358	
<b>Candidate Name:</b>	SAMANTHA PAGE			
<b>Department:</b>	SLAS	<b>First Supervisor:</b>	DR TAMSIN BRADLEY	
<b>Start Date:</b> (or progression date for Prof Doc students)	OCTOBER 2011 at Portsmouth University having transferred from Swansea University			
<b>Study Mode and Route:</b>	Part-time <input checked="" type="checkbox"/>	MPhil <input type="checkbox"/>	Integrated Doctorate (NewRoute) <input type="checkbox"/>	
	Full-time <input type="checkbox"/>	MD <input type="checkbox"/>	Prof Doc (PD) <input type="checkbox"/>	
		PhD <input checked="" type="checkbox"/>		
<b>Title of Thesis:</b>	"Narratives of Blame" - HIV/AIDS and Harmful Cultural Practices in Malawi: Implications for Policies and Programmes			
<b>Thesis Word Count:</b> (excluding ancillary data)	75,221			
<p>If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study</p> <p>Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).</p>				
<p><b>UKRIO Finished Research Checklist:</b> (If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: <a href="http://www.ukrio.org/what-we-do/code-of-practice-for-research/">http://www.ukrio.org/what-we-do/code-of-practice-for-research/</a>)</p>				

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?	YES
b) Have all contributions to knowledge been acknowledged?	YES
c) Have you complied with all agreements relating to intellectual property, publication and authorship?	YES
d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?	YES
e) Does your research comply with all legal, ethical, and contractual requirements?	YES

<b>Candidate Statement:</b>	
I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)	
<b>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</b>	13/14:05
<b>Signed: Samantha Page (Student)</b>	<b>Date: 02/12/13</b>
If you have <i>not</i> submitted your work for ethical review, and/or you have answered 'No' to one or more of questions a) to e), please explain why this is so:	
<b>Signed: Samantha Page (Student)</b>	<b>Date: 02/12/13</b>

Approval from the Ministry of Health, Malawi

Telephone: + 265 789 400  
Facsimile: + 265 789 431  
e-mail: doccentre@malawi.net  
All Communications should be addressed to:  
The Secretary for Health and Population



In reply please quote No. MHL/1/266

MINISTRY OF HEALTH  
P.O. BOX 30377  
LILONGWE 3  
MALAWI

13 February 2009

Samantha Page  
MANASO

Dear Sir/Madam,

**RE: Protocol # 598: Cultural practices and vulnerability to HIV/AIDS in Malawi: What are the implications for HIV/AIDS policies and prevention programmes?**

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and approved your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC 598  
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 13/02/2009
- **EXPIRATION DATE** : This approval expires on 12/02/2010  
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS** Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS** Please contact the NHSRC on Telephone No. (01) 789314, 08588257 or by e-mail on doccentre@malawi.net
- **Other**:  
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

.....  
**FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE**

**PROMOTING THE ETHICAL CONDUCT OF RESEARCH**  
Executive Committee: *Dr. C. Mwanambwa (Chairman), Prof. Miteso Benge (Vice Chairperson)*  
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB  
(IRB Number 18H00003905 PWA00005976)

## APPENDIX 2

### List of Interviewees

Person	Job Title	Organisation	Place	Date
P1	Communication Officer	GOAL	Blantyre	28/11/2008
P2	Assistant HIV/AIDS Coordinator	GOAL	Blantyre	28/11/2008
P3	Director	TransWorld Radio	Lilongwe	28/11/2008
P4	Team Leader Health and HIV/AIDS	Department for International Development	Lilongwe	17/12/2008
P5	Member of Parliament		Lilongwe	17/12/2008
P6	Programme Officer	GOAL	Balaka	18/12/2008
P7	District Health Officer	Ministry of Health	Balaka	30/12/2008
P8	Midwife	Ministry of Health	Balaka	30/12/2008
P9	AIDS Coordinator	Ministry of Health	Balaka	30/12/2008
P10	Cabinet Minister and MP Chiradzulu	Ministry of Trade and Industry	Blantyre	28/12/2008
P11	Doctor	Kamuzu College of Nursing	Blantyre	29/10/2008
P12	District Coordinator	Management Science for Health	Balaka	06/01/2009
P13	District AIDS Coordinator	Balaka District Assembly	Balaka	07/01/2009
P14	Community Development Officer	Balaka District Assembly	Balaka	07/01/2009
P15	District Youth Officer	Balaka District Assembly	Balaka	07/01/2009
P16	HIV/AIDS Coordinator	Concern Universal	Balaka	07/01/2009
P17	Member of Parliament		Lilongwe	07/01/2009
P18	Lawyer	The Law Commission	Lilongwe	11/01/2009
P19	BCI Manager	National AIDS Commission	Lilongwe	12/01/2009
P20	Grants Officer	National AIDS Commission	Lilongwe	12/01/2009
P21	M and E Officer, Central Region	National AIDS Commission	Lilongwe	13/1/2009
P22	Project Officer	Al Barakh	Balaka	28/01/2009
P23	Lawyer	The Law Commission	Lilongwe	02/02/2009
P24	Head of HIV/AIDS Unit	Ministry of Health	Lilongwe	03/02/2009
P25	Programme Officer	UNAIDS	Lilongwe	04/02/2009
P26	Lawyer	Malawi Human Rights Commission	Lilongwe	05/02/2009
P27	Country Director	Trocaire	Lilongwe	10/03/2009
P28	National Director	World Vision	Lilongwe	11/03/2009
P29	BCI Coordinator	BRIDGE Project	Lilongwe	11/09/2009
P30	Country Director	Department for International	Lilongwe	11/09/2009

