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AIDS-talk in everyday life: the presence of HIV/AIDS in men's informal conversation in Southern Malawi

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Abstract

Malawi is one of the world's most AIDS-afflicted countries. In order to cope with the AIDS pandemic, we must know what the people most at risk think about it, how they evaluate their situation and that of their community, and what actions they would consider adopting to lower their risk. However, the main research methods in studying attitudes—surveys and questionnaires—have only a limited ability to capture what people think about AIDS. In order to get a more naturalistic perspective on attitudes towards AIDS from 1999 to 2001 six Malawian research assistants who lived in rural villages were asked to keep journals in which they wrote down information about all the conversations they participated in or witnessed in which the topic of AIDS surfaced in any way. The conversations ranged from graveside condolences following a funeral to stories told during men—only beer—drinking sessions, to women chatting on the bus. In this paper, I analyse these journals in order to see how men talk about AIDS in naturalistic settings, what they perceive as the impact of the AIDS epidemic, and how they understand AIDS risk.

Keywords: Malawi; AIDS; Behaviour change; Social networks; Risk

Introduction

As the HIV pandemic continues to ravage Southern Africa, the spectre of AIDS looms over everyday life. People talk about AIDS, they speculate about their own fate and the fates of their friends and relatives, and they use everyday conversation to consider what they might be able to do to avoid AIDS, if AIDS can be avoided at all. This paper uses everyday conversation in rural Malawi as a window on men's ideas and behaviours concerning AIDS. What men say offers a unique though necessarily partial glimpse of what they think and what they do, and, by extension, what the future of the epidemic may hold for their communities. Here, I address two questions: do Malawian men[1] think that they can avoid AIDS? And if so, what are they doing (or not doing) to reduce their risk of HIV infection? My evidence comes from a collection of observational journals, supplemented by data from surveys, focus groups and interviews all undertaken under the aegis of the Malawi Diffusion and Ideational Change project (MDIC), a longitudinal study of three communities carried out by the Population Studies Center of the University of Pennsylvania and the Demographic Research Unit of the University of Malawi.

The evidence suggests that Malawian men are divided on the question of whether behaviour change can really protect them from AIDS. For those men who do change their behaviour in response to AIDS, the most common form of behaviour change under consideration is being more selective about one's non-marital partners, by using biographical characteristics to estimate whether a particular partner is likely to be HIV-positive, rather than by practising strict monogamy or by using condoms. These conclusions help us to understand why the AIDS epidemic in Malawi shows no signs of slowing, and can help shape interventions which may someday reduce the toll of AIDS.

A particularly intriguing finding, and one which deserves further investigation, is that many men claim

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[1] See Schatz (2003) for a companion paper focusing on the women of the communities discussed here.

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that they are already infected with HIV so that, presumably, it is futile for them to adopt the advice given to reduce one's number of partners or use a condom. Whether or not these men actually do have HIV, or even whether they actually believe what they are saying, is beyond this scope of this paper to establish. However, the use of this argument to rationalize risky behaviours is significant for the design and administration of future HIV-prevention campaigns (see also Kaler, 2003; Thomsen, Stalker, Torotitch-Ruto, Maggwa, & Mwarogo, 2003).

I arrived at these conclusions using methods which are unusual in this field. Public health research in general, and research on AIDS in particular, relies heavily on survey and questionnaire methods. While these methods have the virtues of producing quantifiable and comparable data, many of the ideas and concepts that underlie behaviour cannot be captured within the pre-set categories which define the range of knowledge in survey instruments. Thus, when MDIC sought to gauge whether Malawians were likely to change their individual behaviour in response to the threat of AIDS, we used observational journals in addition to more standard mass surveys. These journals took the form of fieldnotes, kept by trained research assistants, who recorded every conversation, casual chat or passing reference which they heard concerning AIDS in the course of their daily lives. While both men and women talked extensively about AIDS-related matters in their casual conversation, only men talked about their own sexual behaviours and their implications for HIV. Women's mentions of AIDS took the form of worrying about their own or their relatives' vulnerability, deploring the impact of AIDS on community and family, and discussing the prospects of acquaintances and family members who were thought to have AIDS. Sexual agency was not a "women's topic", at least not in the social networks of the female journal-keepers, let alone sexual agency in the context of HIV. Thus, for this paper, our analysis is confined to men.[2]

The existing literature on behaviour change in Southern Africa stresses the complexities of the determinants of behaviour change, on familial, economic and social levels (e.g. Caldwell, 2000; UNAIDS, 1999). On the individual level, behaviour change has been linked to contextual elements, particularly to the size and content of personal networks and to personal experience with AIDS among relatives, acquaintances and neighbours (e.g. Gregson, Zhuwau, Anderson, & Chandiwana, 1998; Kipp, Masheisha, von Sonnenburg, & Weiss, 1994; MacIntyre, Brown, & Sosler, 2001; Kirunga & Ntozi, 1997). However, these studies have relied on survey instruments, which are not ideal for learning how men (and women) themselves view the choice to change their behaviour, and how they decide what type of change is feasible for them. This present study is an attempt to fill in some of the gaps in the existing literature.

In addition, this study focuses explicitly on men—a departure from most work on gender and AIDS which focuses on women's situations (Varga, 1997, p. 51). Given that men are depicted in the public health literature as the dominant or authoritative partner in high-risk heterosexual sex, examining their perceptions of HIV and the options open to them is timely and important.

This study was conducted in rural Southern Malawi, in the area triangulated by the towns of Liwonde and Balaka and the trading center Ulongwe. This is a fairly typical Malawian rural area—extended families live in loosely connected groups of homesteads, formed into villages, relying mainly on subsistence farming and some selling of tobacco and cotton. The area borders one of the main roads in the country, which feeds into the nearby cities of Zomba and Blantyre, the capital city, 2 h away by public transit. Many of the younger adults travel to and from the city looking for work or excitement. To the northeast is Lake Malawi, a major centre for small-scale fishing and fish-trading, with a reputation as the local red-light district.

