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Condoms, HIV/AIDS, and Adolescent Men in Malawi: A Perspective

A Dissertation Presented by

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Abstract of the Dissertation

Condoms, HIV/AIDS, and Adolescent Men in Malawi: A Perspective

by

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HIV/AIDS has had a considerable impact on sub-Saharan Africa and its population for the past several decades yielding a range of consequences on the family as well as on the community as a whole. Malawi is one of the nations in this region that has not seen its HIV/AIDS prevalence rate decrease significantly over the years and is at an estimated 11% (UNAIDS/WHO, 2008). The AIDS epidemic in Malawi has been compounded by other health concerns, economics, education, and social networks which in turn impact prevention and intervention practices and policies. AIDS research has in recent years examined more social and environmental factors in addition to the epidemiological, biological and behavioral aspects. And yet the prevalence rate continues to remain high in Malawi. A review of the literature points to a disparity between knowledge and behavior, frustrating prevention efforts and suggesting that perhaps there is something being overlooked in research and practice.

This study utilizes grounded theory methodology in a secondary qualitative analysis, examining 64 in-depth interview transcripts of adolescent men in rural Malawi for any added insight into the disparity between knowledge and associated behavior. Due to the constraints of a secondary qualitative analysis, there were challenges in strictly following the grounded theory methodology. Results of the study yielded themes centered on condom use, gender roles, economics, and education as well as social networks and cultural stigma; these themes were then compared to individualistic, critical, and institutional (or collective) perspectives. Key findings of the study included the disparity between knowledge and associated behavior change reflected in some of the literature as well as a departure from the stereotypical view of gender roles and gender inequality in relationships. Findings also supplemented those key findings from the original data for which the data was collected, providing implications for practice, policy, and further research.

Dedication

To all those who lost their lives to the HIV epidemic—may we who humbly borrow your perspective be empathetic and emboldened to facilitate a better understanding of your journey and what we need to do as responsible researchers and members of society to ensure that no more will lose their lives to this epidemic in the future.

To all the adolescents in the world – you have valuable insights that we need to hear; may you continue to teach us how to live a better life and leave a better world for you.

To my parents, particularly my father whose soul I pray is at peace – your imprints on my life are immeasurable. I love you both and am eternally grateful for your sacrifices.

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I am also very thankful to my oldest brother for his faith and belief in my abilities to come this far, and for being supportive despite my immaturities and shortcomings. I am certainly blessed to be his little sister.

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And I would not be complete in mentioning the primary reason for my sanity and total heart happiness in the last four years—my beloved Alex who has gone from boyfriend to husband during this time; his unconditional love has taught me more than I ever needed to know about how to be a person with a bigger and kinder heart towards the world in general. He has been the reason I can fight with more passion in the face of injustice and difficulties. And in the most difficult of times after losing my father he has

been an amazing support and bringer of laughter in the midst of sorrow. Alex, I love you with all my heart.

Last but most certainly not least, all my accomplishments in life thus far have been worked through by the Great One who has designed my life, guided me, strengthened me, and humbled me. To Him I give all credit for what success I have achieved and for what journeys I have undertaken. He has been my anchor through all the storms that have come my way; and He has been the igniter of the passion that burns within to be a participant in bringing up our children in a better, more compassionate, and more peaceful world filled with social justice for all.

Chapter 1: Introduction and Background

HIV/AIDS has had a considerable impact on sub-Saharan Africa and its population for the past several decades; children have lost their parents, parents have lost their children, and communities have been impacted by the gaps these losses have created. Countries have also had to contend with considerable loss in their work force. The ripple effect of this disease has been huge and the consequences of such an epidemic continue to wreak havoc in the sub-Saharan African nations, threatening to negate what growth these countries have seen in health and economic sectors. Consequences of this high HIV prevalence have differed from country to country, between regions within a country, and between genders, making the context of the epidemic a complicated one.

Despite the difference in circumstances, sub-Saharan African countries face some similar issues such as poverty, lack of access to regular health care and public education, inequality, and colonial influences. Furthermore, the consensus among researchers, policymakers, and health care professionals seems to be that it is an epidemic, or even a pandemic, that has devastated life in sub-Saharan Africa and continues to do so despite some hopeful figures from the various international entities that document the continued numbers of the epidemic. More than 81% of HIV infected women and 79% of children orphaned by HIV/AIDS live in sub-Saharan Africa (Malawi National HIV/AIDS Policy, 2007). The most current UNAIDS global factsheet indicates that 68% of people living with HIV/AIDS (PLWHA) reside in sub-Saharan Africa, numbering an estimated 22.5 million, and 34% of PLWHA live in the 10 countries of

southern Africa (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). UNAIDS also reported that the continued primary pathways of infection in this region are through unprotected heterosexual intercourse and onward transmission of the virus to infants¹.

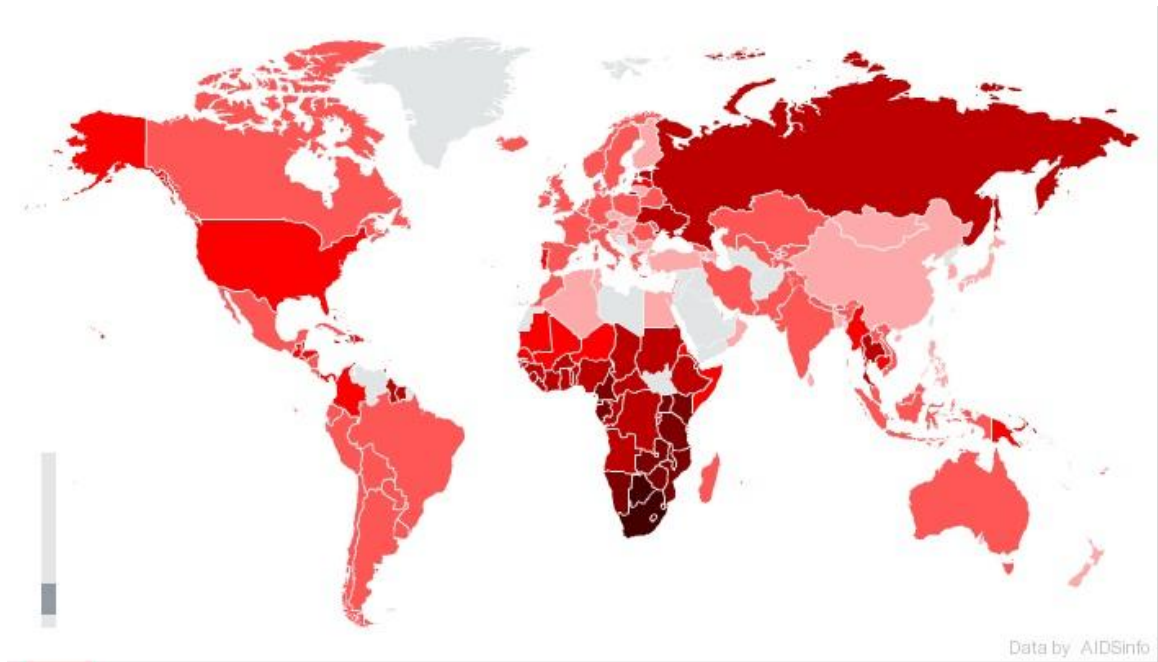
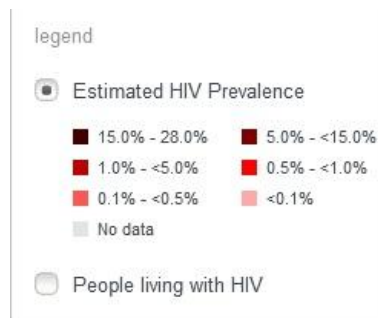


Figure 1a: 2009 HIV Prevalence Rate Worldwide



¹ UNAIDS Fact Sheet, 2009. <http://www.unaids.org>

Figure 1b. Legend for HIV Prevalence Rate Worldwide

Source: AIDSInfo, www.unaids.org²

Among these devastated countries of sub-Saharan Africa is a small one called Malawi, with a population of approximately 13 million. The HIV prevalence rate in Malawi in 2009 was estimated at 11% and it was estimated that the number of infected people (including children) was 920,000 (low to high estimated range being 830,000 to 1,000,000) (UNAIDS, 2010). The overall prevalence rate in Malawi has not seen a significant decrease over the years, although the rate has seen a small decrease of about 2 percent between 2001 and 2007 (UNAIDS/WHO, 2008). UNAIDS did not list any data for antiretroviral treatment (ART) in 2009 but, according to the World Health Organization (WHO) in Malawi, ART reached only about 60,000 of those who need it. There were an estimated 56,000 new infections in Malawi in 2009 according to the UNAIDS 2010 Global Report³ and according to data provided by UNAIDS on AIDSInfo (see Figure 1a), Malawi ranked ninth highest in the world in HIV prevalence rate⁴. In 2009, UNAIDS also estimated that there were 51,000 deaths due to AIDS (low to high estimated range being 38,000 to 67,000). These deaths are said to affect those in the most productive age-group of the nation. The disease also resulted in an estimated 650,000 orphaned children (low to high estimated range being 540,000 to 780,000)⁵, creating many child-headed families as well as causing the elderly to care for their

² <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

³ UNAIDS Global Report 2010 Annexes, p. 10

⁴ <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

⁵ <http://www.unaids.org/en/regionscountries/countries/malawi/>

grandchildren in their old age. Furthermore, in nations like Malawi, poverty compounds the effects of the epidemic: 52.4% of the nation was living at or below the poverty line in 2005, which was MK16165 per year (Second Integrated Household Survey, 2005), or about \$149.61⁶; in 2011, the Third Integrated Household Survey conducted by Malawi's National Office of Statistics reported that 50.7% were now living at or below the poverty line which with the cost of living rise is now MK37002 or about \$244.64⁷. Data from the UN indicated that 73.6% of the population was living on less than \$1 per day in 2005⁸.

Table 1. Malawi's National Poverty Rate in 2005 and 2011

	2005 Poverty Rate (MK)	% of the Population	2011 Poverty Rate (MK)	% of the Population
Poor	MK16165	52.4	MK37002	50.7
Ultra Poor	MK10029	22.3	MK22956	25

*Data source: IHS2 and IHS3⁹

The statistics are staggering but they only tell half the tale. It is typically said that you are either *infected* or *affected* by HIV/AIDS. The statistics cover those who are infected, but what of those who are affected? Who is to say that they are mutually exclusive? Research continues to focus on this epidemic but tends to focus more largely on the statistical aspect as well as the medical aspect. Behind these statistics are

⁶ The exchange rate on January 3rd, 2005 (the first Monday of the year) was 1USD = 108MK according to <http://finance.yahoo.com/currency-converter>.

⁷ The exchange rate on January 3rd, 2011 (the first Monday of the year) was 1USD = 151.25MK, according to <http://finance.yahoo.com/currency-converter>.

⁸ <http://data.un.org>

⁹ IHS2 is the Second Integrated Household Survey published by Malawi's National Statistics Office in 2005; IHS3 is the Third Integrated Household Survey published in 2011.

people—women and children facing various situations, work places losing workers faster than they can train new ones, and other related social scenarios. The epidemic impacts the country in a multi-faceted way: it impacts the country economically and developmentally by affecting the country’s ‘labor capital’ and eliminating a considerable amount of the ‘able’ and most productive part of the population (those between 20 and 50), which in turn contributes to the continued poverty of the nation’s population; it impacts the health of the country by affecting the lives of children who may be HIV-positive, malnourished, and orphaned, and also by affecting the resources of those who are caring for the infected; and it impacts the social structure of the country by eliminating its teachers, professors, parents, and farmers, creating child-headed households and grandparents becoming primarily responsible for caring for numerous grand-children.

Malawi in Brief

Table 2: Socio-economic and demographic profile of Malawi

Population total	15,263,000
Life expectancy at birth, m/f (years)	44/51
Under-five infant mortality rate (per 1000 live births)	110
GNI per capita (PPP US\$)	810
HIV prevalence rate ages 15-49	12%

*Source: WHO/UNAIDS

Malawi is a small, landlocked country in the southern part of Africa, covering a territory of 45,747 square miles (slightly smaller than the state of Pennsylvania). It shares its borders with Mozambique to the east and the south, Zambia to the northeast, and Tanzania to the northwest (see Appendix 1 for map). The topography includes mountains, rivers, and a valley as well as a large lake that makes up about 20.6% of

the country—a large freshwater lake called Lake Malawi. Local fishermen once fished along its shores, but those fishermen have become fewer in number as fish have dwindled and in the case of one (now private) beach, bought out by private property owners—a fact I discovered during my visit to Malawi in the summer of 2008. This then brings one to wonder what replaced those local fishermen’s livelihood and if these fishermen have also been impacted by the epidemic or just the economy.

The country has a large British influence, having been colonized by the British until the 1960s. Malawi became independent in 1964 with Hastings Kamuzu Banda becoming its first president. Subsequently, he declared himself “president for life” in 1971 and ruled Malawi for nearly three decades. Under President Banda and his Malawi Congress Party (MCP), the government was authoritarian with the president exercising a dictatorial rule. Malawi remained part of the British Commonwealth due to Dr. Banda’s decision to maintain close ties with Britain during his government. However, in 1993, factors converged to pressure President Banda into accepting a multiparty rule referendum. In the nation’s first multiparty elections in 1994, the United Democratic Front (UDF) party put forth as its candidate Bakili Muluzi who won the presidency, served two terms, and then supported the candidacy of Bingu Wa Mutharika, who was re-elected in 2009 for a second term. Recently, however, President Bingu Wa Mutharika suffered a heart attack and passed away. His successor and current president is his vice president Joyce Banda who has become Malawi’s first woman president.

Malawi’s major exports are tobacco and tea, primarily produced by large-scale farmers (most in the form of plantations or large farms owned by expatriates or wealthy

locals) and some small-scale farmers, some of which have formed co-operatives. Other agricultural products include ground nuts, maize, cotton, and sorghum. Agriculture is the primary industry in Malawi, accounting for more than one-third of its GDP and 90% of its export revenues, tobacco accounting for more than half of its exports (CIA Factbook). Malawi's GDP has experienced some growth and decreases over the past 10 years. Table 2 shows the trend from 1999 to 2006, as well as the average growth rate over those seven years. Table 2 also gives an overview of basic macroeconomic indicators of Malawi, such as the fiscal indicators including and excluding grants.

Table 1.1 Malawi: Basic Macroeconomic Indicators, 1999-2006

Key Macroeconomic Indicators	1999	2000	2001	2002	2003	2004	2005	2006*	Avg 1999-2006
National Income and prices¹									
GDP (USD million)	1,799	1,727	1,731	1,935	1,765	1,903	2,076	2,239	1,897
GDP Growth (%)	4.0	1.1	-4.2	2.1	3.9	5.1	2.1	8.5	2.8
Inflation (eop)	28.1	35.4	22.1	11.5	9.8	13.7	16.5	9.9	18.4
Fiscal sector indicators²									
Revenues and grants	24.1	27.4	23.5	26.7	34.7	37.5	42.5	42.1	32.3
Revenues	17.2	18.3	16.8	20.0	22.6	25.1	24.4	24.2	21.1
Grants	6.9	9.1	6.7	6.7	12.2	12.4	18.1	17.9	11.3
Expenditures	29.7	33.2	31.2	38.1	42.5	42.9	43.5	43.5	38.1
Current expenditures	19.2	22.6	24.0	30.9	31.4	31.6	33.9	27.9	31.1
Wages and salaries	4.7	5.2	6.8	6.8	6.5	7.5	7.3	7.3	6.5
Interest payments	3.7	4.6	5.0	6.9	10.6	8.7	6.6	4.5	6.3
Domestic interest payments	2.3	3.0	3.9	5.5	9.1	7.4	5.5	4.1	5.1
External interest payments	1.4	1.6	1.2	1.3	1.5	1.3	1.2	0.4	1.2
Other current expenditure	10.8	12.7	12.2	17.2	14.3	15.4	20.0	16.2	14.9
Development expenditure	10.4	10.1	7.2	7.4	11.1	11.0	9.5	15.4	10.3
Overall balance (excluding grants)	-12.5	-14.9	-14.4	-18.3	-19.9	-17.8	-19.0	-19.3	-17.0
Overall balance (including grants)	-5.6	-5.8	-7.7	-11.6	-7.8	-5.4	-1.0	-1.4	-5.8
Domestic balance ³	-2.7	-4.7	-7.7	-11.0	-9.2	-6.5	-9.7	-6.2	-7.2
Primary Balance incl. grants (% of GDP) ⁴	-0.4	-1.7	-3.8	-5.5	-0.1	0.9	-4.2	-2.1	-2.1
Underlying balance ⁵	-1.6	-1.7	-2.7	-1.7	-0.9	1.8	0.9	0.6	-0.7
Net domestic borrowing	2.1	1.2	6.9	11.8	7.7	3.0	0.3	-1.9	3.9
Domestic Debt	2.8	8.9	10.2	20.4	24.8	23.8	19.9	14.8	15.7
Monetary sector indicators¹									
Growth in M2 (%)	33.6	42.4	12.1	25.2	29.3	29.8	14.3	22.0	26.1
Gross reserves ⁶	4.2	4.4	3.3	1.4	1.4	1.1	1.4	1.6	2.4
Interest rate (3 months Tbill, average)	40.1	39.5	42.4	41.7	39.3	28.6	24.5	23.2	33.3
External sector indicators									
Current account balance (percent of GDP)									
Excluding official transfers	-16.9	-11.7	-12.5	-29.3	-17.2	-21.3	-29.8	-21.8	-20.1
Including official transfers	-8.2	-3.0	-6.8	-17.2	-7.9	-10.1	-16.2	-7.2	-9.6
Exchange rate MWK /USD (period average)	44.1	59.5	72.2	76.7	97.4	108.9	118.4	136.3	89.2
*Estimate									
Source: Government of Malawi and IMF									
1. Calendar year basis									
2. Percent of GDP, fiscal year basis (Malawi fiscal years run from July 1 st to June 30 th).									
3. Definition: Overall balance excluding grants, foreign-financed development expenditure, and foreign interest payments.									
4. Definition: Domestic balance, excluding domestic interest payments.									
5. A measure of domestic adjustment effort (i.e. domestic primary balance excluding the health SWAp). Definition: Overall balance plus statistical discrepancy, excluding grants, revenue and expenditure from maize, interest, foreign financed development expenditures and the health SWAp.									
6. Months of current year's imports of goods and non-factor services, calendar year basis.									
Source: Ministry of Finance and RBM, and IMF and World Bank staff calculations									

Table 3. Basic Macroeconomic Indicators of Malawi¹⁰

Demographically, Malawi's growth rate, according to the U.S. Census Bureau's International Data Base, shows fluctuation, although it is beginning to decline on a steady basis (see Appendix 2). The Census Bureau states that, in the case of Malawi

¹⁰ Source: World Bank (2007). *Malawi Public Expenditures Review*, September

and other sub-Saharan African countries, it has adjusted the formula for population growth to take into consideration the impact of HIV/AIDS so that this population decline is inclusive of lives lost to HIV/AIDS, above and beyond deaths brought on by diseases, infant and child mortality, and other factors that would affect population growth and decline rates (for example, having less children). While the growth rate is still higher than some other African countries (e.g., Zambia and Mozambique)¹¹, taking into account HIV/AIDS-related issues, it is questionable if the data can be used as a guide when considering the vacancies of posts in various ministries and departments. The duration of vacancies range from a few months to a few years, according to the World Bank (Suarez, Givah, Storey, & Lotsch, 2008), and further compounded with the so-called "brain-drain" that create gaps that the country must contend with. Thus, while the population is growing, can the growth alleviate the gaps in the economy?