		Development		
P31	HIV/AIDS Cluster Leader	US Agency for International Development	Lilongwe	12/09/2009
P32	Health Team Leader	US Agency for International Development	Lilongwe	12/09/2009
P33	Director	Save the Children	Lilongwe	13/3/2009
P34	Partnership and Liason Officer	National AIDS Commission	Lilongwe	13/3/2009
P35	Procurement Specialist	National AIDS Commission	Lilongwe	13/3/2009
P36	Policy Adviser	ActionAid	Lilongwe	15/3/2009
P37	Director	German Technical Cooperation (GTZ)	Lilongwe	18/3/2009
P38	Director	Voluntary Services Overseas	Lilongwe	17/3/2009
P39	Project Officer	Red Cross Society	Balaka	19/3/2009
P40	Assistant District Project Officer	Red Cross Society	Balaka	19/3/2009
P41	Head of Nutrition and HIV/AIDS	The Office of the President and Cabinet	Lilongwe	28/4/2009
P42	Coordinator HIV/AIDS, Health and Nutrition	World Vision	Balaka	07/07/2009
P43	Lawyer	Malawi Human Rights Commission	Lilongwe	07/07/2009
P44	Assistant Head, Programmes	United Nations Development Programme	Lilongwe	14/10/2008
P45	Health Education Unit	Ministry of Health	Lilongwe	14/10/2008
P46	Research Officer	National AIDS Commission	Lilongwe	14/10/2008
P47	Professor	Chancellor College	Zomba	14/10/2008
P48	Lecturer	Centre for Social Research	Zomba	22/10/2008
P49	Lecturer	Chancellor College	Zomba	24/10/2008
P50	Professor	College of Medicine	Blantyre	29/10/2008
P51	Anthropologist	College of Medicine	Blantyre	13/11/2008
P52	Programme Manager	Malawi Interfaith AIDS Association	Lilongwe	05/06/2009
P53	District AIDS Funding Coordinator	Zomba District Assembly	Zomba	21/11/2008
P54	Regional Coordinator	The European Union	Balaka	23/12/2008
P55	Social Worker	Evangelical Association of Malawi	Balaka	04/07/2009
P56	Project Coordinator	Norwegian Church Aid	Lilongwe	07/10/2009
P57	Member of Parliament		Lilongwe	04/06/2009
P58	Country Coordinator	The Joint United Nations Programme on HIV/AIDS	Lilongwe	05/06/2009

P59	Programme Officer	The Joint United Nations Programme on HIV/AIDS	Lilongwe	05/06/2009
P60	Coordinator	Southern African Network of AIDS Services Organisations	Blantyre	06/07/2009



## In-depth Interview Questions

**Introduction:** My name is Samantha Page. I am a PhD researcher interviewing people who are working in organisations that provide HIV/AIDS programmes in Malawi.

[Consent]

[Start Recorder]

- A. First, I'd like to ask you some questions about your own **personal background**...
  1. What is your home area? Did you grow up there? Is your family still there?
  2. Where did you go to secondary school?
  3. Where did you go after secondary school? What did you study? How did you choose this topic?
  4. What did you do after graduation? What kind of jobs were you most interested in? Can you tell me about the jobs you had since graduation up to the job you have here now?
  5. How did you hear about this job and what attracted you to it?
- B. Now, I'd like to ask you more about your **current job**...
  1. What is your role in this organisation? To whom do you report and who reports to you?
  2. From where does your organisation get funding to do its work?
  3. Can you tell me what a typical day is like for you? Maybe describe for me the work you did yesterday from when you came into the office until when you knocked off.
  4. What do you like the most about your work here?
  5. What is the most challenging thing about your job?
  6. What is your ultimate ambition? Your ideal job?
  7. What do you think is the most important issue affecting your work (i.e. low numbers of people tested for HIV, cultural practices of the people in the area, stigmatization, etc.)?
  8. Do you attend district [zonal, national] meetings about HIV/AIDS? What was the last one you attended? Who else was there?
  9. Outside of your own organisation, do you submit reports either to NAC or some other organisation about the work you are doing? Do they provide you any feedback?
- C. Finally, I would like to ask some questions on the role of **cultural practices** and the spread of HIV  
(Understanding/awareness of culture and HIV/AIDS)
  1. What is your understanding/definition of culture? What about cultural practices?
  2. How did you learn about cultural practices and their effects on HIV? How aware do you think people are (in Balaka) about HIV/AIDS?
  3. Do you think there are any misconceptions of how HIV/AIDS teaching is received in Balaka? (cultural practices, education level etc...)
  4. Do you think cultural practices contribute to the spread of HIV?
  5. Do you think cultural practices should be modified? Why?
  6. What do you think is fuelling the HIV pandemic?

(Programmes)

  7. Are there any particular cultural practices in this area [for national: in the areas where you work] that affect the programming you are doing? What are they? Among which groups are these traditions practiced?

8. Are you working with any organisations that are trying to modify cultural practices? If yes how many?
9. What programmes are you working on related to IEC and HIV/AIDS?
10. Who develops IEC materials? Do the CBOs or work groups develop any materials? Can I get copies?

(Policy)

11. Have you done any of your own research or needs assessments about these cultural practices? [If yes, ask for copies.]
12. How is policy developed? Who is involved in formulating policy?
13. How are policies arrived at, agreed upon and how are they communicated?
14. How is policy used to inform programmes?
15. How do issues get on to the policy agenda?
16. Who makes the decisions to implement such and such programmes?
17. How do you monitor and evaluate policy?
18. What is your evidence of success?

[Stop Recorder]

I want to thank you for the interview. I just have a few quick questions on a short survey that we like to ask everyone at the end. I hope it will take just 5 more minutes of your time. As stated in the consent form, everything – including the survey – is kept confidential.