This research was carried out as part of the much larger Malawi Diffusion and Ideational Change project, a joint venture of the Population Studies Centre of the University of Pennsylvania and the Demographic Research Unit of the University of Malawi.[3] The main work of MDICP has been carrying out large-scale surveys on changing attitudes to family planning and HIV-related behaviour in three sites corresponding to Malawi's three provinces. This particular project is one of the qualitative "offshoots" of the main, quantitative, MDICP.

The national AIDS prevalence in Malawi is estimated at 16%, but the prevalence in southern province, where this study was done, is thought to be around 19%. AIDS is now the leading cause of death for people aged 15–49 (Doctor, 2002). Compared to other African countries with high prevalence rates such as Uganda or Zambia, the Malawian government's response to the pandemic has been low-key. In everyday life, most people encounter "official" AIDS education or prevention efforts in the form of spots on the radio, posters in local health clinics, Chishango ("shield") condoms for sale or distribution from tuckshops and some bars, and in some primary schools, the creation of "Edzi Toto"

[2] See Mtika (2001) for ideas as to why men might talk more about their sexual adventures than women. Other sources of data from MDICP suggest more sexual agency on the part of women than do the Journals.

[3] See www.pop.upenn.edu/networks for a detailed description of the MDIC data.

(''Stop AIDS'') clubs, meant to disseminate AIDS information to youth. The content of these radio spots, posters and clubs is similar to that in AIDS-prevention programmes all over Southern Africa, stressing the devastation AIDS wreaks on families and communities and the dangers of risky behaviour, especially sex with people known to be ''promiscuous''. In the area covered by the MDIC, people are ambivalent about these AIDS-prevention efforts, with some seeing them as indecent because of the explicit information about sex and condoms which they contain, and others seeing them as yet another set of government directives telling people what they must do (Mtika, 2001, pp. 12-13).

In addition to this official ''AIDS awareness'', many people attend funerals of relatives or acquaintance on a monthly if not weekly basis, and if the deceased was part of the ''AIDS group''—young, reasonably well-off, sexually active—speculation about the cause of death runs high. AIDS is the stuff of rumours and gossip: who is sure to have AIDS, who is likely to have it, who has divorced their husband or wife because of suspected AIDS, who is putting their spouse at risk of AIDS through their behaviour, and so on. While some people, mainly the elderly, claim that AIDS is being over-diagnosed and that all sorts of innocuous illnesses are now being attributed to AIDS, for most people, AIDS is omnipresent.

Methods

In order to collect comments about HIV/AIDS, five skilled research assistants were asked to keep fieldnotes in which they would record ''everything that you hear people say about AIDS''. The data included conversations in which the research assistants participated as well as conversations they overheard, in both public settings such as a bus station or a bar, and private settings such as a home. We asked the research assistants to record as accurately and in as much detail as possible. Depending on the journalists, the degree of detail varied from verbatim scripts of overheard conversation, complete with elaborate descriptions of the setting, to summary paragraphs. Journalists did not tell their conversation partners that they were taking mental notes for journal entries, and were asked not to instigate any conversations about AIDS by themselves. The journals therefore consist of ''natural discourse'', drawn from spontaneous settings (Farmer 1994).

This method of collecting information raises some ethical questions, particularly because the subjects of our research—the men and women whose discussions of AIDS was entered into the fieldnotes—were not aware that they were being studied. Our researchers were essentially using a covert participatory strategy. We discussed this issue within MDICP and decided that it did not violate the ethical principles of protecting one's subjects from harm. All identifying characteristics have been changed (including in this paper), and our journalists were asked not to provoke or coerce people who did not want to talk about such a sensitive subject (although they were free to participate actively in the conversation and ask questions to encourage people to elaborate). We are reasonably confident, therefore, that this method of data collection has had no repercussions at all for the people involved.

Journalists used standard school exercise books for their journals, and when each exercise book was full, it was sent either to a friend of one of the researchers who lived in Blantyre or directly to the MDIC project in Philadelphia. In Philadelphia the journals were transcribed into Word files, and these were coded and analysed with Ethnograph software. As of March 2003, more than 150 journals had been completed. Journals are still being kept by the journalists and sent to Philadelphia.

This methodology has its advantages and its drawbacks. Chief among the advantages is that the journals present ideas, concepts and beliefs in the very process of circulation, away from the artificial structures of the interview situation. Data from the journals is therefore free from ''interview effects'', including the very common tendency for interview respondents to give a ''correct'' answer rather than a true one, especially when dealing with sensitive topics (see Watkins et al. (2003) for a discussion of interview biases). In addition, because there are no pre-set categories for responses, the journal method opens up new areas of knowledge and new lines of inquiry, as opposed to confirming or disconfirming the theories of researchers.

Finally, through the journals we hear the voices of those who are not often represented in surveys and standard interviews—the extremely old, the extremely young, the disaffected and the transient. Our five journalists are different people, with different social (and geographic) locations and personal networks; thus when certain themes came up over and over in the journals, I could be fairly confident that these themes represent fairly widely held ideas.

The journal method also has its disadvantages. Unlike survey data, journal data is difficulty to quantify and thus difficult to use in temporal or spatial comparisons. In addition, I am not so naïve as to assume that the journalists wrote down absolutely everything they heard which was in any way related to AIDS, without filtering or subtly (and perhaps unconsciously) altering the content of their observations. The extent and effects of this filtering are unknown. Judging by the content of the journals, however, the journalists did not shy away from including material which showed them and their personal networks in a less than flattering light—for example, one journalist wrote about his wife accusing him of extramarital affairs, while another wrote about her cousin's callous treatment of a brother who was sick with AIDS.