In addition to the lack of economic growth and development in Malawi, the problem of foreign aid further confounds the situation. The country continually receives aid from international organizations and also has extensive involvement in social affairs by numerous nongovernmental organizations (NGOs). As of February 2003, there were at least 100 registered NGOs working formally in Malawi¹². Yet still, according to a local source¹³, there are many rural areas that are not being serviced by any NGO at all while there are other "desirable" areas that have more than their "fair share" of NGO intervention. Where do these issues fit in when we consider the amount of aid that has

¹¹ Source: <http://www.census.gov/ipc/www/idb/country/miportal.html>

¹² See a list at: <http://www.sdn.org.mw/ngo/ngo-mw-list.html>

¹³ Personal communication with a government worker (August 2008)

been given over the past several decades without much obvious impact on the growth of the country, eradication of poverty, or significant decrease in HIV/AIDS prevalence? Furthermore, how does the extensive yet unbalanced involvement of NGOs in the social affairs of the country affect the government's responsibility, or, at least its perspective on responsibility? What is the state's role, then, in issues of citizens' welfare, particularly when we look at how it intertwines in the area of health and HIV/AIDS?

Despite facing such serious problems, the Malawian government has made attempts to improve the overall conditions for its citizens, developing policies for orphans, persons living with HIV/AIDS, and the first five years of a child's life as well as fertilizer subsidies for agricultural sectors. While the focus in the most recent presidential address was on agriculture, agriculture alone is not enough to sustain Malawi's economy even despite recent improvements and success in the sector. Malawi's economy has been and continues to be dependent on assistance from donors such as the World Bank and the International Monetary Fund (IMF) as well as individual donor nations, which account for a large part of its GDP. Table 2 gives an idea of how grants impact not just revenue but the overall fiscal balance of the country. Furthermore, public expenditure has been primarily on general administrative costs as well as education costs, with minimal spending in the areas of social security and welfare services as well as community and social development (see Appendix 3 for more information).

In the midst of all of this, HIV/AIDS, however significant, is just one part of the overall difficulty in which Malawians find themselves. Malaria and tuberculosis are also

among the top killers of the population. According to the WHO, there were 2,853,317 reported cases and 6,993 deaths in 2002 due to malaria. In the same year, the WHO reported that there are 48,000 new cases of tuberculosis (TB) each year and that 68% of all TB cases are also HIV positive. According to UNAIDS (see Figure 2a), Malawi ranked seventh in the world in 2009 in estimated HIV in new TB cases with 64% of new TB cases being concurrent with HIV.

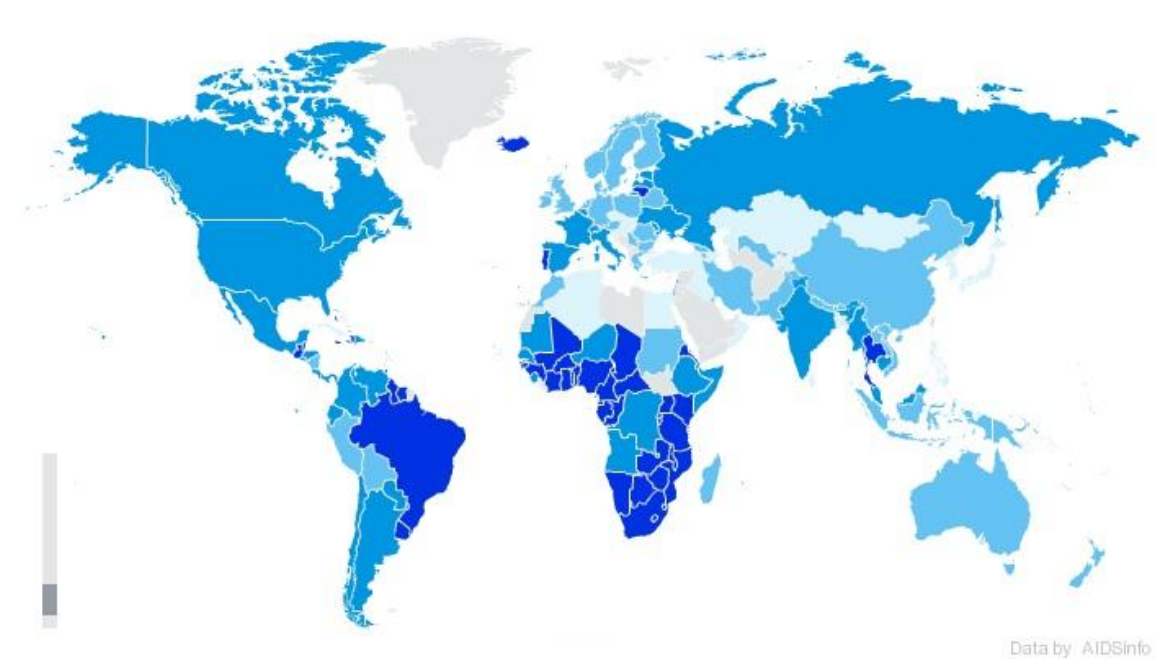


Figure 2a. Estimate HIV in New TB Cases Worldwide

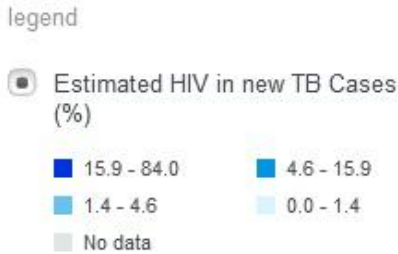


Figure 2b. Legend for Estimated HIV in new TB Cases Worldwide

Source: AIDSInfo, www.unaids.org¹⁴

Much research has been conducted in examining the impact of HIV/AIDS in sub-Saharan Africa, particularly with respect to its epidemiological, biological, and medical aspects as well as related prevention and intervention through gender perspectives (e.g. Anand et al., 2009; Charles & Walters, 2008; Kalipeni, 2000; Masiye & Seekubugu, 2008). Yet with the consistently high prevalence rates, questions of effective prevention still exist and might be better addressed through a more socially broad perspective rather than strictly epidemiological. It is necessary for medical science to advance the research in the fight against AIDS but it is also necessary to examine how the disease impacts social life and how people are making sense of this epidemic. And, the consistently high HIV/AIDS prevalence rate and its impact that has not seen a significant decline in the past decade lead us to ask some questions for this study:

- What are the barriers, if any, to effective HIV/AIDS prevention?
- What has research, if anything, been overlooking in the fight against AIDS?
- What do people who are impacted by this epidemic have to say about it?

¹⁴ <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

These are some of the broader questions that I would like to address in this dissertation by utilizing a perspective of life amidst this epidemic from the point of view of adolescents—who are among the newly infected despite stabilizing prevalence rates, specifically with respect to Malawi; these adolescents are sometimes thrust into adulthood by the epidemic or stand at the cusp of adulthood and face numerous decisions that will impact their future in navigating this epidemic and thus may have some important insight into the fight against AIDS as they make their sexual debuts and plan for their future. While both adolescent men and women are affected by this epidemic, each gender deserves particular attention and for the purposes of this study the focus will be on adolescent men. This study seeks to examine what these young men have to say about the impact of AIDS on their lives and relationships. Are there any particular patterns and themes that will arise from these adolescents' interviews that will inform directions for prevention programs, policies, and future research?

Relevance to Social Welfare and Policy Implications

HIV/AIDS has a crucial impact on people's lives in Malawi; aside from the obvious area of health, the disease impacts communities and social relationships and social structures as well as the workforce of a nation that is attempting to focus on economic development. This study aims to bring more understanding to the story "on the ground," giving voice to the experiences of a sample of the male adolescent population in rural Malawi. As such, the study is relevant to social welfare in two key ways:

- 1) It focuses on problems surrounding the overall “wellbeing” of the adolescents and young adults of Malawi, and
- 2) It causes us to ponder the potential implications for systemic and social change rather than just focusing on a particular problem or focusing on the individual level of analysis.

As for policy implications, not only does the AIDS pandemic claim lives, creating costly losses to society but it also creates significant economic costs to a government that is seeking to improve its economy and overall well-being of its citizens. For example, a World Bank report (2007) reviewing Malawi's public expenditure indicated that 4.4% of government expenditure on education is AIDS-related and it estimates that this cost could potentially increase three-fold. Another World Bank report on HIV/AIDS (Suarez et al., 2008) documented that just in the Ministry of Agriculture, productivity loss from 1990 to 2000 was 2,933 months and total salary lost was MK8,799,000¹⁵. Imagine this occurring in all the ministries, not just one. Though the number of HIV-related deaths was 158 out of 1613 total deaths for which funerals were attended in the Ministry of Agriculture¹⁶, it is highly likely that this number is under-reported due to the cultural stigma associated with HIV/AIDS and the common practice of non-disclosure of deaths related to HIV/AIDS—something I found out in a conversation with some community members while in Malawi; as a result, only the secondary cause of death (such as tuberculosis or pneumonia) are disclosed to family

¹⁵ MK = Malawian Kwacha (the Malawian currency unit)

¹⁶ Ministries are the equivalent of Departments (i.e. Department of Agriculture) in the United States.

members on a death certificate while the primary cause of death (HIV/AIDS) is only kept on record to report statistics to international agencies to record as part of the AIDS pandemic affecting the country. Indeed the report on HIV/AIDS in Malawi published by the World Bank states that over 70% of tuberculosis cases are also HIV-positive in Malawi (Suarez et al., 2008). In a country with relatively small revenue, these costs can only add to the financial burden of the government and impact the overall productivity of the government as well as the country in its move towards improving the quality of life of its citizens.

Furthermore, when we examine the human development index, Malawi has been consistently lower compared to the overall trend of sub-Saharan Africa, let alone the rest of the world. One of the factors that affect this index value is health status (see Appendix 5 for the HDI trends). Health status has been impacted by the fluctuating life expectancy over the years (life expectancy is currently 54.6 years, according to the UNDP's most recent Human Development Report). The average life expectancy was 39 in 2002, 46.3 in 2005, and 47 in 2008¹⁷. The HIV/AIDS prevalence rate is 14.1% and "stabilized" in the past few years (Suarez et al., 2008). There has been plenty of staff attrition in health workers, and in all areas of the "working" society (Suarez et al., 2008). All departments in the government are short-handed, and staff attrition is primarily attributed to AIDS, or at least "deaths" (see Table 3 and Appendix 4 for attrition rates in the Ministry of Agriculture and the Ministry of Water, respectively). This affects the

¹⁷ See <http://hdrstats.undp.org>

overall development and growth of the country, as “manpower” is lacking, albeit this reflects only two of the various ministries in the country.

Additionally, the number of orphaned children is on the rise. In 2009, UNICEF estimated there were 1 million orphans¹⁸, and this figure is expected to rise. This presents another large problem—not simply from a social standpoint, but also from a developmental and economic standpoint. If we see a country’s population as productive citizens who will contribute to a country’s growth, the 1 million orphaned children that have no home, little resources, and little opportunity may or may not reach adulthood, and should they reach adulthood who will train and educate them, and what sort of future will they meet? The future workforce of the country is already depressed, and a shortage of personnel surely does not help matters with regard to development let alone the social structure as whole. Orphans may be resilient as Henderson (2006) argues; however, they are still impacted by the pandemic.

**Table 4. Expected and Observed Death Rates in the Ministry of Agriculture
1995-2005¹⁹**

¹⁸ http://www.unicef.org/infobycountry/malawi_statistics.html

¹⁹ Source: World Bank Report (2008), *HIV/AIDS, Climate Change, and Disaster Management: Challenges for Institutions in Malawi*, May

Staff Category/Cadre	Expected Deaths	Observed Deaths
Agriculture Officers	19.3	39
Research Scientist	8.8	21
DAHI Professionals	4.6	21
Technical Officers	41.9	68
Technical Assistants	474.6	707
Others	258	443

Chapter 2: Literature Review

Much research has been conducted to seek out the underlying factors for the high prevalence rates and barriers to effective prevention and intervention programs. Research has frequently utilized biomedical, epidemiological, and behavioral approaches, examining health care and medical aspects of AIDS as well as access to treatment and services such as voluntary counseling and testing (VCT). And research has also taken a more sociocultural and environmental approach to HIV/AIDS and its contexts—in other words, how Malawians and Africans in general navigate this epidemic and live their daily lives within the social and economic contexts that are uniquely their own.

Studies have focused on people's knowledge of the epidemic, how HIV is transmitted, prevention strategies, and awareness of one's serostatus; studies have also examined issues surrounding people's perception of "risk" and associated sexual behaviors and behavior changes (e.g. Anand et al., 2009; Barden-O'Fallen et al., 2004; Morah, 2007). Some key findings in these studies have indicated that there is little association between knowledge and perceived risk, as well as a disconnect between knowledge and associated behavior change. Not only have there have been mixed messages and several misunderstandings associated with its transmission and strategies of prevention (Houston & Hovorka, 2007; Kalipeni & Ghosh, 2007) but there has also been limited associated protective behavior changes (Schatz, 2005; K. P. Smith & Watkins, 2005). Barden-O'Fallen et al. (2004), for example, found that knowledge does not necessarily equal risk perception and that there were gendered patterns in risk perception; sources of knowledge were found to vary significantly by gender but were

not statistically significant in full model of perceived risk. A study conducted by Morah (2007) found that although Malawians know about HIV prevention in general, behavioral change does not occur proportionately to this knowledge due to some gaps in knowledge about the epidemic and being involved in some cultural traditions that potentially promote HIV infection; but awareness of one's HIV status contributes to the practice of safer sex versus being unaware of one's sero-status.

There have also been other studies that have approached these issues from the perspective of gender, cultural stigma, and ethical issues, focusing on how gender differences impact vulnerability to, and outcomes of, the HIV epidemic, the existence and influence of cultural stigma, and disclosure and confidentiality issues exposing ideological differences in African communities versus Western communities (e.g. Charles & Walters, 2008; Izugbara & Undie, 2008; Kohi et al., 2006; L. Makoae et al., 2008; Masiye & Seekubugu, 2008; Mfutso-Bengo, Mfutso-Bengo, & Masiye, 2009; Muula & Mfutso-Bengo, 2004; Scanlan, 2010). These studies pointed out that not only do gender differences influence the degree of vulnerability and the outcomes of HIV transmission but so do the complications of cultural stigma. Additionally, Western ideas of disclosure and confidentiality bring up questions of applicability in African communities. A study by Muula and Mfutso-Bengo (2004) found that there were cultural customs (sexual in nature) that were barriers to reducing the spread of HIV and a culture of silence and resistance to change which also hampered results of prevention. Some of these cultural practices and differing ideologies brought up complicated issues of disclosure and personal autonomy affected by stigma of AIDS and pointed to the

necessity to consider these ethical and cultural considerations in the fight against AIDS in Malawi.

Additionally, there have also been studies that have addressed issues of health care and economic access associated with the HIV epidemic and the consequences of such access or in-access on a population's vulnerability to the disease (e.g. Kalipeni, 2000; Mtika, 2001). Results of these studies indicate the discrepancy and collapse in healthcare systems as well as the hardships for people in these countries to access treatment, which in turn influences, and even increases, vulnerability to transmission.

Research has tended to focus on individual-levels of risk factors but some research has begun to examine the relationships between social interactions and health outcomes in adolescents (e.g. Clark, Poulin, & Kohler, 2009; Kaler, 2003; Poulin, 2006, 2007). The knowledge of transmission and how social interactions contribute to this knowledge are examined in some of these studies as well as how the adolescents navigate through their lives and plan for their future amidst such difficulties. Results from these studies reveal that despite the epidemic and the risks, adolescents are finding ways to utilize the information they gather from social networks and other sources to inform their decisions regarding relationships, marriage, and their future in general while attempting to minimize risk of transmission.

In sum, there are plenty of issues and factors that influence the disease, ranging from medical and ecological factors to cultural and economic factors, which include but are not limited to the socialization of genders and access to hospitals, condoms, and treatment. Thus the scope of the epidemic seems very broad and complicated. However,

there seem to be several key themes that arise in many of these studies. One of them, as discussed previously, is the disparity between knowledge and behavior change; another is gender. One aspect that seems to be a common thread in many of the studies is the disparity between knowledge and associated behavior change. Another appears to be gender roles and perspectives as they relate to the epidemic. There are also economic influences and ethical considerations related to the fight against AIDS which may or may not raise important issues in the bigger picture of prevention.