## APPENDIX 3 UNAIDS Consultancy Documents

### UNAIDS – List of Participants

Category	Number	Name of Participating Organisation
Government	5	Ministry of Education Ministry of Health Ministry of Local Government National AIDS Commission Office of the President's Cabinet
Local Assemblies	6	Lilongwe District Assembly Mchinji District Assembly Mulanje District Assembly Mzimba District Assembly Mzuzu District Assembly Thyolo District Assembly
Private Sector	2	Alliance One ESCOM
Civil Society	8	Clinton Foundation Concern Universal GOAL Malawi MANASO MANET+ MBCA MIAA Toveraine
Research Institutions	1	College of Medicine
Development Partners	5	EU GTZ UNAIDS USG WHO
<b>Total</b>	<b>28</b>	

## UNAIDS Implementing Partners Survey

This survey is designed to collect information from implementing partners about the degree of participation, alignment and harmonization in the national HIV/AIDS response. It is **not** an assessment of the overall quality of the scope of the national HIV/AIDS response. Areas of assessment fall within the following categories:

- National HIV/AIDS Response and the National Action Framework
- Monitoring and evaluation
- Finances
- Administration, support, coordination and communication

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

Gender: M F

Organisation: \_\_\_\_\_ Job Title: \_\_\_\_\_

Location: \_\_\_\_\_

<b>A1: National HIV/AIDS Response and National Action Framework</b>	
<b>Extent of participation and alignment among implementing partners within the context of the National HIV/AIDS Response</b>	
<b>A1.1</b>	<b>Did your organisation participate in the development of the Extended NAF?</b>
<b>Please Circle</b>	
<b>Yes</b>	Please provide details on your level of participation
<b>No</b>	Please elaborate on how your organisation can contribute to future NAF planning
Comments:	
<b>A1.2</b>	<b>In your opinion, did key stakeholders participate in the development of the extended NAF?</b>
<b>Yes</b>	Please provide details
<b>No</b>	Please provide details
Comments:	
<b>A1.3</b>	<b>Does your organisation have a policy, programme or strategy on HIV/AIDS?</b>
<b>Yes</b>	<b>Please describe it.</b> Describe how it is aligned with the NAF
<b>No</b>	What plans do you have to incorporate HIV/AIDS into your work in the future?
Comments:	
<b>A1.4</b>	<b>Is your organisation's work plan aligned to the Integrated Annual Work Plans (IAWP) of the national HIV/AIDS response?</b>
<b>Yes</b>	Please provide details on how this is done
<b>No</b>	Does your organisation have plans to ensure alignment of its work plan to the IAWP?
Comments:	

<b>A2: National HIV/AIDS Response and National Action Framework</b>
---

<b>Extent of participation of implementing partners in the National HIV/AIDS response</b>	
<b>A2.1</b>	<b>Does your organisation participate in the national response at the national or district level?</b>
<b>Yes</b>	Provide details on your level of participation
<b>No</b>	How would your organisation contribute directly or indirectly to the national response?
Comments:	
<b>A2.2</b>	<b>Does your organisation participate in thematic groups and/or working groups related to the national response (e.g. technical working groups)</b>
<b>Yes</b>	Please provide details on your level of participation
<b>No</b>	What can be done to improve your participation?
Comments:	

<b>A3 Monitoring and Evaluation</b>	
<b>Extent to which implementing partners are using the national HIV/AIDS monitoring and evaluation plan</b>	
<b>A3.1</b>	<b>Does your organisation have a monitoring and evaluation plan?</b>
<b>Yes</b>	Do you use M and E indicators from the national HIV/AIDS M & E Plan?
<b>No</b>	How does your organisation measure the progress of your programmatic activities?
Comments:	
<b>A3.2</b>	<b>Are you using your M &amp; E plan for your own purposes?</b>
<b>Yes</b>	Please suggest ways you could share the information.
<b>No</b>	With whom do you share the information? How?
Comments:	
<b>A3.3</b>	<b>Does your organisation participate in monitoring and evaluation technical working groups?</b>
<b>Yes</b>	Please provide details about your participation
<b>No</b>	Please suggest ways in which your participation could be improved
Comments:	
<b>A3.3</b>	<b>Does your organisation use evidence to inform policy and programmatic decisions on HIV/AIDS?</b>
<b>Yes</b>	Please provide examples
<b>No</b>	Do you have plans to improve on this in the future? Please give examples
Comments:	

<b>A4: Monitoring and Evaluation</b>	
<b>Extent of participation by implementing partners in the annual review process</b>	
<b>A4.1</b>	<b>Did your organisation participate in the last annual review?</b>
<b>Yes</b>	Please describe how you participated in this process?
<b>No</b>	Please suggest ways that your organisation could participate in the future?
Comments:	

<b>A5: Finances</b>
---------------------

<b>Extent to which implementing partners receive funding for HIV/AIDS activities</b>	
<b>A5.1</b>	<b>Where does your organisation receive funding for HIV/AIDS activities?</b>
	Please provide estimated amount of resources received in the past year from each source of funding
Comments:	
<b>A5.2</b>	<b>Are the resources adequate?</b>
<b>Yes</b>	Provide details
<b>No</b>	How do you intend to improve funding levels?
Comments:	

<b>A6 Finances</b>	
<b>Extent of integration by implementing partners in decision-making and reporting about allocation of financial resources</b>	
<b>A6.1</b>	<b>Does your organisation report regularly on HIV/AIDS expenditure?</b>
<b>Yes</b>	To whom do you report? Please describe how it is done.
<b>No</b>	Describe how reporting could be improved
Comments:	