Table 1
Journalists 1999–2001

Name	Sex	Age	Marital status	Occupation	Economic status	Other
"Alice (Note 3)"[a]	F	Early 30s	Divorced, one child	Farmer	Low-middle	Mainstay of extended family, sole support of 10
"Prisca"	F	Mid-20s	Married during course of project	Housewife	High	From local landowning family, married soldier and moved to army base in town
"Ben"	M	Early 20s	Married, 2 children	Peasant farmer/fish trader	Low-middle	Although married, socializes mainly with young single men
"Osman"	M	Mid-30s	Married	Village health assistant	High-middle	Runs educational programs in villages promoting preventive health
"Praise"	M	Mid-20s	Single	Peasant farmer/day labourer in town	Low-middle	Divides time between town and village, travels to Zimbabwe for work

[a] All names in this paper are pseudonyms.

Also, while our sample of conversations about AIDS is very diverse, I do not know whether it is truly representative of the population. Whether or not our sample is representative, however, it is definitely heterogeneous, and that heterogeneity itself makes it valuable for generating knowledge about what people think of AIDS.

Finally I have no guarantee that what the journalists wrote down actually occurred, in other words, that they did not just make up their journals. The five journalists have been working for the Malawi Diffusion and Ideational Change project since 1998 as surveyors, and were chosen because they had proven to be the most reliable, enthusiastic and insightful of the MDIC surveyors. I was therefore willing to take their work on trust. In addition, on a purely subjective level, the journals have a quality of verisimilitude which is difficult, if not impossible, to fake. Although certain themes came up again and again, clichéd situations and characters did not. Given the diversity and range of the journals, it would probably have been more work to invent all the situations and conversations than to simply record them (Table 1).

The completed journals are rich cultural documents, full of "thick" description, which bring to light a wide variety of social practices and current ideas in rural Malawi. I read the journals for how they helped us to answer two questions: Are Malawians responding to the risk of AIDS by changing their behaviour? If so, how, and if not, why not? To provide a heuristic frame for this analysis, I turned to the Health Beliefs Model.

The health beliefs model and HIV risk in rural Malawi

The Health Beliefs Model, developed in 1952 by Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock, is the basis for most interventions concerning preventive health behaviour and for much theory concerning why people behave as they do with respect to their health. The Health Beliefs Model has been criticised for its reductionism and excessive reliance on rational choice to explain action, but it is nonetheless useful here as a way of organizing information. For this paper, I use a parsimonious version of the health belief model consisting of three cognitive preconditions which must be met before an individual will change his or her behaviour for the sake of his or her health. These are necessary but not sufficient preconditions for behaviour change, as many elements intervene between knowledge and action, so that knowing about behaviour change is not the same as putting knowledge into practice. However, without the cognitive prerequisites of the Health Behaviour Model, no autonomous, sustainable behaviour change will occur.

These three preconditions are:

1. *The person in question must believe that the health threat is dangerous*. This condition is clearly met in Malawi. Everyone knows that AIDS is qualitatively different from any previous ailments, and this knowledge is reinforced by constant exposure to the funerals of relatives, friends and neighbours.[4] Indeed,

[4] In the 2000 Malawi Demographic and Health Survey, 100% of men aged 15–49 had heard of AIDS, and 62% were reported to have "no incorrect beliefs" about AIDS, based on a composite of common untruths about AIDS. 85% knew that AIDS cannot be transmitted casually, through sharing food, and 72% and 77% volunteered that using a condom and abstaining from sex (respectively) could protect one from AIDS. This knowledge has been gained relatively recently, as in the 1992 DHS only 26% of men volunteered condoms as a way to prevent AIDS and only 32% volunteered abstaining from sex (www.measuredhs.com/hivdata, September 25, 2002).

annual rates of adult mortality in the area covered by MDIC between 1998 and 2001 were triple those recorded between 1978 and 1988 (Weinreb & Doctor, 2002). AIDS is rumoured to be the cause of excess deaths related to tuberculosis, diarrhea or wasting (probably in excess of its actual impact on morbidity). The journals are punctuated with accounts of visits to hospitals overwhelmed by AIDS patients and with assertions that death comes more frequently and rapidly now than ever in the past. As one old man at a funeral attended by Ben commented, "In my old days, I could experience perhaps one to two deaths the whole year round, and not like today, whereby I experience more deaths within a week".

2. *The person in question must believe that he or she is at risk for the health threat.* Again, clearly met in Malawi. In the MDICP main survey conducted in the same area in 2001, 37% of men and 49% of women said that they were worried "a lot" about contracting HIV (Watkins, personal communication). Women were most likely to worry about catching HIV through their husband, while men were most likely to worry about catching HIV from nonmarital sexual partners.[5] In another study covering the same area, 90% of respondents, male and female, said that they "worried a lot" about contracting the disease (Tawfik, 2000, p. 22). The journal evidence cited below also demonstrates that Malawian men have an acute sense of their personal vulnerability to AIDS.[6]
3. *The person in question must believe that it is possible and feasible to reduce one's risk through one's own actions.* This is where the applicability of the Health Beliefs Model to the Malawian situation breaks down, and where the analysis of this paper is situated. The journals reveal that Malawians are divided over the question of whether or not taking action as individuals would reduce their risk of getting AIDS. In the remainder of this paper, I explore this division as it is played out in bus stations, family homes, bars, schools, workplaces, and churches.

The journals hold two main perspectives on individual efficacy and AIDS risk. The first, which I call the agency perspective, hold that it is possible to lower one's AIDS risk. The second, the inevitability perspective, holds that individual actions are pointless and that one's chances of getting AIDS are determined by forces out of one's own control. Neither perspective is clearly dominant—although the "agency perspective" accords with the messages of most AIDS-education materials, and is indeed hegemonic in the northern hemisphere, in Southern Malawi there does not yet appear to be a standard folk model of AIDS (see Farmer, 1994, 1999; Mogenson, 1997, 1995).

Individuals may switch their allegiance from one perspective to the other, depending on situation, and the link between perspective and actual behaviour can be theorized but not proven. Nonetheless, the existence of these conflicting orientations towards personal efficacy has important implications for understanding the dynamics of Malawian communities coping with AIDS, as well as for the design and implementation of HIV-prevention interventions.