Gender perspectives

Women and children have been identified as the most vulnerable population affected by the HIV/AIDS epidemic. Prevalence rates are higher in women than in men and thousands of children have been orphaned due to HIV/AIDS; and the situation that faces women in southern Africa is definitely one that needs research and heightened awareness. Some studies have found that younger women are among the more highly vulnerable and at-risk for being infected (Kalipeni, 2000; Kalipeni & Ghosh, 2007). For example, the HIV infection rates are reported to be up to five times higher for women than for men ages 15 to 19 (Kalipeni & Ghosh, 2007; UNAIDS/WHO, 2008). Among young people (ages 15-24), estimated prevalence rates for Malawi was 8.4% for women and 2.4% for men with a high estimate of 10.4% for women and 3.8% for men (UNAIDS/WHO, 2008). Understandably, various studies have called for the empowerment of women by educating them and enabling them to gain equality in their communities (e.g. Lindgren, Rankin, & Rankin, 2005).

Women have been reported to have higher rates of prevalence whether in rural or urban settings. And though they are more likely to be HIV tested at antenatal clinics, women in general are not so successful in utilizing prevention strategies such as condom use in relationships. For example, one study found that 75.5% of those who reported that they were not using condoms because their partner(s) had refused were women (Morah, 2007). With respect to societal roles and images, women are seen as less powerful than men in some of these communities and thus demonstrate a lack of agency in not only household decisions but also in the workplace and in intimate relationships (Lindgren et al., 2005). A study by Lindgren and colleagues (2005) outlined some of the key results from several focus groups with Malawian women²⁰, where images of inequality in power relations within society emerged. Despite the attainment of higher education, women were continually subordinate to men and men were the primary decision-makers of society; even messages passed along to children differed according to gender: "Girls are told to abstain from pre-marital sexual relationships if they wish to marry but boys are merely advised not to go with girls who also go with older men, as they may be infected" (Lindgren et al., 2005, p. 77).

But women are not always as powerless as they are often portrayed. Some studies have reported that women in rural southern Africa are finding ways to exercise their own agency and navigating the HIV/AIDS epidemic with strategies that are more applicable and practical to their own local situations (Clark et al., 2009; Lindgren et al., 2005; Poulin, 2007; Schatz, 2005). For instance, Schatz (2005) criticizes the depiction

²⁰ The women in two of these groups were conference attendees—Christian clergy and Muslim leaders, tribal leaders, professionals, and workers in NGOs. The third group was conducted with university students. See Lindgren et al. (2005) for more details.

of women as being passive and ill-equipped and finds out from in-depth interviews that women are exerting their own agency in order to protect themselves by using locally appropriate strategies, such as talking to their spouses, enlisting the support of other family members, and even initiating divorce. Other studies also found that women were finding ways to exercise their agency with respect to sexual relationships. However, this is not to say that in countries like Malawi gender equality exists with regards to HIV or in all aspects of life. Thus, appropriately research continues to examine gender inequality issues, in order to raise awareness of the various factors that may contribute to women (and children) being most susceptible to poverty and disease, particularly in less industrialized countries, and the trend continues towards emphasizing empowerment among women.

While research has certainly not omitted the noted gender differences in prevalence rates, sexual behaviors, cultural stigma, prevention/intervention strategies and the like, most of the studies reviewed that were conducted in Malawi represented a women's perspective. As a result, in order to effectively recommend policies and prevention programs, it is imperative to include the male perspective as well. As Tersbol (2006) discussed, inclusion of the male perspective in female empowerment discourse creates a redistribution of equity in power relationships. Seeley and colleagues (2004) echo this idea in their study stating that "recent growth of research about and discussion of 'masculinities' has evolved from recognition that to address inequalities in gender development one must not just address one gender, women; one also needs to look at men in development—and involve them" (p.91).

Several studies have focused on the male perspective among young men in Malawi and other parts of Africa, attempting to understand their views of sexual behavior related to HIV/AIDS and examining critical socialization of gender in communities that have been impacted by AIDS (Izugbara & Undie, 2008; Kaler, 2003, 2004, 2010; Kalipeni & Ghosh, 2007; Setel, 1996; Simpson, 2007; D. J. Smith, 2003, 2007; Tersbol, 2006). These studies raise some issues to consider in attempts to examine the link, or disparity, between awareness and behavior. Kalipeni and Ghosh (2007) discuss the disparity between concern and practice among men in an urban/semi-urban setting—the low socioeconomic income areas of Lilongwe; Kaler (2003, 2004) focuses on the complexity of the relationship between masculinity and HIV/AIDS in a rural setting in southern Malawi; and Izugbara and Undie (2008) collected data from groups of young men in both rural and urban settings regarding masculinity scripts and social expectations while Simpson (2007) conducted interviews of older men reflecting on their sexual experiences as adolescents. Smith (2003, 2007) examines the male adolescent in the context of Nigeria and migrating from rural to urban settings as well as from traditional to modern notions of marriage and relationships. And while Poulin (2006) primarily focuses on women and their exercise of sexual agency, she also does include a focus on men’s “normatively defined expectations about their obligations in a partnership and their risk reduction strategies” and the gendered differences in marriage processes.

Izugbara and Undie (2008) discuss masculinity scripts that exist in communities, which refer to the notions and expectations of masculinity that are expressed and that

shape an adolescent as he grows; they examine these scripts relative to a group of young Malawian men and help shed some light on the frustrating disparity between knowledge and risky behavior. Participants in this study expressed that sexuality was equivalent with self-esteem and manliness and that there were social expectations for a young male adolescent to be sexually knowledgeable and experienced; thus, this expectation escalated into competitiveness and fear of humiliation if one was not sexually active. Furthermore, participants also explained that young men who impregnated their girlfriends were given more respect and "...[become] a hero to his friends..." (p. 286). The findings of this study are also echoed in the study by Simpson (2007) in a study of masculinity and related HIV/AIDS risk in Zambia, a neighbor of Malawi. While communities in Zambia definitely have their differences with those in Malawi, Malawi and Zambia share some cultural background with the Bantu culture. Thus, this demonstrates that the ideas of masculinity transcend national borders and perhaps are shared due to a similar cultural background. And as a result, this sort of discourse, dominating in adolescent circles, promotes the vulnerability of women and their higher susceptibility to HIV risk. But this also points to the problems that might hamper the success of an ABC²¹ prevention campaign, and why it has continued to be of dismal success in Malawi, as well as the contentiousness of condom use.

Theoretical framework

Studies around gendered perspectives have incorporated different theoretical frameworks and conceptual models to explain HIV risk and sexual behaviors, such as a

²¹ ABC stands for abstinence, be faithful, and condom use; it is a common HIV/AIDS prevention campaign used in Malawi and elsewhere, having been around since the 1990s and adopted by the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003 here in the United States.

gendered perspective, health belief model, life course theory and behavior change models as well as social dominance theory. An article by Rosenthal and Levy (2010) addresses additional theories that have attempted to account for the high rates of HIV infection among women in the world, specifically self-efficacy theory and theories of reasoned action and planned behavior, approaching it from a psychological point of view. Rosenthal and Levy suggest that these theories have fallen short of accounting for the high risk and instead propose the use of social dominance theory along with the four bases of gendered power.

But, in order to discuss gender and gender perspectives, there has to be some definition as to what gender and gender differences mean with respect to this study. Gender differences do not just refer to the biological or physiological differences in men and women but also the social construction of gender. UNAIDS defines gender with respect to HIV/AIDS as the following:

Gender comprises widely held beliefs, expectations, customs and practices within a society that define 'masculine' and 'feminine' attributes, behaviors and roles and responsibilities. Gender is an integral factor in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected by HIV. Gender norms, for example, often dictate that women and girls should be ignorant and passive about sex, leaving them unable to negotiate safer sex or access appropriate services. Gender norms in many societies also reinforce a belief that men should seek multiple sexual partners, take risks and be self-reliant. These norms work against prevention messages that support fidelity and other protection measures from HIV infection. Some notions of masculinity also condone violence against women, which has a direct link to HIV vulnerability, and homophobia, which results in stigmatization of men who have sex with men, making these men more likely to hide their sexual behaviour and less likely to access HIV services.²²

²² UNAIDS, "Gender," <http://www.unaids.org/en/PolicyAndPractice/Gender/default.asp>.

This definition of gender with respect to HIV/AIDS reveals differences that begin with the very beliefs, expectations, and practices within a culture, within a society. Even the stigma that each gender faces is different, despite it being around the same topic in the same communities. For instance, in Nigeria, extramarital affairs are deemed more socially appropriate for men than for women (D. J. Smith, 2007). Thus, while a woman can be socially excluded and perhaps even reprimanded for the husband's affair, her husband does not face the same repercussions even if he was the one who initiated the extramarital affair. These also attest to the gender roles that are constructed in societies that may end up assigning differences to each gender, according to each community and each society's construction of gender. Izugbara and Undie (2008) indicate that it is necessary to examine the masculinity scripts that exist in each community with regards to how gender is constructed, and that it is important to understand these ideas of masculinity and take them into consideration when examining the risks that adolescent males face, particularly with HIV.

Another study approaches the issue using a version of the Health Belief Model (developed by Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock in 1952) and discusses that there must be "three cognitive preconditions which must be met before an individual will change his or her behavior for the sake of his or her health" (Kaler, 2004, p. 288). The study lists these preconditions as: 1) The person in question must believe that the health threat is dangerous; 2) the person in question must believe that he or she is at risk for the health threat; and 3) the person in question must believe that it is possible and feasible to reduce one's risk through one's own actions. Utilizing

this model there is a breakdown in condition 3, where the concept of inevitability appears to be quite poignant—that getting AIDS is inevitable so trying to protect oneself is useless (Kaler, 2004). Kaler contended that this model was useful in organizing information and issues in order to better understand where the breakdown was in efficacy of prevention programs and implementation of successful behavior change strategies. Kaler also reported that the perspective of inevitability was not clearly dominant, however, over the perspective of individual agency, and that individuals appeared to switch their allegiance between the two. This may be due to the complexity and fragility of masculinity that Izugbara and Undie discussed, and perhaps the issues of masculinity impacts young men’s allegiance to either perspective (of individual agency or inevitability).

Perhaps there is more to understanding an individual’s readiness to change that involves more facets than the three cognitive pre-conditions proposed by the Health Belief Model. The transtheoretical model of change (TTM) developed by Prochaska and Velicer (1997) addresses readiness for behavior change by assessing where an individual is a proposed six stages of (behavior) change. TTM also introduces not just the particular phase an individual may be in but also the concepts of self-efficacy in behavior change. This concept of self-efficacy might be akin to the cognitive pre-conditions of the Health Belief Model but elaborates further on processes of change as well. Although most studies have been used primarily with addictive behaviors, Prochaska and colleagues (1994) also applied the TTM to HIV prevention, outlining the stages and examples of behavior in those stages pertaining to HIV prevention/safer sex.

These six stages of change are precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska et al., 1994; Prochaska & Velicer, 1997).

Prochaska and Velicer (1997) describe the stages as follows:

1. Precontemplation—people in this stage do not demonstrate any intent to take action to change their behavior;
2. Contemplation—people demonstrate intent to change in the next 6 months and the awareness of both pros and cons of the behavior change;
3. Preparation—people demonstrate the intent to take action in the immediate future, have a plan of action, and have taken some significant action in the past year;
4. Action--people demonstrate some specific modification in their life style within the last 6 months, but there is a criterion among scientists and professionals as to what this action is because not all modifications count in this stage;
5. Maintenance—people demonstrate that they are working towards preventing relapse but do not apply change processes as frequently as those who are in the action stage;
6. Termination—people in this stage demonstrate total self-efficacy and zero temptation to return to their old habits as a coping mechanism.

In addition to these stages, Prochaska and Velicer also describe processes of change which are the “covert and overt activities that people use to progress through the stages” (1997, p. 39). There are ten of these processes: consciousness raising,

dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, social liberation, counterconditioning, stimulus control, contingency management and helping relationships. There are also two intervening variables that TTM incorporates which mediate movement between stages: decisional balance and self-efficacy; decisional balance refers to the pros and cons of behavior change while self-efficacy refers to the “situational confidence in one’s ability to change and situational temptations to engage in the problem behavior” (Prochaska et al., 1994, p. 9). These two variables, particularly self-efficacy, are key in examining the issues facing the adolescents.

TTM proposes that understanding where an individual is within the six stages of change may help in understanding their readiness for change and also address the appropriate intervention/prevention methods. It is important to note that TTM does not propose that an individual linearly moves through the phases of change but can transition back and forth in a non-linear manner, cycling through the phases depending upon circumstances. Furthermore, there are some critical assumptions²³ set forth that drive this theory, including the assumption that “[t]he majority of at-risk populations are not prepared for action and will not be served by traditional action-oriented prevention programs” (Prochaska & Velicer, 1997, p. 41).

²³ Prochaska and colleagues set forth seven critical assumptions: 1) no single theory can account for all the complexities of change; 2) behavior change is a process that unfolds over time through a sequence of stages; 3) stages are both stable and open to change, just as chronic behavioral risk factors are both stable and open to change; 4) without planned interventions, populations will remain stuck in the early stages as there is no inherent motivation to progress through the stages of intentional change; 5) the majority of at-risk populations are not prepared for action and will not be served by traditional action-oriented prevention programs. Health promotion can have much greater impacts if it shifts from an action paradigm to a stage paradigm; 6) specific processes and principles of change need to be applied at specific stages if progress through the stages is to occur (intervention programs should be matched to each individual’s stage of change); and 7) chronic behavior patterns are usually under some combination of biological, social, and self-control (1997, p. 41).

But there are still some gaps these theories cannot address, although they are useful in shedding light on different aspects of risky sexual behavior and some of the barriers to effective prevention. TTM seemingly comes from a more individualistic perspective, emphasizing the *individual's* readiness to change and *self*-efficacy. The disparity between knowledge and practice still exists, and though possibly explained by the perspective of inevitability and masculinity scripts that do not deter risky sexual behavior as well as the individual's cognitive readiness to change, there is still the need to incorporate socio-cultural factors: economics, gender inequality, and individual versus collective action. Thus perhaps calling for individual action and attempting to understand the individual may only be one facet of the overall picture.

For instance, calls for the empowerment of women do not adequately address the men who now appear to feel "disempowered" because women are now more in control of their lives and their choices. These feelings of disempowerment by men may occur because focusing on the empowerment of women only has created what Paulo Freire called a "false dichotomy", where the notion is that if one group is empowered, another group must suffer the consequences of losing its power. For example, in a study by Strebel and colleagues (2006), as power relations began to shift from men to women, men indicated feeling marginalized and disempowered relative to women in their communities. This is indicative of the whole "tables turned" feeling where the oppressed are now viewed as the oppressor and the oppressors are viewed as the oppressed (Freire, 2004). Thus, it seems that gender roles are not individual constructs but rather are prevailing social institutions handed down from traditions which come

into conflict by the present economic and health circumstances of each individual. As such, it appears that theoretical frameworks that address solely the individual are not appropriate for such a complex situation that is as much social as it is individual.

Perhaps these issues can also be approached from both an institutional framework (Portes, 2006) combined with a critical perspective proposed by Freire. The institutional framework Portes suggests merges economic and sociological developmental concepts whereby "institutions" are an integral part of society and societal structure; these institutions can refer to "norms, rules, conventions, values, habits, etc" (Portes, 2006, p. 235). These concepts form the societal structure and are arranged into levels, beginning at the surface (superficial or easily changed ideas) and progressing to those that are more deep-rooted in society (such as traditions and values inherent within a society that take longer to change). Thus, in order to effectively change behavior, one must understand what levels of ideas/conventions/norms/values are being addressed in order to understand what sort of change can be brought about.

Portes delineates the forces of change that impact the various levels but distinguishes them between elements of culture and social structure²⁴. He describes four levels of cultural elements: deep, intermediate, visible (individual), and visible (collective); he also describes four levels of social structure elements: power, class structures, status hierarchies, and organizations. Within the cultural elements, visible

²⁴ See figure 4, p. 252 in Portes (2006).

(collective) refers to institutions within society; visible (individual) refers to norms and roles; intermediate refers to established skills and repertoires; and deep refers to values.

Forces of change influencing the cultural elements, Portes describes, are as follows: charisma/charismatic prophecies to change values; scientific/technological innovations to change skills and repertoires as well as norms and roles; cultural diffusion to change skills, repertoires, norms, roles, and institutions; and path dependence to change institutions. Forces of change influencing the social structure are class struggles and inter-elite competition on power, class structures, and status hierarchies and path dependence on organizations.

With social institutions in place such as that of gender and masculinity, forces of change, according to Portes, must come from the corresponding level of the institutional/structural level at which that social institution is found (i.e. ideas, beliefs, traditions, values, norms, roles, etc.). If the proposed force of change does not correspond to the appropriate level of the institution, genuine sustainable change will be difficult. In other words, if the proposed programmatic change for HIV/AIDS prevention/intervention only prescribes the physical behavior of condom use without actually addressing the social contexts of masculinity, femininity, trust, and power within relationships, the program will not meet with success in decreasing HIV/AIDS prevalence rates and new infections.

Paulo Freire's notion of change comes from the people themselves and not from the 'elite' or those who dominate in society. According to Freire (2004), lasting change that breaks the vicious cycle of oppressor and oppressed (or men and women,

“developed” versus “developing” nations, and similar dichotomies) can come only from those who are being oppressed but without simply garnering power and replacing the oppressors to once again themselves oppress. Rather, lasting change is facilitated by raising the critical consciousness of those who are oppressed as well as those who inadvertently take the role of the oppressor. This points to the validity of listening to the young men’s perspective in this epidemic and taking issues from their perspective that might inform what is really necessary to bring about lasting change for both men and women in this HIV/AIDS epidemic.