<b>A7: Administration, support, coordination and communications</b>	
<b>Extent to which implementing partners are harmonizing their procurement mechanisms in the national response</b>	
<b>A7.1</b>	<b>Is your organisation using the national procurement policies/procedures and interagency procurement coordination mechanisms (where they exist?)</b>
<b>Yes</b>	Please provide details on your organisation's level of support and involvement for harmonised procurement (whether of materials or services) procedures for the national response
<b>No</b>	Please provide details on how your organisation could increase its involvement in harmonized AIDS procurement. Do you face any challenges?
Comments:	

<b>A8: Administration, Support, Coordination and Communications</b>	
<b>Extent of transparent, timely and accurate communications among implementing partners and policy holders i.e. NAC/OPC, MOH, MoE, MWCD and others</b>	
<b>A8.1A</b>	<b>Of the following policy holders which ones do you work with the most?</b>
Please circle OPC/NAC MOH MoE MWCD Others (Please specify)	
<b>Yes</b> <b>No</b>	Is there an accurate and timely information flow between the policy holder and your organisation?
<b>Yes</b>	Please provide details on how the information flow works. For example are you informed about administrative requirements for grant applications, workplans, reports, financial data etc? Are you provided with feedback regarding submission of reports and workplans?
<b>No</b>	Please elaborate on how accuracy and timeliness of information sharing could be improved.
Comments:	

<b>A8.1B</b>	<b>Is there an accurate and timely information flow between your organisation and other implementing partners?</b>
<b>Yes</b>	Please provide details on how the information flow works. Please describe whether you receive enough information and if it arrives in time to assist your work. How does your organisation normally share information with others?
<b>No</b>	Please elaborate on how accuracy and timeliness of information sharing could be improved.
Comments:	
<b>A8.2A</b>	<b>Is there transparency regarding sharing of budgetary and programming information between the policy holder and your organisation?</b>
<b>Yes</b>	Please provide details about the level of transparency in information sharing. Please describe whether you receive enough up-to-date and detailed information to assist in decision-making and planning.
<b>No</b>	Please elaborate on how transparency can be improved. What more can be done to keep everyone in the national HIV/AIDS response well informed?
Comments:	
<b>A8.2B</b>	<b>Is there transparency regarding sharing of budgetary and programming information between your organisation and other implementing partners?</b>
<b>Yes</b>	Please provide details about the level of transparency in information sharing. Please describe whether you receive enough up-to-date and detailed information to assist in decision-making and planning.
<b>No</b>	Please elaborate on how transparency can be improved. What more can be done to keep everyone in the national HIV/AIDS response well informed?
Comments:	
<b>A8.3A</b>	<b>Does your organisation provide reports to your policy holder?</b>
<b>Yes</b>	What type of reports? How regularly?
<b>No</b>	Please comment
Comments:	
<b>A8.3B</b>	<b>Does your organisation provide the same reports to the policy holder and your donor?</b>
<b>Yes</b>	What type of reports? Do you receive feedback on the reports? Please suggest ways to avoid duplication.
<b>No</b>	Please comment
Comments:	
<b>A9.1</b>	<b>How many HIV/AIDS-related missions were undertaken in Malawi by your donor in the last 12 months (either from your headquarters or instigated from the country office)</b>
	Number _____
Comments:	
<b>Please add any further comments</b>	

THANK YOU FOR COMPLETING THE QUESTIONNAIRE

## Donor and Development Partners Survey

This survey is designed to collect information from donor and development partners about the degree of participation, alignment and harmonization in the national HIV/AIDS response. It is **not** an assessment of the overall quality of the scope of the national HIV/AIDS response. Areas of assessment fall within the following categories:

- National HIV/AIDS Response and the National Action Framework
- Monitoring and evaluation
- Finances
- Administration, support, coordination and communication

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_

Gender: M F

Organisation: \_\_\_\_\_ Job Title: \_\_\_\_\_

Location: \_\_\_\_\_

<b>B1 National HIV and AIDS Response and National Action Framework</b>	
<b>Extent of openness and transparency among donors and development partners and the National HIV and AIDS Response</b>	
<b>B1.1</b>	<b>Did your organisation participate in the development of the Extended NAF?</b>
<b>Please Circle</b>	
<b>Yes</b>	Please provide details on your level of participation. Were you satisfied with your level of participation?
<b>No</b>	Please elaborate on how your organisation can contribute to future NAF planning
Comments:	
<b>B1.2</b>	<b>In your opinion did key stakeholders participate in the development of the extended NAF?</b>
<b>Yes</b>	Please provide details. Were you satisfied with other organisations' level of participation?
<b>No</b>	Please elaborate on who you think should participate in the future
Comments:	
<b>In your opinion did key stakeholders participate in the development of the extended NAF?</b>	
Please provide details. Were you satisfied with other organisations' level of participation?	
Please elaborate on who you think should participate in the future	
<b>B1.3</b>	<b>Does your organisation have a policy, programme or strategy on HIV/AIDS?</b>
<b>Yes</b>	<b>Please describe it.</b> Describe how it is aligned with the NAF
<b>No</b>	What plans do you have to incorporate HIV/AIDS into your work in the future?
Comments:	
<b>B1.4</b>	<b>Has your organisation made changes in its programmes, policies or strategies in order to effectively support the NAF?</b>
<b>Yes</b>	Please provide details on the types of changes you have made. How have you adapted your funding allocations, targets and areas of work to ensure strongest support for the NAF?
<b>No</b>	Please provide information on how your organisation could make changes to better align with the NAF?