To introduce the two different perspectives, below is a snippet of conversation recorded by Alice outside a local secondary school. Here, a schoolteacher and two pupils debate whether or not the students should bother working hard at school, or paying school fees, given the threat of AIDS on their horizons. One of the students claims that AIDS is inevitable and that therefore preparing for one's future is pointless, while his teacher insists that the boys can avoid AIDS if they try, and that investing in education is still worthwhile, even in the face of the HIV epidemic. The other student moves back and forth between asserting that AIDS is inevitable, and speculating that perhaps it is not:

> 1st student: Sir, though you are telling us to work extra hard, how do you see the world nowadays? AIDS is leading a first position in the whole world [the biggest problem in the world], including this small Malawi. Nobody will remain alive in the coming five years. Why are we troubling ourselves working hard in class and wasting our parents' money as if we shall one day work somewhere [get paid employment]? We shall all die very soon, I tell you.
>
> Teacher: No, the best way is to protect yourself from that killer disease and concentrate in class.
>
> 2nd student: It is worse nowadays than earlier. There is no way you can protect yourself from it. I can protect myself by not even having sex with

[5] See also Smith (2001) for an analysis of women's sense of vulnerability to HIV in the MDIC survey area. She found that 63% of women said that they were "a lot worried" about getting AIDS.

[6] This level of perceived risk may seem high, but it is consistent with other research in the region. In neighbouring Zambia, for instance, one study team found that 68% of their sample considered themselves "in personal danger from AIDS" (Sikwebele, Shonga, & Baylies, 2000, p. 68). Among men, the highest risk was perceived among those who were single; among women, highest risk was perceived among those who were married. In another Zambian location, 72% of men and 56% of women men considered themselves "in personal danger from HIV" (Baylies, 2000, p. 135); and in a third field site, 70% of respondents "felt themselves to be in danger from AIDS" (Baylies, Chabala and Mkandawire, 2000, p. 96). See also Ntozi et al., in which a survey of three sites in Uganda found that between 56% and 73% of respondents perceived themselves in danger of AIDS (Ntozi, Ahimbisibwe, Ayiga, Odwee, & Mulindwa, 2000, p. 68).

anyone, but can I tell my father to protect himself from having sex with other women apart from my mother? …. I am very unhappy about today's world. Our parents were better, they did not face this bad life as we are doing in our generation.

Teacher: Don't worry about that. You never know anything [what will happen]. Maybe your parents will not die of AIDS … What you should do is to protect yourself from having girl friends and work hard in class. That will be your good future.

1st student: If one was born to die while at school, then it will happen even if there is no AIDS. You can die of any disease if the time comes for you to die. But you should not stop making your bright future because you never know. Maybe you will just waste your time thinking that everyone will die of AIDS in the next five years, but you will just regret [that you wasted your time thinking everyone would die] when many people are still alive. Just put your heart [into] school and don't think about many things, even though the world is very bad. We all know that nobody knows when they will die but we should still work hard since we never know about our future.

Inevitability

The inevitability perspective on AIDS manifests itself in several different variants in the journals. The first variant is what may be called pure fatalism, the belief that death from AIDS is foreordained, whether by God or by Allah or by witchcraft or by vengeful spirits. AIDS may be perceived as a collective scourge, sent to chastise a wicked population, or as an individualised fate marked down for specific people and not for others.[7] This sentiment was particularly strong among older people, but one young teenage woman told Osman:

> You should know that if God writes that such person will die of such a disease, then there is no way you can run from it. God will fulfill what he wrote. If he wrote that you'll die of AIDS, then definitely you're going to [die from AIDS]. Even if you become faithful to your husband/wife, the disease will come in another way round.

In Osman's own work as a local health educator, he believed that among his clients

> Although they're having several sexual partners 98% of them don't use any means of protection. They say that there is no need of using protection because STDs were sent by God to us human beings not animals, AIDS inclusive [i.e. that God intended AIDS as a plague to punish people for their sins, as distinct from ordinary diseases which afflict animals, who cannot sin]. They say that if God wrote that this person will die of AIDS, then even if you use protection method, long at last you die through any circumstances.

God or Allah was not the only powerful impersonal force blamed for creating AIDS. Ben recounted an encounter in which the notion that one was doomed to AIDS was linked to a common conspiracy theme (Kaler, 2001, 2003):

> Some men I met in the bus were discussing about AIDS, one of them said that all the people are going to perish of AIDS including himself, he is not married and he said he is one of the people to perish because he has slept with many girls in his life. One said AIDS started in the 1980s. He further said that AIDS was created by scientists, but did not mention the reason why they created it. The others did not comment on this. The man had drunk some beer and was talking about this loudly so that the people were not commenting but just listening to what he was saying. He did not specify the scientists' country of origin where he had heard that AIDS was created.

In addition to these extrinsically focused explanations for the inevitability of AIDS, according to which external forces were operating on Malawians in such a way as to render behaviour change useless, some men said that they believed they were going to die of AIDS because of flaws in their own history or their own character. Since they already knew they were going to get AIDS, they said, what was the point of adopting any preventive measures, such as having fewer partners or using condoms?

One variant of the inevitability perspective held that one is doomed to die of AIDS because it was simply impossible and "unnatural" to abstain from un-condomed sex. Since no one is capable of avoiding sex, what reason was there for trying to follow safe-sex guidelines which appeared wildly unrealistic? The phrase "love is blood" encapsulates this claim: the desire for sex is as innate as blood, and as crucial to life. Some men claimed to embrace the knowledge that they were going to die of AIDS because of their hot blood, and to seize whatever sexual enjoyment they could find before the day of their death arrived. Ben's friend told him:

> That's why I always tell you man that there is no way to end AIDS. … it can't be avoided for a normal person to be living without having sex and sex most of the times involves 'plain' [having sex without a

[7] Interestingly, there was very little talk of AIDS as a curse sent by one person (or witch or wizard) to another; and what little witchcraft-talk there was occurred among older people, rather than members of the age group most at risk (see Farmer, 1994, p. 804–805 for AIDS as sent sickness in Haiti).

condom]. Therefore as I see it nowadays it's better to be having sex with girls 'plain' for …if it's the matter of AIDS I have to know that we both have that. … Even these young girls [who] are singing songs like "AIDS, AIDS is the killer, why do people die?" so on and so on and dancing yet some of them are the AIDS carriers so there is no one better [i.e. who does not have HIV]. It's better we must be living and waiting for our date to die.