The concepts that Portes and Freire present are applicable to the circumstances which face adolescent young men in Africa, particularly with the HIV/AIDS epidemic’s influence on their lives. Social institutions define masculinity and gender roles, which make it particularly difficult for young men to adapt to the behavior that is necessary to prevent further infection and prevalence of HIV/AIDS. Despite their understanding and knowledge of HIV prevention methods and the need for condom use as well as other preventative behaviors, it is difficult in the face of strong social definitions of masculinity to actually put this behavior into practice. And thus, the discrepancy between knowledge and behavior seems to arise.

Freire helps us to understand the importance of inclusion and empowerment of adolescents while Portes helps us see the big picture that hinders or enables institutional forces of change. Combined with the understanding of the individual in relation to ideations and willingness for behavioral change, examining the social environment—its socio-economic and cultural factors, may complete the picture to

attempt to resolve that gap between knowledge and behavior when it comes to the HIV/AIDS epidemic, especially in Malawi.

These issues all lend to the applicability of grounded theory (Glaser & Strauss, 1967) in analyzing the data, despite it being secondary data. In the manner of Freire, it should be appropriate that the adolescents themselves speak to the circumstances they face, and thus, the concepts and “theory” should be derived from the data itself reflecting the adolescents’ perspectives which provide insight into bringing about lasting change in the AIDS epidemic. As for methodological discussions related to grounded theory, please refer to the *Methodology* section.

Economic Influences

In this complicated epidemic, it is also important to take note of the context in which Malawians live their lives, particularly regarding economics and poverty. Economics, access, and policies are an integral part of the entire HIV/AIDS picture in Malawi. Therefore poverty is an important consideration as a part of the economics that Malawians face. For instance, health care access is problematic in Malawi due to the cost of health care as well as the lack of an adequate health care system that reaches the rural areas. Furthermore, there is also the problem of limited transportation available for rural villagers to go to a clinic, or a hospital, with the exception of walking²⁵. But economics does not just stop at poverty or access to health care; it

²⁵ Most Malawians walk or hitch a ride on various methods of transportation (bicycles, cart pulled by oxen, or the backs of pick-up trucks); “buses” are few and far between, and usually packed to the brim (sometimes you can see people hanging out of the windows). There are a few charter buses (comfortable bus rides) between cities (but having personally been on one that broke down on the side of the road about half an hour from my destination and not knowing when one would come to replace it), it was easy to see that that was not a common form of transportation for the average citizen as of yet due to both

extends to the availability of work, related migration of men (who usually are the ones that migrate for work), and developmental growth of the country. While the latter issue is beyond the scope of this dissertation, the availability of work and the migration of laborers definitely is a factor to consider within the umbrella of the gendered perspective with respect to division of labor, responsibilities, and accompanying social behavior. Tersbol (2006) discusses the economic impacts on men in Namibia—also located in southern Africa, which is not dissimilar to the impacts that Malawian men are facing, which seems to indicate that there are men in sub-Saharan African countries facing some similar issues relative to HIV/AIDS, despite other aspects of life being quite different and diverse. In Malawi, there has been a rise of *ganyu*²⁶ labor which is a casual form of labor that originally was a beneficial exchange in rural areas but has now become a short-term, desperate solution for hunger or emergencies for those who have no alternative means of income (Bryceson, 2006).

Men are forced to migrate or drop out of school in order to provide for their families, or for a future spouse, particularly because of the societal pressures that place the expectation of economic and material care on the men (although there have been considerable efforts on empowering women and enabling them to engage in self-financing programs in order to subsist in the absence of the male head of households, or to provide additional income). This migration of labor, despite having been the case historically, may contribute to the trends of men's sexual behavior and extramarital

reliability and cost. These are all personal observations from my stay in Malawi, and it is acknowledged that public transportation is improving, but a majority of people still walk as the primary mode of transportation.

²⁶ *Ganyu* labor is "a longstanding form of *ad hoc* casualised rural labour" (Bryceson, 2006, p. 174)

affairs, particularly when men have had to travel to neighboring countries for work. In some of the studies reviewed, connections have been made between the migration of men for work and their sexual behaviors, which contribute to putting women at risk for HIV since there appears to be an association between those men who travel for work (particularly out of the country) and the tendency to have multiple sex partners.

To emphasize, it is important to consider that HIV prevention discourses must be inclusive of not just individual actors but “in the systems and institutions of modernity...” (Esacove, 2010, p. 100). These “systems and institutions” consist of bigger and more complex issues than behavioral changes, individual knowledge and navigation of the epidemic, individual onus of protection strategies, and individual empowerment. Infrastructure issues, availability of sustainable work, societal pressures, foreign aid programs and foreign NGO agendas, governmental priorities, and economics all play their part in the complexity of the epidemic in Malawi. Baylies (2000) also discusses the need to consider the political and economical context surrounding AIDS, in order to utilize prevention and intervention strategies that are of a more sustainable nature. Esacove warns against the oversimplification of analytical models that feed into the gender relations and erroneous “help” of foreign policy programs in HIV/AIDS.

Ethical Considerations

To further understand the complexity of HIV/AIDS issues and look at the systemic, bigger picture than just individual navigation as mentioned, there have to be ethical considerations. Ethics refer to the incorporation of cultural differences, ideological outlooks, and contextual discourses—dominant versus appropriate—with the

approach or perspectives of program and policy. Programs and policies are largely influenced by the Western world, considering that Malawi has been a country that receives, and has received, millions of dollars in funding and donations. Health care systems have been set up utilizing the Western ideologies of individuality and “confidentiality” which have been argued to be contrary to the “ubuntu²⁷” notion of the communal people of Malawi. Although associated stigma understandably promotes the notion of confidentiality, it has been questioned whether it is the most useful notion in a culture that is not individualistic and in a country where AIDS is a huge concern. Such ethical questions and debates must be considered in the fight against AIDS because researchers and program implementers alike must understand the local contexts that may differ from their own cultural lenses (i.e. western ideologies versus non-western ideologies).

Esacove (2010) analyzes the discourse under which most prevention programs are directed, and concludes that the conceptual framework of misguided heteronormativity with respect to Malawians and Africans in general is enabling for an oversimplification of analytical models with regards to HIV prevention. Considering most prevention efforts were driven from the West, Esacove’s study brings up a valid point that cultural and social perspectives need to be considered—and that HIV/AIDS prevention programs should not be a “one-size-fits-all” that originates from the West.

Additionally, Esacove (2010) outlines a “public narrative” in existence that seems to lend itself not just to oversimplified analysis but also a false dichotomy that Freire

²⁷ *Ubuntu* refers to the communal idea of the Bantu people (of which Malawi is a part) as opposed to the individualism that is dominant in the Western world (Ndebele, Mfutso-Bengo, & Masiye, 2008)

describes. It is not just an issue of men versus women, good sex versus bad sex, heterosexuality versus homosexuality, etc.; these are false dichotomies. Women must be empowered but men must also be lifted out of the gendered outlook where women must catch up to them, and will catch up to them to only to disempower and marginalize them. This supports the argument that both genders must be uplifted, even if it means doing it in different ways for each gender according to each situation.

Furthermore, Setel (1996) indicates that each community already has its own very powerful epistemology of AIDS informed by the social and cultural environment of that community, and that formal health care sectors and AIDS education/prevention programs must understand that theirs is only an added voice to what already exists. For instance, in the Kilimanjaro area of Tanzania, Setel (1996) studied the emergence of a concept (or the creation of an archetypical youth) linking AIDS to a degradation of moral character of the community's youth, combined with the demographic and economic shifts that contributed to the risk in these communities. This sort of "moral" argument continues to this day; religious influences contribute to this argument that due to the degradation of moral character, HIV/AIDS has become so prevalent²⁸. And in fact, studies have stated that religious influences contribute to mixed messages in Malawi about HIV/AIDS and its prevention (Houston & Hovorka, 2007; Rankin, Lindgren, Kools, & Schell, 2008).

This leads to programmatic issues where NGOs and governmental organizations need to understand what is happening "on the ground" so to speak, and suggests that

²⁸ Sentiment expressed during a personal communication with a Malawian youth pastor in Lilongwe, Malawi.

perhaps the better interventions/prevention programs may be those that are created with input from the adolescents who are already impacted by the epidemic. I believe this is a key point to understand in developing and maintaining sustainable and effective prevention programs; and who better to help us understand them than those who are the navigators in such a social and cultural environment?

Chapter 3: Problems and Objectives

Previous studies emphasize that awareness of HIV transmission and the toll the disease can take is not the primary issue in the problem of high HIV/AIDS prevalence rates and consequences of the epidemic in Malawi, or in other countries in the sub-Saharan region for that matter. A majority of Malawians interviewed or surveyed in studies are aware of the virus and related physiological symptoms of the disease itself (Kaler, 2003; Kohler, Behrman, & Watkins, 2007; Schatz, 2005; Watkins, 2004). Yet the disparity between knowledge and behavior has been a repeated question that has arisen in the research, in addition to being a puzzling and frustrating public health concern.

Despite the frustration, some of the articles reviewed have noted that some behavioral changes appear to be occurring, as far as protective measures taken by both men and women. Women are choosing to divorce their husbands if they are discovered to be having extramarital affairs and men are acknowledging that this is a possible course of action for unfaithful spouses, even when initiated by a woman; men are beginning to reduce their numbers of extramarital partners; some are choosing to be faithful to their marriage partners; and condom use is increasing, albeit slowly. While this may be cause for optimism, the need to tailor culturally and socially appropriate prevention programs does not go away. These measures may reflect some behavior changes, but in light of the dangers of HIV/AIDS, the behavior change is not occurring fast enough in order to decrease the prevalence rate and decrease the concern over the toll of this epidemic. Thus, the various campaigns including those that aim to empower

women and give women the ability to use female condoms, albeit important, are only a part of the entire picture.

Prevention campaigns have long stressed condom use (primarily male condom use) as one of their primary strategies of prevention but ironically it has contributed to the lack of success in such campaigns. There has been a lot of research focused on condom use in Malawi, and despite the efficacy of condoms as well as the knowledge of that efficacy, in practice, there appears to be very minimal use of the condom. For instance, Kalipeni and Ghosh (2007) found in their study that condom use was extremely low at 8% of the respondents (n = 57 men), and that more education did not translate to better protective behaviors. This is not the only study conducted that has reported low condom use among its participants. Schatz (2005) also indicated low condom use at 5% of 995 women and 23% of 682 men, using 1998 MDICP data. This number is alarmingly low, despite the fact that condom use is a highly effective method for HIV prevention. A study conducted by Bracher, Santow, and Watkins (2004) demonstrated the potential for consistent condom-use and related percentage of women's life-time risks of acquiring HIV; using a microsimulation model with biological data from women in rural areas of southern Malawi, the results of the study found that consistent condom use with non-marital partners could decrease women's life-time risk of acquiring HIV, going from a 42% lifetime risk with no condom use to a 17% lifetime risk with universal condom use.

The reasons for low condom-use are not economic; studies point to condoms being a contentious issue in couples invoking a devaluation of pleasure with its use. In

long-term relationships, suggestions of the use of a condom are the equivalent of raising suspicions of mistrust in partners. Studies have also reported various myths associated with the condom, such as it having holes that are large enough for the AIDS virus to pass through and the manufacturer (not being African, or Malawian) deliberately places the virus within the condom. And furthermore, the use of the condom interferes with family planning.

The potential source of the myths and mixed messages about condoms point to yet another aspect of the big picture: social networks. An adolescent is not isolated in their communities but instead they are part of a social network. These social networks are also being recognized as playing an important part in behavior change, impacting risk perceptions, and influencing prevention, and they have become the focus of several studies (Gerland, 2004; Helleringer & Kohler, 2005; Kohler et al., 2007). In fact, Gerland (2004) reports that, social isolation for women, in particular, carries a huge negative impact on risk perception and knowledge gain with regards to HIV/AIDS. These studies also examine one of the strategies that men and women tend to use when selecting a partner—consulting their social network of friends and relatives (one of the increasingly more common strategies used to diminish chances of getting infected). There's a "local knowledge" base (Watkins, 2004) that people access when trying to select a partner and/or determine whether they should use condoms with a certain partner. These social networks maintain an important place in HIV/AIDS prevention, knowledge, and navigation, particularly for adolescents; not only do they provide adolescents with needed information about who is a good partner for them or

not but these social networks also contribute and/or reinforce ideas of masculinity and relational interactions.

Furthermore, social networks also include such organizations as churches, NGOs, village communities, along with influence from the government. As such, numerous efforts have been made in creating an effective prevention program with collaborations between NGOs, the government, the church, and local communities. However, conflicting messages about HIV/AIDS prevention and transmission have hindered these collaborations from achieving their effectiveness according to one article by Houston and Hovorka (2007). For example, in a prevention campaign, called the “ABC” campaign—abstinence, be faithful, and condom use/condomize—most parties participate in promoting abstinence and faithfulness but hesitate in promoting condom use due to the perceived message associated with the advocacy of condom use. Houston and Hovorka (2007) also addresses this lack of unity between the national strategy and those collaborating at the local levels, namely the churches, teachers, and traditional elders of villages and communities, but the article continues to stress social networks as a crucial entry point for promoting behavior change in Malawians.

Another point of consideration is stigma, which is closely tied to HIV as well as gender roles in terms of behavioral expectations as well as interactions in social networks. Stigma by gender impacts behavioral change with regards to multiple sex partners—men are expected to have numerous partners whereas women are expected to remain monogamous. But stigma also impacts the understanding of sexual behavior, trust within a relationship, and accurate HIV/AIDS knowledge in general.

Cultural stigma and taboo hold parents silent in their relationships with their children—there are virtually no discussions of sex, sexual behavior, and the like, apart from the generalized gender expectations and advice given to boys versus girls (to girls: be monogamous and be very careful; to boys: boys will be boys) (Lindgren et al., 2005). And cultural stigma also influences homosexual relationships which are considered very taboo in Malawian culture, where it is illegal to be gay²⁹. Facing this sort of stigma, it is highly likely that despite being homosexual, men make an effort to present themselves as heterosexual. Sex workers are also stigmatized and brothels are illegal, so sex workers are unlikely to come forward and get tested for HIV.

Interestingly, a study finds that those who are HIV-positive are more willing to talk openly about their status (Morah, 2007) and that perhaps the source of stigma was not within those who are infected but rather elsewhere (from health workers and the like). Morah also stated that perhaps the issue of stigma is over-exaggerated in southern Africa albeit definitely a consideration and recommends studying the sources of stigma. This is interesting in contrast to those studies that find that stigma around HIV/AIDS is so serious of an issue that it is equated with the violation of human rights (Kohi et al., 2006; L. Makoae et al., 2008).

Taking into account the multiple facets of the HIV epidemic, quantitative studies can only reveal certain results; analyzing qualitative data yields a more in-depth understanding of what impressions, attitudes, and understanding adolescents have and carry with them—things that are difficult to quantify. As such, this study proposes to

²⁹ In May of 2010, President Mutharika, after much UN pressure, did pardon a couple that had been jailed and sentenced to 14 years in prison for being openly engaged the previous December (see <http://www.nytimes.com/2010/05/30/world/africa/30malawi.html>).

conduct a secondary analysis of in-depth interview transcripts collected by Michelle Poulin from a male perspective. Secondary data analysis is usually conducted with quantitative studies, with statistical analyses and hypotheses testing conducted from various angles to see different segments of the data. However, secondary analyses of qualitative data are few and far between. But the topic is not new, and will be discussed further in the methodology section.

The qualitative interview transcripts used for the current study were originally collected for several other studies (Clark et al., 2009; Poulin, 2006, 2007) and were collected as part of a larger research project (the Malawi Diffusion and Ideational Change Project, hereafter MDICP³⁰). These studies examined young people's response to the disease reflected in relationships and sexual behavior from a primarily female perspective. Poulin (2006) examined the sexual and social relations of young women as well as how they exercised agency amidst the difficulties of this epidemic in the northern and southern regions in rural Malawi; she also examined the validity of gift-exchange as a real relationship rather than one of transactional sex and the ability of women to exert control over their own bodies (2007). Clark and colleagues (2009) discussed women's marital aspirations and sexual behavior related to HIV/AIDS and how the findings point to exertion of agency by women for their own protection in the

³⁰ The Malawi Longitudinal Study of Families and Health (or MLSFH), formerly known as the MDICP and will continue to be referred to as the MDICP for the purposes of this paper, is a multi-phase research project that originates from the University of Pennsylvania's Population Studies Center with funding from the National Institute of Child Health and Human Development (NICHD) and the Rockefeller Foundation as well as various other funding sources. MDICP's broad goal is to investigate the role of social interactions in changing demographic attitudes and behavior, particularly related to but not restricted to HIV/AIDS. More information about the MDICP and related research components can be found at www.malawi.pop.upenn.edu.

epidemic. The study also revealed that beyond women's exertion of agency condom use and sexual behaviors differ in those that are engaged to be married and those that are married, as opposed to expected differences between those that are engaged and those that are just dating. These studies concluded that these patterns in adolescent relationships are significant issues that have implications for prevention policies that are more tailored to adolescents.

Yet these same transcripts examined from a male's perspective—especially in light of the study conducted by Izugbara and Undie (2008)—could attest to these premarital and marital relationships reinforcing the perception of the fragile masculinity that needs to be protected. Thus, potentially the ability of women to exert control over their own bodies and over their own desires for particular partners may contribute to the anxiety that young men may have in trying to retain their “masculine” public image. These points provide more reasons for the necessity of including both perspectives in a grass-roots effort of prevention programs and campaigns because there is a mismatch between what is being prescribed by governmental, NGO, and health sector campaigns/programs and what these adolescents actually face on a day-to-day basis. While it is understandable that generally women find themselves at the lower end of the power-relations spectrum and thus the focus on women empowerment is indeed valid, men should be included in this discourse if more sustainable and long-term prevention measures are to be designed. It begs repeating Esacove's warning about oversimplifying the task at hand and utilizing a theory of heteronormativity that does not apply to such a complex issue in a different culture (2010).