<b>B1.5</b>	<b>Does your organisation have its HIV and AIDS documents reviewed by the policy holder (i.e. NAC/OPC, MOH, MOWCD, MoE) that you work with in the national response?</b>
<b>Yes</b>	Please provide details on how this was done and the type of feedback that was received. What changes (if any) did you make as a result of the feedback?
<b>No</b>	Does your organisation have plans to ensure that the policy holder reviews your HIV and AIDS documents? If no, why not?
Comments.	
<b>B1.6</b>	<b>Overall, do you feel that the HIV and AIDS plans of donor and development partners are aligned with the NAF and District HIV and AIDS plans?</b>
<b>Yes</b>	Please give examples of strengths and weaknesses
<b>No</b>	Please indicate areas where you think better alignment is most critical
Comments.	

<b>B2: National HIV and AIDS Response and National Action Framework</b>	
<b>Extent to which donors and development partners are supporting the National HIV and AIDS Response</b>	
<b>B2.1</b>	<b>Does your organisation participate in the national response at the national or district level?</b>
<b>Yes</b>	Please provide details on your level of participation
<b>No</b>	How could your organisation contribute directly or indirectly to the national response?
Comments:	
<b>B2.2</b>	<b>Does your organisation participate in specific technical coordination mechanisms, thematic groups and/or working groups related to the national response (e.g. technical working groups)</b>
<b>Yes</b>	Please provide details on your level of participation
<b>No</b>	How do you intend to contribute to the national response?
Comments:	

<b>B3: Monitoring and Evaluation</b>	
<b>Extent to which donor and development partners are using the national HIV and AIDS monitoring and evaluation plan</b>	
<b>B3.1</b>	<b>Does your organisation have a monitoring and evaluation plan?</b>
<b>Yes</b>	Do you use M and E indicators from the national HIV and AIDS M & E Plan?
<b>No</b>	How does your organisation measure the progress of your programmatic activities?
Comments:	
<b>B3.2</b>	<b>Are you using your M &amp; E plan for your own purposes?</b>
<b>Yes</b>	Please suggest ways you could share the information.
<b>No</b>	With whom do you share the information? How?
Comments:	
<b>B3.3</b>	<b>Does your organisation use evidence to inform policy and programmatic decisions on HIV and AIDS?</b>
<b>Yes</b>	Please provide examples

<b>No</b>	Please give reasons
Comments:	
<b>B3.4</b>	<b>Is your organisation supporting the development of national HIV and AIDS monitoring and evaluation coordination mechanisms and technical capacities?</b>
<b>Yes</b>	Please describe how.
<b>No</b>	Please suggest ways that your organisation could be part of the HIV and AIDS monitoring and evaluation system
Comments:	

<b>B4: Monitoring and Evaluation</b>	
<b>Extent of participation by donor and development partners in the annual review</b>	
<b>B4.1</b>	<b>Does your organisation support and/or participate in the annual review?</b>
<b>Yes</b>	Please describe how you support and/or participate in this process? How could it be improved or enhanced?
<b>No</b>	Please suggest ways how your organisation could be part of the annual review process
Comments:	

<b>B5: Finances</b>	
<b>Extent to which donors and development partners have indicative multi-year commitments (i.e. more than three years) for the national response</b>	
<b>B5.1</b>	<b>Does your organisation have an indicative multi-year (3+ years) commitment to the National Action Framework for HIV and AIDS?</b>
<b>Yes</b>	Exactly how long is your commitment and what is the approximate size and scope of this commitment (to which programming areas etc.)?
<b>No</b>	Would it be possible to increase the length of your resource commitment? If no why not?
Comments:	

<b>B6: Finances</b>	
<b>Extent to which partners support pooled funding arrangements for the national response</b>	
<b>B6.1A</b>	<b>Is your organisation involved in pooled funding arrangements for the national response?</b>
<b>Yes</b>	Please provide details on how you are currently participating in pooled funding arrangements
<b>No</b>	How much money have you given to HIV/AIDS programmes per annum for the past three years? To which organisations? Would you like to participate in pooled funding arrangements?
Comments:	
<b>B6.1B</b>	<b>Please indicate the total annual sum provided by your organisation to the national response, and the amount of this that goes into pooled funding</b>
Comments:	
<b>B6.2</b>	<b>Does your organisation provide funding to intermediary organisations?</b>
<b>Yes</b>	Which organisations? Does your organisation provide details to NAC on all your financial disbursements for AIDS support? Please describe the mechanism for reporting on these resources

	to NAC to facilitate oversight of national AIDS resources.
<b>No</b>	Please provide suggestions for how to better capture financial information for the national AIDS response.
Comments:	

<b>B7: Administration, support, coordination and communications</b>	
<b>Extent to which donor and development partners are harmonizing their procurement mechanisms in the national response</b>	
<b>B7.1</b>	<b>Is your organisation using national procurement policies/procedures and interagency procurement coordination mechanisms (where they exist?)</b>
<b>Yes</b>	Please provide details on your organisation's level of support and involvement for harmonized procurement (whether of materials or services) procedures for the national response
<b>No</b>	Please provide details on how your organisation could increase its involvement to harmonise AIDS procurement. Are there any challenges?
Comments:	

<b>B8: Administration, support, coordination and communications</b>	
<b>Extent to which donor and development partners are strengthening technical capacity on HIV and AIDS and harmonizing their HIV and AIDS strategies in the national response</b>	
<b>B8.1</b>	<b>Is your organisation strengthening technical and organisational capacity on HIV and AIDS including that of government and civil society in the national response?</b>
<b>Yes</b>	Please describe what your organisation is doing and at what levels.
<b>No</b>	How could your organisation strengthen its technical approach to HIV and AIDS?
Comments:	