Praise's friends concurred:

It is just a waste of time to go for a blood test [to confirm the presence of HIV], as long as you are a human being there is no way you can resist sexual desires and it means that you are also on the line-up to get infected and nobody is going to remain in this world because no one can say that he/she will never have sex until death, never.

Ben was part of a group conversation, in which two of his friends used the claim that they were bound to die from AIDS as a *carpe diem* justification for further sexual exploits:

Daniel: If it is a problem of AIDS, then [we must] just accept it … for it has come for us. There is no escape, because AIDS has built its habitat in a sweet environment [i.e. sex].

Martin: You can't avoid it; even we young men [who] are not married and even married men. [Sex] is nature which can't be changed … And if [a woman known for having many partners] passes again here, I will try to persuade her to be my girlfriend.

Sex was associated with "nature", a strong, primordial, often irrational force which could not be resisted.[8] By contrast, guidelines about safe sex and condoms appear "unnatural", coming from a realm outside the normal course of life.

A third variant on the inevitability perspective came from men who claimed that they had already been infected with HIV, and so any behaviour change would be futile. It is important to realize that this claim was primarily a rhetorical act, and does not necessarily reflect an inner conviction that one is HIV-positive. Virtually all the men who made this claim had no way of knowing whether they were actually infected or not, as HIV tests are not available in rural areas, and very few men would make the trip to the city hospitals to get a blood test. However, by making the claim to be HIV-positive, men could draw attention to their own sexual history and the number of women they had slept with, often in the form of boasting or friendly competition with other men. I discuss this phenomenon in much greater detail in a separate paper (Kaler, 2003); what is important to note here is that the claim to already be HIV-positive is a way of rationalizing a lack of individual agency in the face of HIV risk.

I have never even tried to use [condoms]. I have slept with many girls and if it is the cause of AIDS then I have already got it because the girls with which I had been having sex, gathering them all could fill a Yanu-Yanu bus [a large inter-city rural bus]. Were they all safe? Then why be using condoms when I prefer not using?

Friend: I don't fear AIDS because I know that I have it already.

Praise: How do you know that you have got AIDS?

Friend: I have malaria and some coughs so I know that I have it.

Praise: Do you use condoms when [sleeping with] these bargirls?

Friend: What for, since I know that I am already infected?

Praise: How did you get the disease then?

Friend: I got it from the same bargirls.

Praise: Why don't you just stop [sleeping with] them?

Friend: I can't stop, since I am already infected, and I just go for them without any fears about [getting] AIDS.

One of Ben's friends argued that young men might as well enjoy as much sex as they could get, since there was no benefit to be gained from abstaining:

And don't be cheated, Ben, everyone nowadays has AIDS. One gets AIDS even before you were born. You will find that those who don't go for girls most of the time are the one who are dying in great numbers. And the ones who go for girls are the ones staying long [not dying quickly]. … And you know we men, we can't stay for long without sex. If you are a real man you must exercise [your sexual prowess].

Many of the men in Southern Malawi leave the area in search of work throughout the Southern African region, so that the social landscape is one of "mobile male population and relatively immobile female population" (Mtika, 2001, p. 5). This mobility not only brings them into contact with many possible sexual partners, but also makes them particularly successful in finding partners when they return to their homes:

Tom said that he has no doubts he has HIV. He said himself that after coming [back] from Johannesburg

[8] See Mtika (2001, p. 16) for more evidence of this conception of sex as an irresistible drive. See also Setel (1999) for a discussion of the parallel concept of *tamaa* in Kilimanjaro.

> he had a TV and after selling [it] he had almost 17 000 kwacha [roughly $US 200], and the girls were after him, those beautiful ones.
>
> Andrew jokingly said that any woman who flirts with him is only digging her own grave, because as he has traveled widely, he is sure of having HIV, since he has been sleeping with different women in all the places he has traveled. To me, the issue carried weight when he told me that he has been to Zimbabwe, Mozambique and Zambia when he was a truck-driver, because I know that in a country like Zambia and Zimbabwe, it's risky, since most women depend on sex for business.

One of Praise's acquaintances made a direct link between the belief that one has AIDS already and the refusal to use condoms. He pointed out a sex worker at a bar to Praise, saying that she had a lucrative business going among the fish traders of Mangochi because she was known to never insist that her clients use condoms. Ben expressed surprise that men would choose this particular sex worker, knowing that she had in all likelihood been exposed to HIV. His acquaintance responded that

> So many men do pay money ranging from 100 kwacha [about US$2.25] and above to have sex with [her], for they say AIDS can't be avoided … people here say everyone has AIDS, only that we will be dying at intervals [i.e. different people will die at different times].

Agency

All of these variations on the inevitability of AIDS—that dying from AIDS is foreordained by God, that any thoughts one might have of avoiding AIDS will be overwhelmed by "nature", or that one has already got HIV—militate against behaviour change. However, it would be very wrong to assume that Malawians are simply persisting in destructive behaviour patterns, caught up in fatalism in the face of AIDS (see also Setel, 1999, p. 178). To go back to the conversation between teacher and pupils near the beginning of this paper, there appear to be many men who believe that behaviour change really will help them avoid AIDS. These are the people who have already changed, or are on the brink of changing, their own sexual behaviour, motivated by the belief that such a change is worth the extra effort and foregone sexual enjoyment which it entails. In this group of men, all of the elements of the Health Beliefs Model are present.