Thus, the objectives of this study are as follows:

- To examine the attitudes and perspectives of young Malawian males with respect to relationships, HIV/AIDS, and related issues;
- To analyze these perspectives for any common/unifying themes across the male interviews or if any themes stand out as different and see if any of such themes might explain the disparity between knowledge and behavior as well as provide insight into any potential barriers to prevention, issues to be mindful of, and how their perceptions of the disease (including the knowledge of their status or lack thereof) play a part in helping or hindering prevention;
- To make policy recommendations and recommendations for future research that are informed by the themes and patterns from the male interviews that will complement any empowerment work done with women.

Chapter 4: Methodology

Secondary Analysis of Qualitative Data

A secondary analysis of qualitative data is generally uncommon but not unprecedented. In fact, there have been some discussions regarding secondary analyses of qualitative data such as Heaton (2008), van den Berg (2005), Szabo and Strang (1997), among others. Secondary analysis of qualitative data has brought about some controversial arguments regarding not only the usefulness of re-analyzing qualitative data but also regarding the feasibility of such an analysis and the ethics surrounding it.

Heaton (2008) identifies five types of secondary analysis:

- supplementary analysis (analysis of an aspect of the data that was either only partially addressed previously or not addressed at all)
- supra analysis (analysis aims and objectives that transcend those of the original research)
- re-analysis (re-examining data to confirm and validate findings of the original study)
- amplified analysis (utilizing two or more qualitative data sets for comparison or combining them for analysis)
- assorted analysis (analyzing existing data alongside additional collection and analysis of primary data for the same purpose; or mixing naturalistic and non-naturalistic data for study).

This study falls under the *supplementary analysis* categorization, as analysis of an aspect that was only partially addressed in the original study will be the primary focus.

The discussions regarding a secondary analysis of qualitative data indicate the advantages of conducting a secondary analysis as primarily one of convenience and cost-effectiveness as well as maximum use of the data. Obvious reasons such as finances, time, and logistics make secondary analysis advantageous to researchers, whether it is qualitative or quantitative. In the case of qualitative research, it presents research with cost-effective options such as saving time and difficulty in arranging to travel to sub-Saharan Africa from the United States (particularly Malawi as there are no direct flights from the North American continent), arranging accommodations, travel within the country (as much of Malawi is still rural and semi-urban and the public transportation infrastructure is not as developed as other places), and acquiring consent, translators/interpreters, and the like. With funding, this would be a large undertaking; without funding, the costs and logistics can almost be prohibitive to such a study, despite the fact that I was born and raised in Malawi and would not be a complete foreigner.

Furthermore, the richness of qualitative data allows for maximum use of data. Qualitative interviews contain a rich amount of information that may not only pertain to one or a few research questions but other relevant research questions that the interview can shed light on. And, in cases of sensitive and private topics, secondary analysis of qualitative data also enables different research questions to be examined

without revisiting the participants to have them endure a second or third round of in-depth interviews (Szabo & Strang, 1997).

Primary discussions of limitations include the potential for decontextualization and the limits to theoretical sampling, in addition to other limitations which will be discussed in more detail later. Szabo and Strang (1997) cover two dominant limitations in the use of secondary data analysis: the lack of control in generating the data set and the inability to follow strictly the guidelines of the chosen data analysis method. The lack of control in generating the data set refers to the conception, generation, and/or recording of data as well as any biases or problems that arose when collecting this data. In a secondary analysis these procedures of data collection are in essence not there because the data has already been recorded and collected.

The inability to strictly follow the guidelines for the chosen method for data analysis refers to the difficulty carrying through strict techniques of a particular methodology of research because the techniques of data generation and sampling are not applicable. For example, if a particular methodology calls for theoretical sampling, this in its strictest sense would not be applicable in a secondary analysis.

Szabo and Strang (1997) also discuss ways that these limitations may be overcome. One particular way of overcoming the lack of control in data generation issues, they suggest, is to maintain close communication with the original author(s). Furthermore, they recommend that in order to overcome the inability to adhere to the guidelines of the chosen methodology for data analysis, it is best to utilize a data source

that has large enough data so that while theoretical sampling, for example, may not occur as accurately to the letter, it can still occur appropriately in the secondary study.

Heaton (2008) also describes three main areas of debate in the literature regarding secondary analysis of qualitative data, which include the question of data re-use being in keeping with some of the fundamental principles of qualitative research (issues such as problem of data fit, problem of not having been there, and problem of verification), ethical and legal issues (such as those pertaining to confidentiality and consent), and sources of data (publicly archived data versus other informal sharing of datasets). However, Heaton does not further add to the debate except for advocating the inclusivity of incorporating other datasets and acknowledging that authors will frequently re-access their data for subsequent study as well as share them informally with others who are interested, rather than simply publicly archiving them.

The Original Study

The original study for which the data was gathered was a project conducted by Michelle Poulin for her doctoral dissertation (2006) as well as consequent studies that were published (2007, 2009). It was a mixed methods study utilizing the in-depth interview, survey data, and biomarker results, which were all part of the MDICP currently on-going in Malawi. The study sought to answer several questions related to adolescent sexual relationships and HIV/AIDS. More specifically, the study focused on the link between marriage and AIDS, the influence of schooling on sexual activity, social network differences between those attending school and those not attending school, a

connection between money for sex, and the choices of women in these sexual relationships. Additionally, the study primarily focused on the perspective of women and their roles in the epidemic and in sexual relationships as adolescents.

The original qualitative project focusing on adolescents' attitude and sexuality conducted 131 in-depth interviews drawn from the larger sample of MDICP-3 participants in two of the three project sites: Rumphi that lies in the north and Balaka in the south. The project's sampling strategy was not designed to be representative of the national rural population but was instead designed so that sample characteristics resembled those of a Malawi Demographic and Health Survey. Interviewees were selected at random after stratifying by region. While the adolescents were ages 15 to 24, the age range was further divided into a younger cohort (15 to 19 years old) and an older cohort (20 to 24 years old) to reflect the age distributions in the regions. 49% of the sample in Rumphi was in the younger cohort and 51% was in the older cohort; 61% of the sample in Balaka was in the younger cohort while 39% was in the older.

In order to conduct the interviews for the original research project, Dr. Poulin hired several local interviewers after intensive training³¹ (who spoke both the local language—primarily Chichewa and Yao—and had a good command of English) along with a pilot study, to conduct these interviews, with supervision, in two rural areas: Rumphi in the north, and Balaka in the south. Interviews were conducted without the use of tape recorders as it was noted that during the pilot study some participants

³¹ See Appendix for a copy of the training guides utilized to train interviewers as well as the informal interview guide—both provided by Dr. Poulin and included with her permission.

found it rather intrusive and thus became reluctant to respond to conversation about personal and sensitive information. The interview guide was loosely structured and included seven broad topics that were garnered from the initial pilot study: 1) partnership beginnings and endings, 2) gift and money exchanges, 3) sexual behavior, 4) partner and partnership characteristics, 5) marriage values and expectations, 6) conversations with friends, and 7) perspectives on formal education. See Appendices 5 and 6 for the original project interview and training guides.

Data

A total of 131 in-depth interview transcripts were made available via the MDICP project in conjunction with MDICP-3 from 2004 upon contacting Michelle Poulin regarding her studies. In addition to providing the data, Dr. Poulin has also agreed to be a member of my dissertation committee. All interviews were anonymized using *QualAnon* during Dr. Poulin's work and prior to my receipt of the transcripts.

*QualAnon*³² is a web-based tool that can be utilized to anonymize qualitative data that takes a user-generated name key to utilize pseudonyms for identified names. Thus, there are no identifiers that link the names in the interview data to the participants of the original data collection.

Although the original study includes qualitative data based on interviews with both men and women, only those interviews conducted with men were selected for the purposes of this study. Thus the interview transcripts were separated into folders for

³² <https://www.icpsr.umich.edu/icpsrweb/DSDR/tools/qualanon.jsp>

men and women, after which the transcripts of interviews of men were uploaded into the qualitative software program selected for this study. Interpretive analysis with the use of software (Atlas.ti version 6.2) was conducted on the in-depth interviews with men.

Quantitative data for adolescents was also available through this project and is also available for incorporation. The MDICP quantitative data was collected via survey, comprising of people from ages 15-49 living in rural areas of Malawi, covering three different regions (north, central, and south) at 4 different periods of time (1998, 2001, 2004, and 2006). MDICP-1 (1998) interviewed 1541 married women and 1198 men; MDICP-2 (2001) followed up with the same population, excluding those who died (1571 women and 1097 men, which included 186 new wives and 28 new husbands); MDICP-3 (2004) interviewed 400 adolescents ages 15-29; MDICP-4 (2006) expanded the interview to collect data regarding the role of social interactions on the AIDS epidemic. However, considering that this is a secondary analysis of qualitative data, the quantitative data was not utilized.

Sample and Fit of Data with New Question

As mentioned previously, the original study examined adolescent sexual relationships in the northern and southern regions of rural Malawi utilizing various sources of data that included in-depth interview transcripts. The original study employed a sociological perspective and focused primarily on women and their social interactions. However, the data sample contains in-depth interviews from both men

and women, which provides rich information to examine perspectives from the adolescent men's perspective and appears to be a good fit for this study's proposed research questions.

In analyzing the in-depth interview transcripts, this secondary analysis sought to answer research questions pertaining to the men's perspective but takes a more social welfare perspective (the study's relevance to social welfare is discussed in Chapter 1). Albeit there are myriad issues that impact HIV/AIDS and its prevention, this study narrowed its focus to just a few of these issues from a gendered perspective in the context of Malawi: sexual behavior/behavior change patterns, stigma and consideration of any ethical and economical contexts. This study also proposes a focus on understanding the local context in which adolescents navigate, hoping to shed some light on the frustrating disparity that seems to exist between people's awareness and knowledge of HIV and actual measures of self-protection (Izugbara & Undie, 2008; Kalipeni & Ghosh, 2007; Palekar, Pettifor, Behets, & MacPhail, 2008). Although the issues of religion and spiritual traditions will not be addressed to its full extent in this study, it is important to note the impact of such institutions such as church and spirituality in an analysis of the complex context of HIV/AIDS as they are a part of the factors that contribute to the social construction of genders in any given community as well as influence the social behaviors of the community.

This study chose to target the adolescent males (ages 15 to 24) as young people are the most likely to be those who are newly infected as they begin their sexual debut around these ages. Not only is the epidemic a major threat to their health and well-

being but it is one of many issues with which they must contend as they make up a vital part of the country's future and already contribute to society. These adolescents do not simply engage in risky behavior which exposes them to the possibility of becoming HIV-positive but also incur the possibility of becoming transmitters of the infection to others and to their children as they begin courtship, get married and start their own families.

Limitations of a Secondary Qualitative Analysis

Previously the limitations of a secondary analysis were discussed with the primary limitations being the lack of control in data generation as well as the inability to strictly adhere to the established guidelines for particular methodologies. One of the ways the limitation of lack of control in data generation can be overcome, according to Szabo and Strang (1997) is by maintaining close communication with the first author(s). In the case of this study, the first author will be on the dissertation committee. Therefore, in addition to being a reviewer of the dissertation and its results, the first author will be available for questions and consultation with regard to the data analysis. Thus, it is felt that this limitation can be overcome.

One of the recommended ways to overcome the limitation regarding the inability to strictly adhere to the guidelines of the selected methodology is to ensure that the original data set is large enough. The original data set consists of 131 in-depth interviews from two different regions of the country, with 66 male interviews and 65 female interviews. While only male interviews will be selected and utilized due to the focus of this study being specifically on male perspectives, should there be a need, the

female interviews are also available for cross-referencing if necessary to address the patterns that arise from the analysis. Thus, it is felt that 66 interview transcripts is a large enough data set to overcome the inability to strictly adhere to guidelines for qualitative analysis.

Methodology for the current study

The 66 interview transcripts were sorted by identifying whether the participant was male or female. Then the male interview transcripts, which were in Microsoft document format, were imported to Atlas.ti and each transcript was reviewed and coded. Two transcripts were discarded after discovering that they were duplicates of two other transcripts, resulting in 64 unique transcripts for analysis. Analysis of the transcripts was conducted following grounded theory methodology (Glaser & Holton, 2004; Glaser & Strauss, 1967) . Each transcript was coded minutely using open coding and then re-examined for reoccurring codes, patterns, and themes. After coding all the transcripts, the coded segments were reviewed in order to ensure that each quotation expressed the appropriate concept reflected in the code (i.e. "reasons for condom use/non-use" versus "ideas of condom use" – the latter being a more general impression of condom use rather than a reason for personal use or non-use) and then compared to the other coded quotations in the same category.

Upon review of coded segments for accurate coding, transcripts were analyzed for patterns and themes. Related and associated codes were analyzed further and grouped into larger networks surrounding broader themes, which then assisted in drawing a bigger picture of topics that seemed to be a running theme throughout the

transcripts (such as condoms, HIV/AIDS awareness, and economics). Associations and relationships with codes and patterns from which certain information could be pieced together, along with the themes, were examined particularly with a focus on those topics that arose that provided any interesting insights into these adolescents' lives that helped paint a picture of the cultural background and differences were noted for discussion.

There were challenges and limitations in attempting to strictly adhere to grounded theory methodology due to this study being a secondary analysis as was pointed out in the discussion of limitations of such a study. Theoretical sampling, for example, was not possible. Additionally, further clarification or probing of some statements was not possible and essentially had to either be ruled inconclusive or just taken as stated. However, with 64 transcripts to work with, it was felt that the sample size was fairly substantial to overcome some of these challenges. And due to the original interviews being loosely structured (beginning with topics of interest with questions for probing) the pattern of questioning was more similar to the procedures of a classic grounded theory study.

Furthermore, utilizing the TTM's stages and processes of change, each participant's attitudes and reasons were examined to see if there was any indication of what stages these participants might be in. Reasons for condom use, non-use, or inconsistent use were examined as well as any personal expressions of decisions of abstinence or behavior change. Prochaska and colleagues (1994) applied TTM to HIV prevention and provided some examples on where an individual might be pertaining

specifically to HIV prevention; these examples were helpful in examining the transcripts with respect to specific HIV prevention methods and awareness/knowledge of the epidemic overall.

Chapter 5: Data Analysis and Results

Analysis of the interview transcripts yielded some interesting patterns and key themes that will be noted in this section. While there is a wealth of information in these interviews, findings reported are those that appear to permeate through a majority of the 64 interview transcripts as well as those that appeared to address the problems and objectives that arose from a review of literature. Predominant themes centered on condom use, economic issues, school challenges, and relationship dynamics (both with peers as well as partners). Some descriptive information regarding the adolescents in the sample is summarized in Table 5. Participants' ages ranged from 15 to 25 years of age. Most were in school, some were drop-outs or had never gone to school before, and some were married.

Table 5. Age, Marital status, and Education status

	Number of participants	Number in school ³³	Number of drop-outs ³⁴	Number married
Age 15	8	8	0	0
Age 16	7	7	0	0
Age 17	3	3	0	0
Age 18	10	9	1	1
Age 19	6	4	2	0
Age 20	3	2	1	0

³³ Number in school includes those participants who have finished secondary school but did not pass their examinations for college or those who cannot afford to pursue a college education.

³⁴ Number of drop-outs includes those participants who have never gone to school before as well as those who did not mention whether or not they were in school; after examining their transcripts, it was ascertained that they most likely do not attend school

Age 21	5	0	5	1
Age 22	6	1	5	3
Age 23	4	2	2	1
Age 24	1	1	0	0
Age 25	3	0	3	3
Age not mentioned	8	4	4	2
Total	64	41	23	11

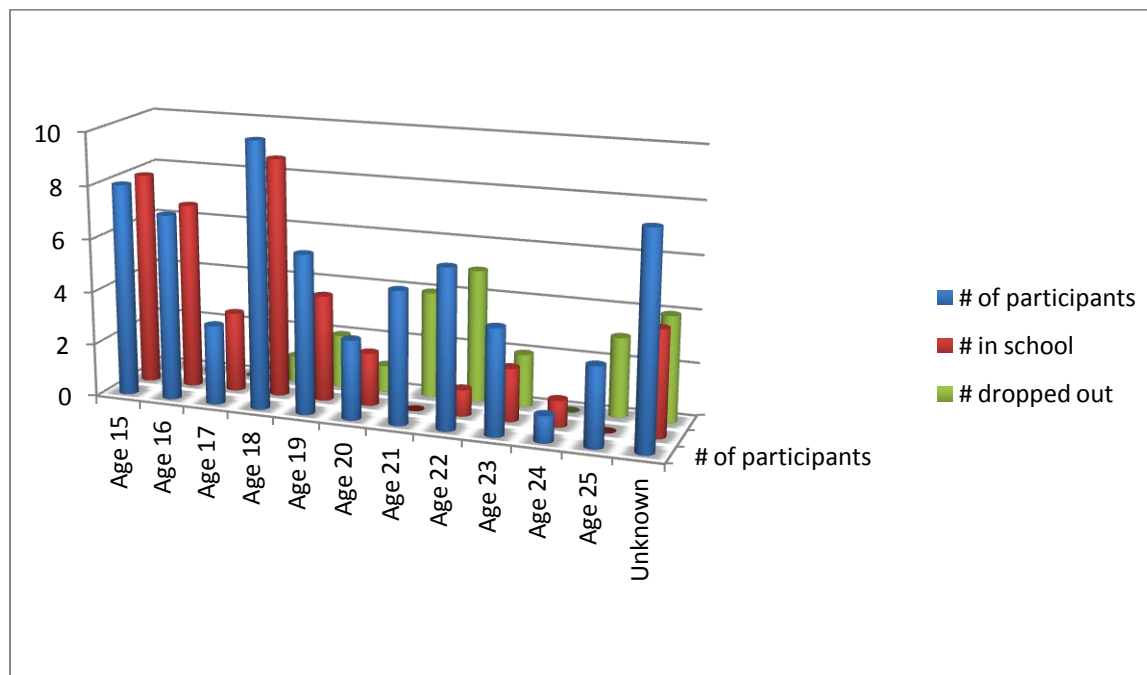


Figure 3. Graphic Representation of Age and Education Status

A majority of the participants mentioned the personal use or non-use of condoms in current and past relationships, except for a few that mentioned that they have never had a sexual partner and are abstaining. Out of 64 participants, 12 mentioned the use

of condoms consistently throughout their interviews and with each of their partners; 23 stated that they did not use condoms at all consistently with each of their partners. 17 participants indicated that they used condoms sometimes and sometimes did not. The remaining 12 participants indicated that they are abstaining, ten of whom have never had a partner previously while two of them indicated that they had a girlfriend but had no sexual encounters with them and plan to abstain in the future. See Table 6 for a summary of participants, condom use, and behavior change.