<b>B9: Administration, Support, Coordination and Communications</b>	
<b>Extent to which donor and development partners are harmonizing technical/financial reports and human resource approaches with each other and in relation to the national response</b>	
<b>B9.1</b>	<b>Is your organisation harmonizing technical and financial reporting?</b>
<b>Yes</b>	Please provide details on how your organisation is harmonizing its reports with the National Response and other donor and development partners.
<b>No</b>	Why not?
Comments:	
<b>B9.2</b>	<b>Does your organisation strengthen the human resource base for the national response?</b>
<b>Yes</b>	Please provide details regarding how you are doing this.
<b>No</b>	Please elaborate on how your organisation can ensure that human resources are not attracted away from national partners to donor and development partners
Comments:	
<b>B9.3</b>	<b>How many HIV/AIDS-related missions were undertaken in Malawi by your agency in the last 12 months (either from your headquarters or instigated from the country office)</b>
	Number _____

Comments:

<b>B10: Administration, Support, Coordination and Communications</b>	
<b>Extent of transparent, timely and accurate communications among donor and development partners and policy holders (NAC/OPC, MOH, MOWCD, MoE)</b>	
<b>B10.1A</b>	<b>Which policy holder do you work with the most on HIV and AIDS?</b>
Please circle NAC/OPC MOH MOWCD MoE Others (Please specify)	
<b>Yes</b>	Is there an accurate and timely information flow between the policy holder and your organisation?
<b>No</b>	Please provide details on how the information flow works.
<b>Yes</b>	Please elaborate on how accuracy and timeliness of information sharing could be improved.
Comments:	
<b>B10.1B</b>	<b>Is there an accurate and timely information flow between your organisation and other partners?</b>
<b>Yes</b>	Please provide details on how the information flow works. How does your organisation normally share information with others?
<b>No</b>	Please elaborate on how accuracy and timeliness of information sharing could be improved.
Comments:	
<b>B10.2A</b>	<b>Is there transparency regarding sharing of budgetary and programming information between your policy holder and your organisation?</b>
<b>Yes</b>	Please provide details about the level of transparency in information sharing. Please describe whether you receive enough up-to-date and detailed information to assist in decision-making and planning.
<b>No</b>	Please elaborate on how transparency can be improved. What more can be done to keep everyone in the national HIV and AIDS response well informed?
Comments:	
<b>B10.2B</b>	<b>Is there transparency regarding sharing of budgetary and programming information between your organisation and other partners?</b>
<b>Yes</b>	Please provide details about the level of transparency in information sharing. Please describe whether you receive enough up-to-date and detailed information to assist in decision-making and planning.
<b>No</b>	Please elaborate on how transparency can be improved. What more can be done to keep everyone in the national AIDS response well informed?
Comments	
<b>Please add any further comments</b>	

Thank you for completing this questionnaire

## APPENDIX 4 Participatory Ethnographic Evaluation and Research (PEER) Questions

### QUESTIONS FOR PEER RESEARCHERS - LUNZU

**Number of Interviewee**  
**Village**

**Age**  
**Date**

#### Interview 1: Health and Illness

Start by explaining that you want to talk about the experiences of people like them or the people they spend time with, relating to health and illness.

Conversational prompts

Ask them to tell you about:

- The people who have good health and the people who suffer from poor health and why
- The illnesses that the people they spend time with have had and are most concerned/worried about (or talk about the most)
- The things that people do so that they won't get those illnesses
- To whom people turn to first for help if they have an illness
- What the person might do if the person to whom they go to first cannot help them

Ask them to tell you a story about someone they spend time with who has or has an illness like the ones they have talked about. Ask them to describe:

- The illness and what the person and other people have said about it
- Who the person went to first for help or treatment for the illness
- What happened when they went to that person for help or treatment

**Number of Interviewee**  
**Village**

**Age**  
**Date**

#### Interview 2: Sexual Health

Where do people get information/advice on Sexually Transmitted Infections (STIs) and HIV/AIDS?

What do people say about STIs and HIV/AIDS?

What type of person says this?

What do they say about people who have HIV/AIDS?

Do people feel they at risk of getting HIV? Why?

What kind of behaviour facilitates transmission of HIV? Why?

Where do people go if they want to get treated for STIs and HIV/AIDS?

What do the people say about VCT?

Where do some people go for VCT?

What do people say about those who go for VCT?

What kind of people go for VCT?

Is VCT important and why?

What distance do they have to travel?

Why do women go for VCT?

Who initiates those women to go for VCT?

What type of people have a say if a woman goes for VCT?

Why don't some women go for VCT?

Is it different for women?

Is yes, why?

Where can women go for VCT?

Do people talk about the service?

What do they say?

What can be done to increase the number of women who go for a test?

How easy or difficult do women find it to discuss these issues about STIs and HIV/AIDS

-With other women in their family or community?

-With men in their family or community?

How can women become more involved in protecting sexual and reproductive health in their communities?

Tell a story about someone who went for a test

**Number of Interviewee**

**Age**

**Village**

**Date**

### **Interview 3: Sexual Knowledge, Sexual Behaviour and Sexual Health**

Explain that in this conversation you want to talk about how the people they spend time with learn and talk about sex and sexual relationships

Conversational Prompts

Ask them to tell you what people say about:

Sexual Knowledge and Behaviour

- How they first learn about sex (Probe Anankungwi/parents)
- How they first start having sexual relationships
- To whom they talk about sex and sexual relationships
- What they say is good/bad about having sexual relationships
- What they say is good/bad about not having sexual relationships
- Are your friends guided on how to behave in a sexual relationship? In what way?