Although older people tended towards a fatalistic interpretation of AIDS, both the younger male journalists, Praise and Ben, reported that their maternal uncles had told them specifically to change their behaviour in order to avoid HIV. In both cases, the advice took the form of telling their nephews to avoid "moving with girls", rather than to use condoms.

> My uncle came into my [Praise's] room at home and told me that I should be careful with the girls because boys who are fond of moving around with girls are dying rapidly. He told me that after the death of a certain boy in the Kalembo area who was said to have died of AIDS. I told him that I was glad to hear his advice.
>
> I [Ben] was escorting this uncle to the bus depot he started warning me, "Be careful with ladies nowadays. You are married and though you are young [you are] the father of two. You have a great responsibility to look after the whole family here. … You are the one responsible. Most of the ladies know that you have money and may flock to you … the end result is that you may die fast with AIDS. … So be careful, I just wanted to tell you this, I don't mean I assume that you go for other sexual partners besides your spouse. I know you are married. Respect your spouse.

Advice on avoiding AIDS is consistent with the "agency perspective" but descriptions of one's own behaviour change provides more convincing evidence of an agency perspective on AIDS. In the journals, men talk about three forms of behaviour change: being more selective about their sexual partners; reducing the number of partners they have; and using condoms. Of these three strategies, partner selection appeared to be the most common, followed by partner reduction. Condom use was the least popular, and indeed most references to condoms were disparaging.[9]

Having partners outside marriage is common, though not necessarily normative. 8% of men surveyed by MDICP in 2001 reported having an extramarital partner in the year before the survey (although 25% of married women said that their husbands had had such a partner). Of more salience to this paper, 70% of men said that the form of HIV transmission they worried about most was catching it from an extramarital partner. Clearly, men have identified extramarital sex as risky business, and are looking for ways to minimise the risk.

Men claimed to be using both biographical and characterological criteria for choosing partners. As a result of local educational campaigns, they knew that a healthy-looking person can be carrying the virus, and physical appearance was rarely mentioned as one of the

[9] For quantitative evidence which supports this conclusion for Tanzania, next door to Malawi, see Ng'weshemi et al. (1996) and Munguti et al. (1996).

criteria for choosing partners. Women were described as being desirable partners on the basis of their social position (schoolgirls, town girls, village girls, bar girls) or on the basis of their personality (gregarious or introverted) and what could be learned of their biography. The men produced a discourse about "risk groups", and located AIDS risk within the categories to which a particular woman could be assigned (Seidel, 1993). In particular, "town" women and women who wore trousers and other "non-traditional" clothes were identified as an AIDS risk (cf. Setel, 1999). However, there are signs that some men are moving away from group membership and relying more on observations of a particular woman in order to find a sexual partner.

In their travels, especially going to Mangochi to trade fish, men sought out women who belonged to "low-risk" groups, not easy in a setting where the only places for itinerant men to meet women were bars and resthouses. One of Ben's acquaintances explained how he stayed AIDS-free in Mangochi by enlisting local friends to help him find girls from low-risk categories:

> When I asked him about the dangers of AIDS, he said the disease was there in Mangochi, but not so common if you refrain from sex with those who stay at beer centres, and go with schoolgirls and village girls. And everywhere he goes he [finds] one of his friends, and the friend will tell him about [a girl he can sleep with], who is not from a bar, who is free from AIDS. And then I said "it's better to have friends to avoid AIDS, no?". And he said, "Indeed, because your friends tell you the way the girl behaves".

Women and girls who came from "good" families were preferred, as they were thought less likely to have AIDS. One of Praise's acquaintances reported that he chose an extramarital partner who was not only a schoolgirl but also the daughter of a well-respected and devout family, on the grounds that she was unlikely to have AIDS:

> Johannes told me that there are about seven relatives who died in his family and these all died of AIDS. He therefore began to fear that there is AIDS, and to keep himself safe from getting it, he said that he [told] his wife to be faithful in order to avoid getting infected. Meanwhile, Johannes has a sexual partner outside marriage, a schoolgirl at [a rural secondary school nearby] in Mangochi. I asked him "how can you be safe since you have got a partner outside marriage and you don't know how she behaves when she is away there at school?" … He said that he believes that she can keep herself safe because she is from a God-believing family of a priest at the Anglican Church.

A workmate described his strategy of switching, rather than cutting back on, his sexual partners because of the risk of AIDS. The man in question worked at a bakery in town, which employed 15 women and 40 men. Initially he, like many of the other men at the bakery, started a sexual relationship with one of his female co-workers, but later switched his allegiance to a woman he judged less likely to be infected:

> Last year he was among those men who go for the [factory] girls but he was disappointed when he realized that his sexual partner was also having another affair with the personnel manager. And he said that he left her because he was afraid that the girl could infect him with AIDS as the personal manager she was sleeping with had [other] sexual partners at that factory which was showing that he was at the high chance to contract HIV. He then said that he got a certain schoolgirl at [a local secondary school] after he left that [factory] girl. He got that schoolgirl through his friend who is schooling at the same school. He told [his friend] to find a girlfriend for him and his friend tried his best and got one for him.

As the quote above suggests, schoolgirls were considered desirable partners because they were likely to have had few previous partners. Men described switching their allegiance from bar girls and casual girlfriends to schoolgirls:

> Mr. T is a primary school teacher and also happens to be my friend. This teacher is in love with a schoolgirl who is at [a church-run school] where she is in form four. The teacher is a married man and has four children. This other day when I were playing *bawo* [a board game similar to backgammon], he started telling me that since AIDS came into being, he has lost two relatives with the disease and therefore since he saw for himself how AIDS victims suffer, he did not want to catch the disease. When he told me that, it [interested] me so that I wanted to learn more from him. I started by asking him that, since he has a partner and a wife, how will he prevent himself from catching the disease? Upon hearing my question, he laughed and went on to say "I knew that you will ask that question …When my partner comes back from school, the first [thing I discuss] is HIV and AIDS." He said that the girl assures him that she doesn't go out with any other man except him and that if she will be found positive, then he will be the only person responsible. And he further said, when the girl tells him that, he also assures her that being a family man, he doesn't go out with other girls except her and his wife therefore there are no chances for HIV to get into them.