Table 6. Condom use and behavior change

N = 64	Use condoms all the time	Do not use condoms at all	Use condoms sometimes	Had a girlfriend but no sexual activity	Abstain
Number of Participants	12	23	17	2	10
Behavior change to abstinence	0	4	1	2	n/a
Behavior change to condom use	n/a	3	3	0	0

Economic issues revolved around the need for participants to work and make money for various daily needs, school fees, and relationships. All participants indicate being involved in some sort of work. Most work that participants were involved in was *ganyu* – doing manual labor for a fee. Because of the need for money, particularly with parents’ income not being enough, participants demonstrated their need to make

money for purchasing necessities, pay school fees, and spending it on relationships. Some participants have dropped out of school in order to make more money while others have dropped out due to their parents not being able to afford school fees anymore. A few participants who had completed the secondary level of school could not afford to continue on to college due to these financial constraints. Beyond economic issues influencing school drop-out, additional school challenges were documented with those adolescents wanting to return to school but facing ridicule due to the age and grade-level mismatch after being out of school for a year or more as their peers have already moved on.

With regards to relationships, most participants indicated that they have had more than one sexual partner up to the point of interview. Age did not seem to have an influence on the number of partners. Of those who mentioned how many partners they have had in the past, the number of partners ranged from one to 4, with one participant mentioning he has had 10 girlfriends although not all for the purpose of sexual activity. A few indicated that they have never had any partners at all and one participant indicated that his wife was the only partner he ever had. Results also indicated that some adolescents had multiple, concurrent partners and concurrent partnership was not always initiated entirely by the young men or by the young women; rather, both genders initiated in multiple concurrent partnerships.

Peer relationships also appeared to be an important theme for these adolescents as well as larger social networks such as religious institutions and public media. Most of the young men interacted with their peers, whether at school or at the football pitch.

Some talked about girlfriends, relationships, and HIV/AIDS while others discuss education. Peers appeared to be one of the trusted sources of information as well as a source of pressure regarding girlfriends. Public messages of prevention also appeared to be a trusted source for some participants, specifically messages heard from church, mosque, and radio.

Cultural taboos and traditions were present in these interviews as well as typical teen-parent relational dynamics, whether explicitly addressed or not by the participant and the interviewer. Most participants did not mention that his parents were aware of his personal relationships with women. Even when an interest is there to marry a young woman, young men indicated that they approached the young woman's aunt rather than her mother in order to propose interest and begin courtship. Parental involvement therefore seemed to be minimal up until the issue of marriage comes up on a more serious level for various reasons. Cultural practices for these adolescents also included the separate physical housing of children and adults. Adolescents mentioned that they met their partners late at night, leaving their own housing to sneak into their partner's housing where they slept with their siblings or both partners leaving their own dwellings to meet in a designated area.

Another interesting result was that most adolescents did not explicitly mention HIV/AIDS. Even for those who used condoms expressed that they used them because they were afraid of catching STIs or "diseases". It is not certain whether or not this is the language used in prevention/intervention programs but despite the interviewer's free use of HIV/AIDS, the adolescents do not seem to utilize these acronyms.

Interviewers did ask about HIV/AIDS to ascertain adolescents' awareness but adolescents did not offer up the expressions as frequently as the interviewers did.

In relationships between young men and young women, traditional gender stereotypes did not seem to be typically or overtly present. This was particularly apparent in the topic of condom use where choice did not primarily reside with one gender; in fact, choice was frequently exerted by women rather than the men. This was not just in the insistence on condom use but also in the refusal of condom use. Women also were noted to ask these young men for money when in relationships. Stereotypical gender roles and power relations were not overtly represented in these interviews. And as mentioned previously, gender did not necessarily determine concurrent multiple partnerships.

With respect to willingness or readiness for behavior change, according to the stages of the transtheoretical model of change, the participants primarily appeared to be either in the pre-contemplative stage or in maintenance/action stage. Although 13 participants made a behavior change to abstinence or consistent condom use, 16 participants (out of a total 23) who stated they did not use condoms all the time seemed to be in the pre-contemplative stage, demonstrating no intent to change their behavior. 13 participants (out of 17) who used condoms sometimes also appeared to be in the pre-contemplative stage with no demonstrated intent to change their behavior. The 12 participants who indicated that they used condoms all the time appeared to be in the maintenance stage, demonstrating consistent condom use with all partners previous and present despite probing to check otherwise. The participants who were

abstinent from the beginning as well as those who made the behavior change to abstinence and consistent condom use (a total of 25) also appeared to be in the maintenance stage expressing that they were committed to abstinence until marriage or consistent condom use for future relationships.

Chapter 6: Interpretation of Results and Discussion

Interviews reflected perspectives of adolescents endeavoring to navigate their world, where AIDS is only a part of the larger challenges they face. This group of Malawian young men were interested in relationships, believed in marriage, understood the need for an education, were struck by the need for money and a promising economic future, and had developed some understanding of the HIV/AIDS epidemic including condom use, all while negotiating the hormones of adolescence. Culturally “male” ideas did seem to permeate their perspective but subtly. The young men did not tell tales of their socialization as young boys to be “a man” but talked more of peer pressure and conformity, native to adolescence around the globe regardless of culture.

Condom Use and HIV/AIDS

One of the primary themes that arose was condom use among this group of adolescents. Condom use is one of the effective methods of prevention, according to the CDC³⁵. It is true indeed that condoms can break, but when used correctly, they are an effective method of prevention. However, some participants in this study expressed some gaps in their knowledge. They mentioned that condoms were useless because they break; they were and are not effective; they cause various diseases; and that they are useful only for family planning. 12 participants out of the 64 in this study sample indicated they used condoms all of the time. 17 participants indicated that they used

³⁵ <http://www.cdc.gov/hiv/topics/basic/index.htm#prevention>

condoms some of the time and 23 participants did not use them at all. The rest of the participants (12) indicated that they were abstaining from sexual activity.

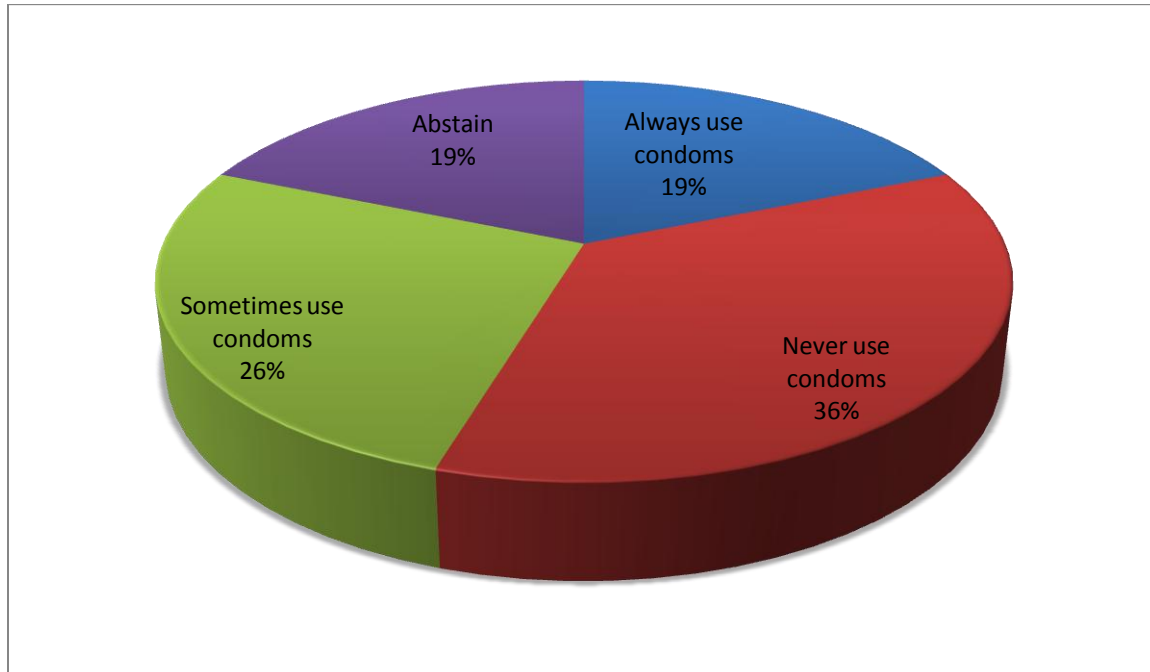


Figure 4. Participants' condom use behavior

Their primary reasons for condom use were fear of AIDS and other sexually transmitted diseases as well as unplanned pregnancies though not necessarily all at the same time. Regardless of the reason for use, the actual use of condoms in this situation is deemed to be more important than the reason for its use. And while it is important to make a note of those who use condoms, it is more important still to examine why more of the adolescents in this study indicated that they never used it or used it infrequently.

The adolescents that did not use condoms seemed to reflect frequent misinformation about condom use in particular as well as a few misinformed facts of HIV prevention. While they were and are certainly aware of the fatality of AIDS and

how it is transmitted as well as some ideas about the purpose of condoms, there were gaps in their knowledge or in converting that knowledge into practice—such as condoms do not really protect one from AIDS and are not to be trusted, thus they are not to be used. Others simply did not see the need to use it. One participant concluded that “...he doesn’t like to use them and ever since he had never tried to use from all the partners he had been having.”

Furthermore, some adolescents indicated that their reasons for non-use of condoms was because they were “too young” and did not need to worry about the use of condoms as they were for adults.

For the 3 times he had sex with her I [interviewer] asked if he used the condoms? He [participant] said that: *Zamakondomu tisanadziwe, timangoyesa za akuluakulu okha* (Chichewa meaning ‘We were not knowing about the condoms we thought were for the adults’). (*Participant #4*)

Asked to whether he [participant] was using condoms he said that was not using for he was no knowledge of condoms by then and he was young. (*Participant #5*)

Some adolescents indicated that condoms were only for those who have *chibwenzis* (girlfriends).

I don't know if a condom has its function to those in marriage. Only those who have other partners should use condoms with the outside partners. (*Participant #19*)

He [participant] said, ‘Condoms should be used by those who are not in marriage.’ He continued to say that he had never used it. He added that condoms are now common and they are sold at the cost of k5.00 only but are for those who are in *chibwenzi*. (*Participant #21*)

I [interviewer] asked to know the reasons for not using a condom. He [participant] said that those who ignore a condom say that one cannot enjoy sex

and a condom is not good for sex. He also added that some other boys say that for a chibwezi a condom is better. *(Participant #34)*

Some participants also indicated that condoms were not readily available for use while others did not believe they were necessary even for purposes such as preventing unplanned pregnancies. Some of the young men reflected the understanding that it is socially desirable to say that they use condoms but when pressed and probed indicated that they actually did not use them.

Most adolescents who did not use condoms or used it sometimes indicated that it was because they wanted to “taste the sweetness” during sexual intimacy and that “sweets are not taken while in their wrappers”.

[Interviewer:] Why not using [condoms] that day? He [participant] answered saying that he wanted to taste that day to differentiate himself how sweet one feels using the condom or not using? He laughed and I too. I [interviewer] asked: How did he felt? He [participant] laughed and said it was not sweet the times he uses the condom as compared to the time he did ‘plain’. *(Participant #6)*

I [interviewer] asked him why using [condoms] sometimes and not sometimes? He [participant] said that sometimes he wanted to feel sweet because can't feel sweet. *(Participant #11)*

And he [participant] laughed and said even if they [condoms] could not be rare, he could not have used them. Asked why, he said nothing only wanting and in order to feel sweet he laughed. *(Participant #17)*

He [participant] felt (foolish) to do sex while it is in no body contact. ‘Champepala ndi champepala, sichingawonetse kukoma kwina kulikonse’ meaning ‘You cannot feel taste when you are eating anything while it is in its wrapper.’ In short he continued to say nobody had ever eaten sweets while in its wrapper. Otherwise he can be said as a mad one. *(Participant #20)*

They did not use condoms because they had no access to them and also they could not enjoy sex if they could not enjoy sex if they could use a condom he argued. *(Participant #24)*

But the girl sometimes wanted me to be using the condoms but I was refusing just because I wanted to feel her sweet. (*Participant #50*)

Because we were young at the age of 16 but also we were not interested in using condoms because we wanted to feel sweet (sweet ukuyera mpepala cha), sweet is not taken while it is inside the wrapper. (*Participant #53*)

We were not using condoms because we agreed that sex is sweet without a condom. (*Participant #61*)

There were some myths about condoms and condom use; most adolescents either expressed information that was incomplete or simply incorrect. Several participants mentioned that they did not want to use condoms because they were useless, that they broke easily or may break/burst. Condoms can burst while having sex, one adolescent described, and then the girl can get pregnant. Another participant stated that he and his friends had no interest in condoms because they learned at school that condoms were for family planning (and thus concluded that condoms were used *only* for family planning). A third participant stated that “a condom is not 100% perfect” and “condoms are for child spacing”.

He [participant] then continued to say that he does not like condoms and it just useless to use a condom. He said, ‘makondomu sachedwa kuphulika ndiye bola kudalira Mkazi mmodzi yekha basi’ - the Chichewa expression says ‘Condoms do not take time to break and therefore it is better to have one partner only whom you trust’. [Participant #16]

Then I [interviewer] asked him, so why not using a condom yet you know that a condom also protects. He [participant] however, said that a condom is just useless because a condom may break/burst. [Participant #29]

To me I can't use them and I always hate it as it can burst while having sex and you can get sexual transmitted disease and even give the girl pregnant that can destroy the future. A pregnant girls parents will want you to marry their daughter as a result you stop school and lose your future with that case I don't

want to use them but rather abstain as that the best way for me to avoid the sexual transmitted diseases. [Participant #39]

[Interviewer:] Why didn't you use condoms?

[Participant:] She doesn't believe in condoms she said that condoms are not 100% perfect and that they can burst during sex. in that you can get pregnant or STI's.

[Participant #53]

[Interviewer:] So why not using condoms?

[Participant:] Sorry I don't trust condoms, they are not 100% perfect and its use cannot protect someone from HIV but from other STI's and for family planning, he said. [Participant #57]

Still other adolescents indicated they did not use condoms because they were not worried about unplanned pregnancies—and did not mention AIDS at all. And some of those adolescents who did use condoms indicated that they did so because they were not 100% sure of their partners' faithfulness or because they were afraid of unwanted pregnancy.

...asked why he said that he was afraid to give her the pregnant and he didn't wanted that because by then he was not even working as he is nowadays and support her during her pregnant could have become the great problem for it requires money to be buying her food, clothes even for the baby. (*Participant #11*)

He then continued to say that at every sex he had to use a condom. In addition he said that both of them share ideas of using a condom she also wants to continue with school and therefore she fears getting pregnancy. (*Participant #26*)

Yes I was always wearing a condom since I was afraid of getting sexual transmitted diseases like AIDS and I was also fearing that I make her pregnant which could make us be expelled from school. (*Participant #41*)

I was also using it and it was because I was afraid of getting AIDS and giving the girl pregnant and the parents can force you to marry her there by dropping out of school while with AIDS you just know that when you have got it then you will die. And that's the same reason why my friends also used it. (*Participant #43*)

I was mainly afraid of impregnating her; that would have made me marry before I was ready financially and materially. (*Participant #45*)

[Interviewer:] Why condoms?

[Participant:] Because we wanted to avoid unwanted pregnancy that may lead to dismissal at school. As a result, we would have dropped out of school.

[Interviewer:] What?

[Participant:] Sometimes we were afraid of STI's but that wasn't serious because we thought we were faithful to each other and that I was taking her as my future wife. So we didn't even discuss of STDs. (*Participant #56*)

We were using condoms each time because we were afraid of unwanted pregnancies. (*Participant #63*)

One particular participant described that he read from a book that condoms cause TB (tuberculosis) and cancer due to the oil in the condom.

Asked if he [participant] has another reason in mind that he declared of not using condoms, he said that it is because condoms are bad. They cause some diseases like TB. To you the man or to the woman? I [interviewer] asked. He [participant] said to both of you. Where did you hear this? I [interviewer] asked. He [participant] said that he read this from a certain book and asked if he really believed that? He said really he believes that because for such a book to be written like that it has gone through various educated people who proved to say that whatever was written in the book was true. [Interviewer:] When did you read this book? He [participant] said last year. Asked as to where he got the book from, he said from the school library. (*Participant #17*)

This same participant further stated that even his friends mentioned that condoms cause diseases and the message from religious institutions confirmed this (both Christian and Moslem).

While most of these have elements of correct information in them, aside from the last idea of condoms causing diseases, the information is not complete. Not all the adolescents expressed the understanding that condoms can be used for both family

planning and protection from HIV as well as STIs. Condoms can indeed break if used improperly but do not break if used correctly.

Some adolescents also mentioned that the introduction of condoms into sexual intimacy was the equivalent of stating that there was a distrust/suspicion of promiscuity in the partnership. One participant stated the following:

...if you think to use a condom it means you have a doubt with your partner. I don't know if a condom has its function to those in marriage. Only those who have other partners should use condoms with the outside partners. It cannot be used even for contraception. Condoms can break so they are useless. I had never used a condom; I will never use a condom. *(Participant #19)*

He answered that those who use condoms distrusts each other but he trusts his wife and the wife also trusts him. 'To use a condom means you are doubting, I don't get worried with my wife at all,' he said. *(Participant #24)*

Thus several adolescents in this study did not use condoms or tried to use them secretly. Others just assumed that there was not a need for condoms because their partner looked "healthy" and they trusted that their partners were faithful; for example one participant stated that he did not use condoms because "'sindinkakaira kuti ali ndi Flao' (Meaning I was not suspecting her having diseases)".