Sexual Relationships

- The people with whom they have sexual relationships and what they say is important about these people
- The things they consider when deciding whether to have/not to have a sexual relationship with someone
- How they make decisions when they are having the sexual relationship (for example how do they make decisions whether or not to use a condom)
- Who makes the decision about having the sexual relationship and why?
- To whom they talk if they are worried about their bodies or about a sexual relationship

Ask them to tell you a story about someone they know who is having/has had a sexual relationship. Ask them to describe what they say is good and/or bad or worrying about the relationship they are having. What have they done if/when they have had a problem with the relationship?

**Number of Interviewee**

**Age**

**Village**

**Date**

### **Interview 4. Cultural practices**

What type of cultural practices exist in your community? (Probe: kuchotsa fumbi/ kuchotsa milaza/fisi/kupita kufa)

Can you explain what happens during these practices?

How long has the practice taken place in your community?

What is the purpose of the practice? (take each practice one by one)  
 What do people in the community feel about the practices?  
 Are there good things about the practices? What are they? Why?  
 Are there bad things about the practices? What are they? Why?  
 Do your friends see these practices as promoting risky sexual behaviour? How? Why?  
 Do your friends think these practices spread STIs/HIV/AIDS? Why do you think that?  
 What messages do people you know get from these practices about sexual relationships? (Probe for example how a man should treat a woman, how a woman should treat a man)  
 What do people say if a person does not want to/refuses to participate in a certain practice?  
 What do people say will happen to them if they do not participate?  
 How do these practices impact on people's health?  
 How do people you know feel about religion?  
 What is religion telling your friends about sexual relationships?  
 Which is the more important? Religion or tradition? Which do your friends follow more? Why?  
 How do your friends cope with different messages from different sources? (Probe: messages from friends, parents, media, school as well as tradition and religion).  
 Do your friends believe in witchcraft? If they do, how do they think it affects them? Why?  
 What is the connection between witchcraft and cultural practices?

Ask them to tell a story about someone who has been involved in a cultural practice and how they felt about it.

**Number of Interviewee**  
**Village**

**Age**  
**Date**

#### **Interview 5. Gender Dynamics**

Who makes the decisions in the household?  
 Who makes the decisions when it comes to sex?  
 How are women perceived in your community? What is their role?  
 How are men perceived in your community? What is their role?  
 Are women seen as submissive or do they make decisions?  
 Who is the head of the household?  
 Do your friends have multiple sexual partners? (probe which sex are they?)  
 Who has responsibility for marriage, funeral, initiation ceremony?

## APPENDIX 5 Informed Consent Form

### INFORMED CONSENT

My name is \_\_\_\_\_ and I am affiliated with the College of Medicine. I am conducting research for my PhD on cultural practices and HIV/AIDS. I am interested to learn more about the work your organisation is conducting on cultural practices and HIV/AIDS; what programmes exist; what is the organisation's policy on cultural practices and how was the policy made?

The interview will last approximately one hour. I will ask you a series of questions and I will use a tape recorder.

Do you agree to participate in the study?

I agree..... No I don't agree.....

Signature \_\_\_\_\_ Date: \_\_\_\_\_



# Catholics hold prayers on Aids

by Dickson Kashoti

Catholics in the country yesterday held special prayers in all their churches asking for divine intervention and total abstinence to check the spread of the disease as opposed to the use of condoms.

The clergy read out special messages on the disease apart from distributing leaflets and posters, just a day after commemorating the World Aids Day.

"As we are celebrating the Centenary of our Church in Malawi, we should not forget the responsibility of reminding each other on the HIV/Aids epidemic which is bringing such havoc on the health, peace, justice and development of our

beloved nation.

"It is the Church's duty to talk about HIV/Aids during this season of Advent, as we await the coming of our Lord Jesus Christ, the Prince of Life and Peace on Christmas Day," says a passage from a leaflet distributed at St. Pius parish in Blantyre.

Parish priest Reverend Father Focus Chikweya said in an interview after the mass yesterday his church's stand on preventive measures still remain that the disease can be prevented if people avoided sex.

"Condoms are not a solution. You cannot be 100 percent sure that you are safe after using a condom," he said.

During the church service, he

read out a special message to the congregation on HIV/Aids, saying it was sad most of the victims of the disease are the youth whom, he said, Jesus loved most.

"Out of every four patients of HIV/Aids, one of them is a youth. The youth, especially boys, don't care, they can sleep with as many girls as they can," he said.

He said statistics from the World Health Organisation say that six out of 10 persons are HIV positive of whom the majority will develop full blown Aids leading to death within the next 10 years.

He said of these infected persons, it is estimated that 25 percent are youths between the age of 15 and 25 years.

Nyasa Times, p2, December 2003

# Church maintains stand on condoms

by Aubrey Mchulu



Gunya: Not moved

**B**lantyre CCAP Synod General Secretary Rev. Daniel Gunya said on Wednesday the church will maintain its stand that HIV/Aids can only be controlled through abstinence and faithfulness in marriage.

Gunya's remarks were in sharp contrast to Health Minister Yusuf Mwawa's opening address in which he asked the faith community to be proactive in the fight against HIV/Aids by promoting condom use besides faithfulness and abstinence.

"Both the government and faith community preach abstinence and faithfulness among

partners but we are saying that those who cannot abstain should use condoms. The faith community must promote this," he said.

Gunya, speaking in an interview after the opening of an international consultation workshop on HIV/Aids for the Church of Scotland and southern Africa Presbyterian Partner Churches, said the church allows its flock to use condoms within marriage for family planning purposes or where one partner is infected with HIV/Aids.

"It is a general feeling that condoms do promote promiscuity, that is why we [the church] do not encourage use of condoms outside marriage,"

he said.