Even the youth and geographical isolation of the schoolgirls was no longer considered proof that they were not infected. Praise described a conversation between two of his workmates in a factory in town, in which a man who was known to consort with women in bars and beerhalls was told that he was risking AIDS with these women. He retorted angrily that

> If he doesn't want to get AIDS he should be going for female babies in the maternity [ward] if he wants to avoid getting AIDS, because there is nowhere he can get a girl who did not have sexual contact before the time he [met] her.

A more reliable criterion than social status or age for selecting AIDS-free partners was personality or character. Men who were looking for a one-night stand might have to rely on membership in groups like "schoolgirls" or "village girls" to assess risk, but men who sought a more long-term partner, such as a girlfriend, mistress or wife, observed the personality and behaviour of a particular woman in order to assess the likelihood that she had HIV. Women who were known to have rejected the advances of other men, who were described as "controlled" or "proud", gained value in the sexual marketplace. One of Ben's friends, complaining that his wife was annoying him and that he would be better off with a girlfriend, explained that he had set his sights on a particular young woman because:

> She has no AIDS I believe because *ndi wosunga* [she has self-control]. And even most young men have failed proposing her [approaching her for sex]; and I don't know [why I am so] lucky that she accepts me, a married man.

Another one of Ben's neighbours, a middle-aged man who had recently divorced, was contemplating remarriage. For a second wife, he had his eye on another divorced woman whose home-brewing business was thriving since she had left her husband Saul. This neighbour claimed that schoolgirls were no longer reliable AIDS-free partners, because so many of them had been "spoiled" by wealthy older men offering them clothes and jewelry in exchange for sex. The safest choice, for him at least, was a financially independent older woman, who supported herself without any male patrons. Ben asked how his friend could be so confident that his intended wife was AIDS-free. Was it simply because she looked "fat" and healthy? No, his friend responded, "other things can be noticed".

> Before I visited her, I first of all stayed for almost 3 months trying to find more about her. … I know she didn't go for more boyfriends, [Saul] was her first husband in life. I believe she doesn't have HIV, for I can remember one day she rebuffed a certain guy who proposed [sex to] her when I was there.

A smaller number of men said they had cut out nonmarital sex altogether, sticking with their wives as a means of preventing AIDS. The men who chose this option tended to be older and more respectable than the younger men who sorted through categories of women in order to find the ones least likely to be HIV-positive. Men who adopted monogamy justified their decisions on the basis of their status as "family men": responsible husbands and, especially, fathers.

> A primary school teacher named Matthew told me that he would have been AIDS/HIV positive if he wouldn't have left his extramarital affairs, behaviour that he said he left in the year 1997 after being aware of the killer disease AIDS. He is married with three children. He is a friend of mine and I have surely learned that he doesn't go for other women other than his own wife.

> A man I met in Blantyre told me he doesn't like to drink beer together with bargirls because he is afraid he might get AIDS and transmit it to his housewife.

Prisca met up with a man who had once worked for her father, and he confessed that he was tormented by the memory of an encounter he had recently had with a prostitute in Mangochi. He insisted that he would never take such risks again, for the sake of his wife and children:

> "I was thinking about my wife who is very faithful, that I can take AIDS from that prostitute and give it to her. …And on top of that we have many children and some of them are little. So if I and my wife can die with AIDS, who will take care of our many children? Oh, that's why I became afraid of sleeping with a prostitute, and I confess that it was my first and last time, I will never do that again. And I don't want my wife to know that one time I did such a thing".

This man believed that he had "failed" because he was "unable to hold his heart [keep his head]" in the presence of attractively dressed women. He resolved not to "chat with ladies", and to avoid bars and other places of temptation. For him, the strength to resist "beautiful ladies" was provided by his responsibilities to his family. For a few other men, the strength to resist temptation was provided by religion and by commandments and instructive stories from the Bible. Ben was exhorted by a friend who had been born-again to study the Bible in order to build up "spiritual momentum" which would enable him to resist temptations:

> Yesterday I went to visit this friend … at the football match, we met there and we were chatting. After

> football we went to the market, I provided us with cassava, we sat there eating it. Before I finished I saw a man and a woman, they were [being affectionate with] each other. My friend said 'eh, nowadays, my friend, men should be careful most of the times, because there are more beautiful women nowadays than in the past, so if one isn't careful one can catch AIDS, a majority of people are dying of AIDS.' So I said 'My friend, how can we young men- we are much attracted to these girls, how can we come out of that?' He said 'The only thing I know is reading the Bible, if you can read Genesis 39, there was a certain man Joseph who ran away from Potipher his wife [Joseph actually fled the advances of the wife of Potiphar, who was his Egyptian employer]. This man trusted God a lot, because it is rare a man can leave a beautiful wife.' Then I said 'But I'm interested to know, you look like a pious man, you don't go for these ladies, why is that?' And he said 'Ever since I was born again in April 1999 … If you want to live in a good life you have to try to refrain from these girls. By reading the Bible, you will always do good and be encouraged by it, you will come across certain verses that say stealing is bad, drinking, molesting other people's properties [is wrong]. By reading frequently the Bible, one builds spiritual momentum. Whenever you want to do something bad, you recall what the Bible says, and you will live a long life''.

As of the summer of 2001, it appeared that ''born-again'' churches were proliferating in Southern Malawi, and that more and more people were reporting being ''born again'' or having regenerative Christian spiritual experiences; or making *tauba*, an Islamic practice interpreted locally as a ritual of repentance and rededication to a holy life. Whether this increase of religious fervor is related to the dangers of AIDS is not clear. However, for a person who wanted to abstain from nonmarital sex but feared he would not have the strength, joining such a church would be a smart strategy for providing oneself with spiritual ''armour'' against temptation.