Condoms were by then only found in groceries and I had no money to have it and she was looking healthy that I didn't suspect her to have diseases. *(Participant #40)*

[Interviewer:] Was there any protection?

[Participant:] I didn't use anything to protect myself as I was afraid to go into the house to collect condoms as the other family members would have discovered and the mission would have failed and I rather had it plain since I was also confident that she doesn't have anything in case of sexual transmitted diseases because her husband died of Malaria early this year and I believe she was safe. *(Participant #48)*

However, this did not mean that adolescents were not aware of AIDS and its fatal consequences. They demonstrated the understanding and the seriousness of this epidemic as well as its transmission, primarily through sexual intercourse, despite the general lack of condom use or other prevention measures. Most of those who used condoms consistently indicated a fear of catching AIDS or STIs.

It was in moving past the general information of the disease that there seemed to be a breakdown of complete information about methods of prevention and application of this information to their current sexual relationships. For instance, in addition to the myths and incomplete knowledge of condoms, the interviewers asked participants if it was possible to avoid getting AIDS by getting married. Some participants mentioned that it was possible while others mentioned that it was not. Thus, the demonstrated lack of condom use cannot be attributed to their lack of awareness of the seriousness and fatality of AIDS. There must be some other factors impacting the translation of AIDS awareness into practical life applications.

These findings are consistent with some of the findings reviewed in the literature. Anand et al. (2009) reported that only 6% of participants (out of a weighted sample of 664 people) indicated condom use at last sexual intercourse. In the present study sample, considering that there is a 19% reported condom-use, one might be more optimistic about a potential increase in condom use. However, this may also be due to over-reporting. As indicated in this study sample, there were participants who initially stated that they used condoms on a regular and consistent basis but when probed further actually stated that they did not use condoms at all. This might be a more

accurate reflection of participants' true behavior as social desirability is a factor as is the understanding that consistent condom-use is a desired answer. Considering that in the literature, quantitative studies conducted with large data samples and self-reporting questionnaires have reported results of such low condom-use, it is more likely that in this face-to-face interview with the participants, the adolescents over-reported their actual condom use. Thus, this is an important factor to keep in mind again emphasizing that although knowledge is there, associated behavior is not.

Behavior Change

A variable associated with condom use that arose was behavior change particularly because these adolescents stood out from the rest. There were 12 adolescents in this sample who seemed to have actually absorbed some of the seriousness of HIV/AIDS and expressed that they had chosen to practice abstinence; 10 indicated that they had never had a girlfriend and planned to abstain till marriage while two indicated that they had a girlfriend, had not engaged in any sexual activity, and had made a decision to practice abstinence beyond those relationships. Another 11 demonstrated a change of behavior from sexual activity to abstinence or condom use. Five participants out of the 64 actually described their change of behavior from sexual activity to abstinence while six participants indicated that they would like to use condoms consistently in the future – three of whom had not been using condoms at all. The reasons for their change were varied; however, the evidence of behavior change is encouraging, although it might cause one to wonder why there were not more young

men who decided to change their behavior as 13 out of 64 is less than 20% of this study sample.

I am abstaining from sex. Afraid to catch the disease which has come nowadays.
(Participant #9)

[Participant:] 'Ndi kwabwino kumalewa zamdzikoli chifukwa Edzi yaopsa'
(meaning 'It is important to abstain because AIDS is a great risk to life.')

[Interviewer:] 'If you are telling about abstinence, Do you mean you do it?' I asked him to know if he just tell friends.

[Participant:] 'Yes I do.'

[Interviewer:] 'For how long have you been doing this.'

[Participant:] 'Since I joined the Mkisi ndi Mkisi youth club, I had been hearing about it two months ago, it when I decided to abstain.' (Participant #22)

Then I [interviewer] asked to know the kind of advice they are given at the church? He [participant] answered that [they] are told to abstain. That is why [he does] not think about sex anymore. (Participant #29)

A pregnant girl's parents will want you to marry their daughter as a result you stop school and lose your future with that case I don't want to use them but rather abstain as that the best way for me to avoid the sexual transmitted diseases. (Participant #39)

There were no notions of fatalism in this sample of young men but rather more of the adolescent ideas of invincibility or lack of seriousness regarding this epidemic; those who sometimes used condoms did not think that it was necessary to use them when his partner "looked healthy" or when they wanted to "taste the sweetness". This is not to say that they were not **aware** of HIV/AIDS as indicated previously but they seemed to not demonstrate the understanding of the connectivity between their behaviors and the potential consequences of the epidemic.

According to the TTM's stages of change, a majority of this group of adolescents for the most part did not seem to be ready to change their behavior or practice safer

sex. There were 25 participants who appeared to be in the maintenance/termination stage having made and maintained a behavior change to abstinence as well as consistent condom use; it was difficult, however, to say that these participants were in the termination stage because there was limited information to help pinpoint specific time periods that are outlined in the criterion for TTM stages. There were a few contemplating a behavior change or making a verbal indication to plan to use condoms in the future. But for the most part, those who did not use condoms did not plan to use them in the future, and those who did use condoms planned to continue to use them. Those who were inconsistent did not express any clear decision to go either way.

All participants expressed knowledge of HIV/AIDS as a primarily sexually transmitted disease. Some participants expressed incomplete information as to methods of prevention while others demonstrated a fairly comprehensive understanding of methods of prevention as well as transmission. However, this cannot be a foregone conclusion as to whether the participants have a comprehensive understanding of preventative methods or not as interviewers did not always probe for comprehensive answers related to methods of prevention or avenues of transmission; any information gathered were primarily the participants' voluntary and spontaneous expressions to open-ended questions regarding condoms. Some participants expressed the knowledge that HIV/AIDS can be transmitted via needles and blood transfusions as well as neonatally. There were those who also expressed awareness of the various methods of prevention rather than just one (i.e. condom use and abstinence, condom use and being faithful to one partner). A few adolescents also mentioned the necessity of

knowing one's HIV status and going to testing and counseling. However, only a few of them actually had participated in testing. Several adolescents participated in voluntary counseling and testing (VCT) and were aware of their results; some others had either participated and not learned their results yet or did not get the opportunity to participate. For those adolescents who had received the results of their tests, upon learning their results they all made decisions to change their behavior while one participant indicated that he already knew his HIV status as did his partner so they "always use condoms".

But now I will start using condoms because those people at VCT told me that I am negative so I will be using condoms as they advised me to. (*Participant #53*)

The adolescents who have made the behavior change to abstinence merited a closer analysis to see what the reasons for their change were. The primary reason for behavior change appears to be as a result of some specific event. One particular adolescent changed his behavior due to the death of a relative followed by the death of a peer.

He [the participant] started abstaining from the time he dropped out school in 1996. He dropped out school after knowing that there was nothing in the future. He developed this idea after the death of his uncle whom he relied upon to keep him at school until his secondary education....His Uncle died in October 1996 and from there he thought it wise to abstain. Not only his Uncle's death shocked him, he also had two more examples. Another friend of his died in 1997 and he was also suspected of dying with HIV/AIDS. He also added more that a certain boy in Namande 1 was also suspected to have died of HIV/AIDS....He could not give me [the interviewer] these examples but after probing for what made him to abstain for that long period 1997-2000 is when he gave me his examples. (*Participant #24*)

Two made decisions to change their behavior after participating in VCT and learning their results, which is interesting because not all adolescents in this study who learned their status chose to be abstinent as discussed previously.

[Participant:] 'I believe the Nurses told me the results and now I don't think of having a sexual partner soon.'

[Interviewer:] Okay? They told you the results?

He [participant] said 'yes and I am okay.'

Okay, smiling over him and I [interviewer] asked 'what was your reaction then upon hearing that?'

He [participant] said that 'I was happy and from there where I heard the results I went straight home and tell my parents about my results.' (*Participant #2*)

'Tell me the one who gave you the best advice that made you change your behavior?' I [interviewer] further asked.

[Participant:] 'Poyamba ndimanyozera koma atabwera adokotala ndi kudithandiza maganizo kuti ndisinthe mayendedwe ndinawona kuti kunylanyaza the fact kunali kuuma mutu kapena kufoira kumene' (meaning 'I was ignoring about it at first but when the doctors advised me to change, I felt it more foolish to ignore the fact.')

'Which doctors do you receive here? Do they come at your club meetings or go door by door sharing advice?' I [interviewer] asked.

[Participant:] 'Anandiwuza ndi a dokotala omwe antenga malovu ndi mikodzo aja mu June. Kuyambira pompo, ndi naganiza osashalanso ndi bebi pofuna kupewa' (meaning 'I was told by the doctor who collected saliva fluid and urine in June. From there, I decided to have no sex in order to avoid STIS.')

 (*Participant #22*)

And yet another participant decided to become abstinent due to discovering his girlfriend with another partner during the time of their relationship. There was one participant who stated that he changed his behavior after hearing a public prevention message advocating abstinence. Most of the other adolescents did not express any personal experiences with loss of family or friends to HIV/AIDS or for that matter going to counseling to learn their status, despite demonstrating understanding that AIDS is a fatal disease.

While it is noteworthy that there are adolescents who have made a behavior change, it is also equally noteworthy that more than half these adolescents (namely those who did not use condoms at all or only used condoms some of the time) did not demonstrate any type of behavior change. Once again these findings also correspond with some of the studies in the literature that have found a discrepancy between knowledge and associated behavior change. This lack of behavior change or contemplation of behavior change continues to raise questions rather than enable us to draw any conclusions. Why do most of these adolescents not contemplate behavior change? Is it because they do not thoroughly comprehend the consequences of AIDS? That does not seem to be the case because most of them understand that AIDS is a fatal disease and it is to be feared. So then, is it because they do not directly experience the consequences of HIV/AIDS (i.e. know anyone personally who died of AIDS, or know anyone in their family who is living with HIV/AIDS)? Could it be because of the taboo and stigmatized nature of AIDS?

According to the Malawi Demographic and Health Survey 2010, 41% of women ages 15 to 54 in the survey and 44.7% of the men ages 15 to 54 had comprehensive knowledge about AIDS³⁶ whereas the percentage of those who had *heard* of AIDS was estimated at 99%. This might account for the gap between awareness of AIDS in general and the lack of behavior change in these young adolescents as well as perhaps

³⁶ According to the MDHS 2010, comprehensive knowledge meant “knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention –that HIV can be transmitted by mosquito bites, and that HIV can be transmitted by supernatural means” (p.168).

a notion of invincibility that they cannot be affected by something as serious as HIV despite it not being an overt and obvious notion permeating the interviews. Perhaps this notion was presented in a more subtle manner, such as in the way a certain participant smilingly declares that he will not use condoms in future relationships or how some participants laugh about “sweets” not being tasted while in their “wrappers”. Could this account for the lack of behavior change?

According to TTM’s stages of change, most adolescents were found to not even be in a stage where they were contemplating behavior change. As recalled from previous sections, according to Prochaska and Velicer (1997), decisional balance and self-efficacy are the two intervening variables that facilitate movement between TTM’s stages of change. To review, decisional balance refers to the pros and cons of behavior change while self-efficacy is the belief that one has the ability to change the problem behavior. The problem behavior in this study refers to the lack of condom use while desired behavior is consistent condom use with every sexual intercourse or abstinence. Results of the analysis convey the lack of comprehensive knowledge to engage in an appropriate decisional balance self-discourse and make the question of self-efficacy almost irrelevant. If the pros and cons these adolescents are considering fall along the lines of condoms being useless or condoms breaking, or even the extreme idea of condoms actually causing diseases, they are in effect making sound decisions according to the information they have and are doing so with appropriate self-efficacy. However, what prevention programs and AIDS research see as a problem behavior—lack of consistent condom use—is not really being conveyed as such according to these

adolescents. It appears from the perspective of these adolescents that the problem behavior is sexual intercourse and not the lack of condom use. Thus it appears that the discrepancy between knowledge and associated behavior may largely be due to the lack of comprehensive knowledge about HIV transmission, risk, and protective/prevention methods, including VCT and circumcision. As a result, perhaps affecting the decisional balance variable may then bring into questions of self-efficacy and consequently movement through the stages of behavior change.

Gender

The interviews with these adolescents reveal a surprising turn in gender relations. Common notions of young women's vulnerability and powerlessness do not seem to be the case, at least from the young men's perspective. Young men revealed their difficulty in maintaining relationships due to economic pressure from their partners to continue to supply them with gifts and money; otherwise, they could be sure to lose them to either another wealthier man or to school and subsequent lack of interest in the young man. This reflects a power of choice that rests with the young women rather than solely the young men. Young women were able to express their desires and demands such as asking for money prior to having sex with a new partner even as young men discontinued relationships because it was costing them much money.

Some young women were also found to initiate the request of condom use during sex, or express their refusal to use condoms during sex; and the young men

generally complied with such wishes of the young women. Some participants stated that they had women partners who insisted on condom use.

[Interviewer:] Why was she asking for condoms?

[Participant:] She was afraid of getting pregnant and be chased out of school while forced by her parents to marry me as well; and she would say that she can't take care of the child as she is also still a child. She told me that she feared diseases transmitted sexually for we had not gone for testing and she never know who I was with before her.

[Interviewer:] Does she suspect you of having a disease?

[Participant:] No I don't think so but I only think she does that for protection.
(Participant 38)

[Interviewer:] Where did you meet for sex?

[Participant:] At the same bush down there that we usually meet.

[Interviewer:] Did she accept at once?

[Participant:] Yes, she did and she was the one that told me to use a condom. She said she was afraid of getting STI's for she never knows my status since we had never gone for testing blood and also early pregnancy that may lead to losing her education as well as her dreamed goal of being a nurse.

[Interviewer:] Did you use it?

[Participant:] Yes, because everything she said was right. *(Participant #46)*

She was at first refusing to have sex because she was afraid of unwanted pregnancies and in the end she requested for a condom if I wanted sex.
(Participant #60)

He used condoms in the other relationship because the girl was commanding for it that she was even bringing/carrying the condoms each time they met.
(Participant #61)

[Interviewer:] Who decided [to use condoms]?

[Participant:] She [his partner] was the one who came with that decision.
(Participant #62)

...[S]he told me that I should bring a condom with me. I argued that there was no need but she insisted and made it clear that she cannot have sex without a condom.... *(Participant #66)*

Some participants expressed that the women would encourage them not to use condoms by refusing sex; one participant stated that his partner told him that he has a

choice of either being “willing to use a condom but not with her or not using a condom [and having sex] with her”. Other participants described the following:

He said sometimes they were not using condoms. Asked why? He said she was refusing to use condoms sometimes. I [interviewer] asked further, why? He said that she was saying that “switi jwangelira mpaketi, jwanganong'a” Yao meaning “Sweets are not chewed while in wrapped paper, you do not feel the sweetness”.
(Participant #13)

‘To my side I felt okay using a condom but the partner refused. There was no way I could keep on using them.’ In his speech he commented that the partner also said a condom is useless. *(Participant #22)*

In one situation, an adolescent stated that he had to “hide” the condoms in order to use them or his partner would refuse to have sex with him. He described the situation as follows:

At first, I used to take two condoms out of their wrappers and placed them on the bedside in readiness of the sexual act. Then I would go to get her. When she came into the house, I would turn off the light before she sees the condoms. I wore the condoms in the dark and she never realised I was using a condom. Then, one night I forgot to take the condoms out of the wrapper. So I tried to take them out when she was already in the bedroom. Although it was dark, she heard the sound of the wrapper and immediately lit a match. She got upset upon seeing the condoms and asked me: ‘Why are you doing this? You think I have (sexually transmitted) infections?’ I did not know what to tell her I was not going to use the condoms. From that time, I have never used a condom again.
(Participant #52)

These actions do not portray a group of young women thought to be vulnerable and powerless. Granted that universal feminine empowerment may not be an acknowledged reality, it is evident that women are finding ways to gain power and choice in relationships whether it is through condom use or non-use or in other ways.

This power and choice of women was also reflected in another aspect of relationships: choosing to have concurrent partnerships. There were several participants that indicated they ended relationships due to the discovery of their girlfriends being unfaithful. The reasons for these concurrent partnerships were not always clear. Some of the participants indicated that it was influenced by money—the women would go for men who could provide more for them. Two participants describe what happened:

After three days from the day she had accepted, she wrote me [participant] a letter in which she wanted me to give her money of about K100 so that she could buy note books and pens which she gave to my neighbour who was her class mate, to give me. I then answered the letter and refused to give her money. Yes, she came and she insisted on the money demand and I told her in person that I did not have money, and we agreed that she should wait for sometime so that I do ganyu (piece work) for me to get money and she accepted. After some days, I started hearing from friends that she had another boyfriend and this pained me as I did not want someone to share her with me. *(Participant #42)*

[Participant:] The relationship lasted for 6 months; this was the time when I realized that my girl was going out with another man.

[Interviewer:] How did you know?

[Participant:] Rumours were all over that she was going out with Mr Pherson (mswahilli), a Tanzanian by nationality, a business man.

[Interviewer:] Did you ask her?

[Participant:] Of course yes, I did and she refused.

[Interviewer:] So why believing in rumors not in her as you were trusting each other?

[Participant:] It's not just because of the rumours but I caught them myself at the dambo busy caressing....After I caught them, it is when I called it quits.