Mwawa said 70 out of 100 beds in the country's hospitals are occupied by patients with HIV/Aids related-illnesses while one out of every six people in the productive 15 to 49 age group are infected with the disease.

He also said 400,000 children to date have been orphaned due to HIV/Aids according to statistics from the National Aids Control Programme.

Gunya said the impact of the HIV/Aids pandemic has not spared his synod which, he said, loses at least 33 people weekly.

Gunya said the consultation, which has grouped technical experts from the Church of Scotland, Malawi's three synods—Livingstonia, Nkhoma and Blantyre, South Africa, Mozambique, Zambia and Zimbabwe, will explore the impact of the HIV/Aids pandemic in southern Africa and assess responses developed in terms of medical work, education and community involvement.

He said the meeting will also identify deficiencies which church leaders, the flock and communities have identified in the responses.

The consultation workshop, to last five days, is being held under the theme 'Confessing faith in Christ in the context of the HIV/Aids pandemic'.

# Pastors, sheikhs hone skills

RELIGIOUS leaders in Nkhotakota have been called upon to bring about behavioral change in the lives of their faithful in order to contain the spread of HIV/Aids pandemic.

William Banda, the diocesan chief clinical officer of the Lake Malawi Anglican Diocese, made the appeal when he closed a week-long HIV/Aids workshop for

church leaders and sheikhs at Lozi Primary School in Nkhotakota.

Banda said the pandemic could be contained if religious leaders preach abstinence.

He said the scourge is crippling the country's development by claiming lives of economically productive citizens.

Banda told the leaders to

encourage their faithful to avoid immoral behaviour, which contributes to the spread of the pandemic.

"Religious leaders should help government to combat the spread of the disease," he said.

Speaking earlier, World Medical Fund executive director Francis Nkhoma, called on all religious leaders in the country to cooperate

in the fight against HIV/Aids.

Nkhoma said HIV/Aids needs a common initiative among all stakeholders regardless of religious leanings.

The workshop was funded by World Medical Fund, a British non-governmental organisation which supports orphans, people living with HIV/Aids, the aged and the needy. —*Mana*

Nyasa Times, p6, 2001

# Condom use sparks debate

## **CHITIPA:**

A SERVICE of worship held on Sunday at St. Kizito Roman Catholic Church at Ch.tipa Boma ended up with a disagreement among worshippers over usage of condoms as a means of avoiding HIV/Aids and other sexually transmitted diseases (STD)s.

Kemeso Mbale, who attended the service of worship, told Mana that the disagreement surfaced when the church's vice-secretary T.K.T. Nyirenda stood up to comment on the misconception many parents have on the use of condoms.

Nyirenda, who is also a senior nurse responsible for family planning programmes at Chitipa District Hospital, said it was sad to note that parents are in the forefront condemning to death their children by denying them use of condoms.

"As parents what we should know is that our children are at risk of catching the Aids virus due to their sexual promiscuity. Experience has shown that it is difficult for them to abstain from casual sex. Which is better, allowing our children to use condoms and survive or warning them against its usage so that they die?" Nyirenda queried.

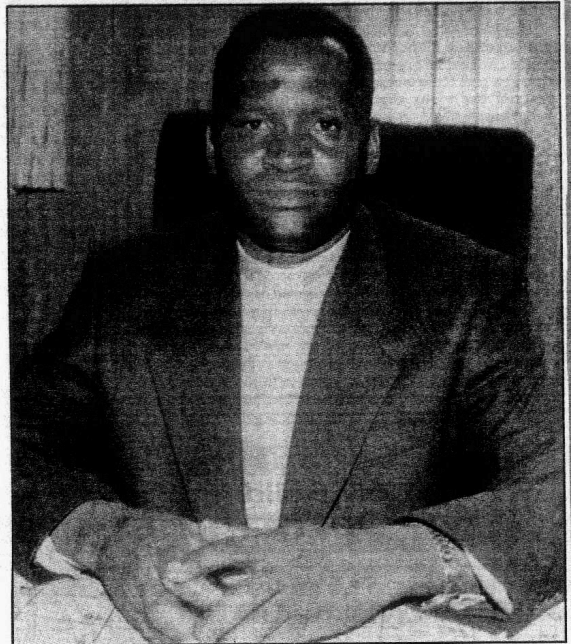
She challenged that the hospital will continue providing condoms to the boys and girls who have reached their sexual maturity in order to save the young generation.

However, her concern did not go well with the majority of the congregation: "Brethren don't be confused with what our colleague has said. She was speaking as a hospital worker but as far as the church is concerned we do not accept use of condoms," Mbale charged.

He told the congregation condoms encouraged adultery and reminded the worshippers that the real condom is Jesus Christ, he concluded amid hand clapping and ululation. -*Mana*

Nyasa Times, p3, 2000

# BT Synod's alternative to condom under fire



Rev. Gunya: We want a culture of abstinence

While government urges those who cannot abstain from casual sex to use condoms to prevent the spread of Aids, religious leaders have opposed the call, arguing that sex outside marriage is immoral and sinful.

**by Innocent Chitosi**

CCAP Blantyre Synod sparked the anger of human rights activists when it announced it would offer free education to girl-students at its Neno Girls' Secondary School on condition they shun sex and test negative for HIV virus.

Three weeks after announcing the controversial HIV/Aids

bursary, the synod said this week it had received "overwhelming" support from its faithful, registering more than 90 applicants.

Synod general secretary Rev. Daniel Gunya told the press in Blantyre on Wednesday that the response

**Catholic Church warns its members —p2**

Nyasa Times, pp1-2, 2000.