After partner selection and partner reduction, the least popular form of agency in the face of AIDS risk was the use of condoms. Condoms were disparaged on many grounds: they were un-aesthetic and deprived both men and women of pleasure in sex; they were an insult to one's female partner because of their connotations of disease and adultery; they were ineffective against AIDS, or they were actually tainted with the AIDS virus or a cancer-causing agent, as part of the Malawian government, or some unnamed international cabal's efforts to wipe out the population.[10]

[10] See also Kaler (2003). For an extensive discussion of men's antipathy towards condoms in nearby Zambia, see Bond and Dover (1997).

Peer pressure and negative peer comments about condoms also figured in men's stories (see also MacPhail & Campbell, 2001). One group of men explicitly mocked the idea that condoms could save them from AIDS, as recounted by Praise at a *bawo* game he attended:

> Among us, there was a guy who is working as a motor mechanic there at [a suburb of Blantyre] … and his friend known as Musa saw some condoms inside the mechanic's shirt pocket and he pulled them out of the pocket and he said ''You are [going around] with these 'Chishangos', condoms, so that you can use them when you find a sexual partner'' and [the mechanic] agreed, he said that he couldn't be shy to have some condoms in his pockets because even on the radio, they advertise the use of condoms. One man who is named Mr. Welenisiki said ''You don't have to boast of having condoms in your pockets so that you make us to think that you use them. You are fooling yourself because you can't use them all the times you have sex with your sexual partners. One day you will forget about using them and you will catch the infection [AIDS] and you will be [embarrassed] when we will come to see you at the hospital when you will be admitted in the TB ward, and we will remind you of having the condoms. What will be the result, even though you are moving with condoms? [i.e. You will get AIDS anyway, despite carrying condoms with you].''

Men who had adopted other forms of behaviour change, such as being more selective about who they slept with, claimed that they did not need to use condoms.

> And I asked whether he has sexual partners and he said he has only one partner. And when I asked him whether he uses the condom with her he said he doesn't use the condoms because she is a schoolgirl and beautiful at that (and [we were] laughing) and he said, ''I eat her up with all her bones''.
>
> I don't use condoms. And I don't think of using that and my [plan] is that I don't go for bargirls but schoolgirls and village girls who don't have AIDS.

Men who did use condoms did so selectively, with the partners whom they felt were most risky, and categorized their partners into those women with whom condoms could be used and those with whom they should not be used. A friend of Ben's, who had recently discovered that his wife was cheating on him with another man, gave a detailed description of the different categories of partners, elaborated on by other men who were part of the conversation:

> I said, ''You only slept with her once, only the first day you came home, before hearing about her behavior when you were away in Blantyre? … Did you use a condom?''

Acton said, "I never used the condom since she was my wife."

Then I asked, "You don't use the condom with the wife?"

Acton said, "No! I don't and moreover I was away for several months …and I had a great desire to have sex with my wife, then could I have worn a condom? She could have suspected that I had HIV/AIDS or a particular disease like *chizonono* (syphilis) or *mabomu* (gonorrhea), [she could have claimed] that I had been playing with other sexual partners while I was in Blantyre. All in all, I could not use for she was my wife."

And his friend agree, "Indeed, even me, I have never used the condom with my wife because simply she is my wife". And I asked him, "But you use with other sexual partners?"

Acton's friend said, "But with some partners he used [condoms] and with others [he does] not".

And I said, "Why with some and not with others?"

He said, "Those [with] whom I use the condoms are the ones whom I suspect of having HIV/AIDS and I hear that they run with other partners and those [with whom] I don't use are the ones which I trust that they don't go for other partners besides me".

And I laughed, he laughed too. And I said, "And right now you have some?"

…

He said, "I have two partners [with whom] I go plain and one [with whom] I always uses the condom, and luckily I don't [have sex with] her often as these two partners".

Conclusions

These journals suggest that Malawian communities are divided over whether or not personal agency can make a difference in reducing one's risk of AIDS. In the terminology of the Health Beliefs Model, many Malawian men have not accepted the third premise of the model, that it is within their ability to resist AIDS.

First, this paper suggests that educational campaigns and other interventions may need to be rethought, if many Malawian men still harbour doubts as to whether they can do anything to change their risk. While Malawians share many ideas about AIDS, where it comes from and how one contracts it, there is evidently a lack of consensus about whether it is worthwhile to change behaviour in order to avoid it. Even if a man is determined to stop all his "risky" behaviour, the change still may not save him from AIDS if he has already contracted the virus, or if "nature" proves to be stronger than individual will, or if God or fate has dictated that he should die from AIDS. Educational programmes are evidently not converting everyone to the agency perspective. Malawian men know what one is supposed to do in order to avoid AIDS, but many men are not convinced that these behavioral changes will actually make a difference to their lives. (For a fuller discussion of the relationship between knowledge about AIDS and behaviour change, see Donovan and Ross, 2000; Gregson et al., 1998; UNAIDS, 1999.)

Second, the "inevitability perspective" is not simply a monolithic, unreflective fatalism. Different men believe that AIDS is in their future for different reasons, based on theology or knowledge of "human nature" or their own autobiographies. These different forms of inevitability are the result of different forms of reasoning, and might be addressed by different motivational strategies.

Third, this paper suggests that the men who believe they can reduce their risk of HIV infection are more likely to act on this belief by scrutinizing prospective partners more carefully than by abstaining from sex or using condoms. Men's preference for this risk-reduction strategy over the other two may reflect a deep-seated antipathy towards condoms, as well as the persistence of a masculine culture which encourages men to keep taking on sexual partners, even when AIDS is known to be omnipresent (see Campbell, 1997, 2000; Kaler, 2003). Because partner scrutiny is likely to be the least effective of the three forms of behaviour change, the patterns of behaviour suggested by these journals have implications for the future course of HIV in Malawi, as well as for the interventions which might hold the prospect of slowing it. However, larger-scale research informed by the findings from these journals will be necessary before these conclusions can be safely generalized.

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