(Participant #50)

These examples certainly seem to go against the stereotypical notions of women being the weaker gender and subject to the dictates of men in relationships. Despite what the underlying reasons may be for initiating condom use or refusing condom use by giving their partners ultimatums in some cases (i.e. stigma, cultural views, pretense

of power), the ability for some of these women to make the choice or initiate the choice rather than simply allowing their partners to decide for them is a step in the direction of empowerment. Although sometimes the adolescents in this study had women partners that insisted that no condoms are used, the key here is that women seem to be able to make decisions in the relationship rather than it being solely the decision of the men. Furthermore, the young women also seem to demonstrate a choice in deciding their partners or acquiring multiple partners for whatever reason they see fit. Of course, it may be more complex than simply a shift towards empowerment of women.

This brings important light to the gender issue in HIV/AIDS and prevention as well as women empowerment on the whole. Consistent with some of the studies in the literature that demonstrated how women are finding their voice and can exercise control over their future and their relationships, the young men in this study also provide some insight into gender roles as they see it rather than as is typically portrayed. As such, men are contending with a shift in power relations or rather a completely different type of power relations between gender roles than those that are usually depicted. Young men in this study did not express any notions of "machismo" or stereotypical masculine expressions of being "the man" in the relationship. However, the young men did not express any notions of powerlessness either. In this group of adolescents it is not evident that the young men are trying to deal with sentiments of disempowerment so there may not yet be an obvious large-scale shift in power relations. It is also not evident that there is any particular masculinity script of needing to demonstrate domination over women or disproving suspicions of their manliness.

This points to the importance that not just young men but young women need to be given thorough information about HIV/AIDS as both genders are expressing an exchange of choice in relationships.

These findings also suggest that perhaps the stereotypical view of gender inequality is not quite an accurate picture of what is truly happening in adolescent relationships in Malawi, and perhaps in Africa on the whole. These results are similar to the conclusions drawn in other studies regarding women's sexual agency and ability to plan for their future according to what information they gather from social interactions and other sources (Clark et al., 2009; Poulin, 2006, 2007; Schatz, 2005). It also indicates that while women are able to demonstrate control and choice in relationships, it is still crucial to ensure that an inclusive empowerment movement is being fostered to prevent an imbalance in gender power relationships that might lead to unhealthy and unsafe environments for both genders.

Education and Economics

Education appears to be largely influenced by economics with these participants. In Malawi, primary education is compulsory and is free (primary education being up to Standard 6 – the equivalent of Grade 6 here in the U.S.). Beyond that, fees are collected for secondary education³⁷. Families and students themselves understand the importance of education but often the finances of a family do not permit the continuation of a child's education because it is often very costly, particularly to a family

³⁷ In a private high school, school fees are approximately \$277 for the entire year (three "terms"), according to personal communication with a director of a school in Malawi.

living on only a few dollars a day³⁸. Thus, some families are forced to make a decision between educating their children and using that money for needed provisions; unfortunately this perpetuates the cycle of poverty for most families. There are some families that make a choice between educating the boys and the girls while others make a choice between educating those children who they think “show more promise” than others (see Footnote 27). Some adolescents drop out of school to work and raise school fees on their own but end up not returning to school for various reasons, most of them related to limited finances. Other students find it difficult to return to school even if they are able because their age peers have moved on to the next grades and they feel out of place with students who are younger.

All 64 participants expressed that they work, usually manual labor (ganyu). With the money they earn, they either buy provisions they need, pay school fees, or buy their girlfriends provisions and gifts. Some also indicate that it is too costly to budget condom purchases. For example, one participant indicates that a condom costs MWK5 for 3 of them which amounts to about 0.03 USD³⁹ in current day exchange rates; another participant indicated that condoms cost MWK5 for one of them. This may not seem costly to those of us in the western world but to people who are most likely living

³⁸ The director told me stories of students who could not afford their fees and had to drop out. One student wanted so much to be in school that she would come to school anyway and listen to the lectures outside the window. Another student was forced to drop out on the account of his parents choosing not to pay his school fees due to poor grades the prior year; instead his parents chose to use his school fees for another of his siblings who showed “more promise”. Thus the director of the school gave him a part-time job cleaning up her yard and around her house after school so he could use the money to pay for his school fees.

³⁹ Exchange rate accessed on 4/17/12 was 1 Malawian Kwacha (MWK) to 0.0060248 US Dollar (USD); conversely, 1USD = 165.97999MWK, according to www.xe.com.

on less than a dollar a day 3 cents is money that could be spent towards sustenance rather than condoms. When asked why he was not using condoms, one participant stated that he had “no money to buy the condoms”. Another participant stated, “Condoms were by then only found in groceries and I had no money to have it....”

[Interviewer:] Where do you get them [condoms]? He [participant] answered saying buying.

[Interviewer:] Where? He [participant] said at Mr. Pagonja’s shop.

[Interviewer:] How much? He [participant] said that K5 for 3 of them....

(Participant #6)

[Interviewer:] ‘Had you ever decided to use a condom with her?’ He [participant] answered, ‘Yes, when I have money, I buy a condom.’ In his explanation he said, ‘Condoms are not easily found. You need to have money to have a condom. They are sold at K5.00 per condom. It’s difficult to budget for condoms every time.’

[Interviewer:] So why sometimes you use condoms? Which is better to use no condoms at all times or using condoms at intervals?

[Participant:] ‘I cannot stop buying condoms because I wish I could be using them but only that I cannot budget for condoms the whole month.’ In his explanation he [participant] included that if he were getting enough money. He would budget for enough condoms. *(Participant #28)*

He explained that he could not manage to buy condoms every day therefore he just slept with her without using a condom. [Interviewer:] ‘How much does it cost to buy a condom?’ [Participant:] ‘By that time a condom was five kwacha but nowadays condoms are sold at a cost of ten kwacha each.’ *(Participant #35)*

However, it is interesting to note some inconsistencies about the availability and access of condoms. Some adolescents readily expressed their knowledge of where to obtain condoms for free while others only mentioned needing to purchase them. One young man knew that his friend was getting “the condoms from Kuyewawa Health Centre free of charge.”

Condoms are common nowadays but that time they were seldom found. It is almost a year now from the time I have seen most of the people using condoms.

(Participant #21)

He [participant] also added that the boys cannot manage to bring condoms every time and condoms are also scarce in the villages. *(Participant #)*

I had no access to them [condoms]. It has taken a long time, almost four years now, so I had no chance. Now condoms are shared common but that time they were scarce. *(Participant #29)*

Then I [interviewer] started asking him if he had ever used these condoms when he was in Zondani village. He [participant] said that he would use them if he had a chance to do so but he had never used a condom in his life. Do you wish to have used a condom in your life? I [interviewer] asked. Yes, he [participant] answered, but only that I do not find them because condoms were not commonly available. *(Participant #34)*

[Interviewer:] Where will you go to get the condoms?

[Participant:] They gave me some condoms [a clinic] and told me to be collecting from the hospitals (government). *(Participant #53)*

[Participant:] I was responsible [for having condoms], but not buying.

[Interviewer:] But what?

[Participant:] Collecting/getting them [condoms] free from government hospitals.

[Interviewer:] Oh, were you not shy? Which hospital?

[Participant:] No, I wasn't shy. How can I be shy for something I know that it will help me? I was collecting (condoms) at Chiudzu Health Centre.

[Interviewer:] How far is Chiudzu?

[Participant:] There is a distance but not really far.

[Interviewer:] Were you not tired of going to collect condoms?

[Participant:] No, each time I needed condoms, I was visiting the health centre. *(Participant #56)*

One adolescent indicated that he had no money to buy condoms but proceeded to tell the interviewer that he was giving his partner money as a gift.

He explained that he could not manage to buy condoms every day therefore he just slept with her without using a condom.

[Interviewer:] 'How much does it cost to buy a condom?'

[Participant:] 'By that time a condom was five kwacha but now days condoms are sold at a cost of ten kwacha each?'

[Interviewer:] 'What kinds of gifts did you give her?'

He [participant] said he could give her even hundred kwacha when he had found money. Sometimes giving her soap and sometimes when she asked him for lotion, he could buy and give her.

[Interviewer:] 'How often did you give her money or gifts?'

He [participant] answered that when he had sold his chickens he could voluntarily give her money but for soap and lotion, she could buy when she asked him for it. (*Participant #35*)

A second participant also mentioned that he was giving his partner monetary gifts but then proceeded to tell the interviewer that he did not have money to purchase condoms.

And I [interviewer] asked why he said that he was not using the condoms because of scarcity of money to buy condoms and where did he get the money to be giving her to buy maize and clothes? He laughed and said that the reality is because he had no any interest on wanting to use the condoms-he laughed and I laughed too. (*Participant #10*)

Not only with respect to condoms but just maintaining relationships often cost young men money. Most participants mentioned giving money to their girlfriends as gifts rather than the reciprocation of sex; however, in some relationships it tended to be a large influence. For example, one participant indicated that his partner told him when he first proposed⁴⁰ to her "give me money first so that we may meet and if you don't then we won't meet...meet in this case means having sex". As a result the young man gave her K15. There were some young men who decided to end their relationships because it was costing them money to keep a *chibwenzi*. One participant also reasons that one can avoid HIV/AIDS by marriage because the woman will have all the support

⁴⁰ The adolescents in the interviews used "propose" as a proposition for relationship and not necessarily isolated to a proposition of marriage.

and provisions she needs, such as soap, clothes, and the like once she is married; therefore there would be no “moving about”⁴¹.

Thus economics seems to influence the education of these young men, their relationships, and their outlook on the future not to mention whether or not they budget for condoms. Moreover, these findings further support the potential for over-reporting of condom use. If the adolescents are having a hard time budgeting for condoms, then it is possible that they are really not using condoms as consistently as they are reporting.

Poverty is a crucial factor in HIV prevention. If consistent condom use is desired, economics must be taken into consideration. Making condoms more universally available and accessible at no charge will help adolescents at least not have to try to budget for condoms and coupled with comprehensive knowledge dissemination may assist in moving adolescents toward safer sexual practices. Furthermore, poverty impacts the completion of secondary education where some adolescents are unable to pay for their school fees and are forced to drop out; these adolescents are unlikely to return to school later. Making secondary education more attainable would enable more students to stay in school and motivate them to make better prevention-related choices in order to safeguard their future.

Family, Culture, Stigma, and Ethics

⁴¹ “Moving about” or “movious” is a word that the adolescents use to describe having multiple partners or going from one partner to another.

Adolescents in Malawi may be experiencing common global notions of peer pressure and conformity but aspects of their lives continue to reflect the differences in western and non-western cultures. One of the surprising findings in these interviews is the separation of children's sleeping quarters from their parents. It is unknown if this is a common practice all over the country but most participants mentioned that either their partners or they themselves sleep in a different physical dwelling than their parents.

Asked to how frequency regarding to their sexual intercourse he [participant] said that it was once a week.

Asked where? He answered that 'kwao' (at her home).

[Interviewer:] Whose house her own house?

He [participant] said that the small house near her mother's house built by her parents where she was sleeping with her young sisters. He said it was a secret love that both parents didn't know about this. (*Participant #12*)

In his speech he [participant] said 'I could wait for everyone of our household to go to sleep. Sometimes I could leave for Sarai's house around eleven o'clock at night (23:00 hours). We could do sex twice only, upon arrival and when I was leaving her dorm by 03:00 hours at dawn,' he said. (*Participant #22*)

Then he answered that they could meet three times a week, spending the whole night together in his dormitory. Had you ever slept in her dormitory? I [interviewer] asked. He [participant] refused, no she was sleeping in the same house with her smaller sisters and therefore she had to withdraw during the night. (*Participant #32*)

He answered that sometimes the boy could go to her dormitory every night. He says 'I could go there around twenty-three hours when everyone is asleep. We could do sex twice or thrice and then around three o'clock dawn, I then come here and sleep in my house.' (*Participant #35*)

Turning to the current relationship, he said that they have sex at least once or twice in two weeks. He said that he takes her from her 'mphala' and spend a night in his 'mphala.' He said, 'I go to her home at around 8 o'clock at night and pick her. She sleeps with her young sister. The young sister knows about our relationship so we spend the night together until around 4 o'clock in the morning. Then I take her home before everyone wakes up to see us.' (*Participant #52*)

This might suggest the ability for these adolescents to engage more easily in unsafe sex, as there is less opportunity for parents to monitor their children's behaviors. This sort of physical distance between parents' dwellings and children's dwellings, although unknown exactly how far apart the separate dwellings are, appear to enable the adolescents in this group to meet for sexual activity late at night away from the watchful eyes of any adults.

There is also a certain lack of parental/family involvement expressed in these interviews. Participants expressed that their relationships were "secret" and hidden from their parents; one participant indicated that only his grandfather knew of his relationship. Parents are less likely to know of or find out about relational interests and less likely to know of risky behaviors, not necessarily because there is no desire to be interested in their children's lives but perhaps because it is difficult to be involved in difficult economic circumstances where both parents are heavily involved in working outside the home and/or maintaining the household by fetching water, wood, and meeting other household needs as necessary. Furthermore, the physical separation of sleep quarters which might be tied to cultural reasons may contribute to the dynamics of parent-teen relationships in Malawian communities, although this is not necessarily clear from the data. Relatives more often than not appear to be the more key people in some of these adolescents' lives, seeming to be those who can actually influence adolescents in a more positive and effective manner.

For example when parents were away from home for work, one of the participants was sent to his uncle's home to live. Interestingly the participant stated that while living with his uncle he could not even have a girlfriend because he was afraid of his uncle. When asked what his uncle said, the participant replied, "He told me that chibwenzi is bad for it can make me lose my education since I get STI's like HIV/AIDS. That's why I am afraid of going for another chibwenzi."

This raises an interesting question: why was he more afraid of his uncle than his parents? It would seem that relatives were more involved in adolescents' lives than parents. Or perhaps it denotes the relationship that extended family members still have with the parents and assist in child-rearing by exerting discipline; thus pointing to a more communal nature of society than the individualistic western nature of society. Relatives were also noted as being integral in creating courtships and assisting in marriages. For instance in one participant's interview, he expresses that he went to discuss his interest in a young woman with the young woman's aunt rather than directly to her parents.

[Interviewer:] What did you do then?

[Participant:] Her in-law told me to go and tell her aunt so that she helps me, and that worked as she accepted when her aunt was telling her that I wanted to marry her.

[Interviewer:] Why tell her aunt?

[Participant:] You know here it is the aunt who knows much about the girl's marriage rather than parents as it is very easy for a girl to confide in her aunt than her mother and that goes with culture. (*Participant #45*)

One adolescent did mention some advice his parents gave him regarding condoms, in which his parents said, "sweet wampepala sangakone (meaning sweets are

tasteless when they are in wrappers).” As influential figures in children and adolescents’ lives, it is important that parents and relatives disseminate advice that is reflective of the current concerns with prevention of HIV. Thus, it appears that HIV awareness and prevention education needs to not just focus on the adolescents but the family and the community as a whole. Mfutso-Bengo et al. (2009) advocate for behavior change to include adults being more open about safer sex practices, AIDS, and sexual activity in general.

Interestingly, when responding to questions at length, a number of adolescents tended not to use the terminology HIV or AIDS frequently. Instead they indicated that they were afraid of catching STIs, the disease, various diseases, syphilis, or infection. One adolescent expressed that he was afraid of “zatchukazi za matendawa (the most famous)” while another expressed that he was afraid “to catch the disease which has come nowadays”.

[Interviewer:] Why sometimes they [participant’s friends] use condoms? He [participant] said that tusaiona kuti mpaka itukamuchisye kupewa kujigala yakulekanganalekangana -Yao meaning we see or consider that they can help us in preventing from various diseases. Like? (mpera - yao)? I [interviewer] asked. He [participant] said yes, indoko (syphilis). (*Participant #13*)

This may be indicative of the influence of cultural taboos, AIDS being one of them. If AIDS is so associated with stigma and is taboo, it is likely to expect that in conversation it is referred to as “the most famous” or other such phrases. Stigma of AIDS and PLWHAs has been a noted concern in Malawi and other African countries and some studies have brought up the need for adults to be more open about sexual practices (Kohi et al., 2006; L. Makoe et al., 2008; L. N. Makoe et al., 2009; Mfutso-

Bengo et al., 2009). However, adolescents did not mention any of the cultural sexual practices that are mentioned in some of the studies (Mfutso-Bengo et al., 2009; Muula & Mfutso-Bengo, 2004) which might mean that as the adults refrain from speaking about such sexual practices adolescents might not be aware of them; or they may understand that it is not appropriate to speak about those types of practices.

Furthermore, while it is possible that adolescents do not give much thought to the diseases, indicating that there is a lack of awareness with respect to HIV and its consequences, there seems a lack of evidence in this study for this latter interpretation considering that almost all the adolescents did mention some fear of AIDS or contagious diseases and demonstrated the understanding of its fatality. Thus, one might wonder if the lack of thought to and verbalization of AIDS is due to the taboo and stigmatized nature of HIV/AIDS in Malawian communities. This would be another area of concern for HIV awareness and prevention programs to address.

There is also an element of social desirability where adolescents understand that it is appropriate to say that they use condoms and will certainly express this up front. However, several participants who at first indicated they used condoms ended up expressing that they actually did not when the interviewer probed further.

Asked if he [participant] used the condoms he said that yes he used the condoms. I [interviewer] laughed and said that he was cheating me and begged him to if at all possible, tell me truth he [participant] laughed too and said that koma zoonza zake sindinagwiritse ntchito. (Chichewa meaning to say but in reality is that I didn't use.) (*Participant #1*)

I [interviewer] said probably you are cheating me how can you feel sweet in a condom? He [participant] laughed for a minute and lastly said that sometimes he

was not using the condoms kumanena chilungamo ntawi zina (Chichewa meaning sometimes speaking honestly is needed). (*Participant #11*)

This also again raises the question about expressed condom use by most of the other participants as well as those in other studies; how accurate are the numbers and how many adolescents **actually** use condoms? One participant expressed, “we have seen some people who always claim to use condoms but they are dying of AIDS.” Over-reporting of condom use seems to be highly likely.

If in interviewing 64 participants, 12 indicated consistent condom-use while 17 indicated inconsistent condom-use, it might even be possible that more than half these adolescents do not use condoms on a regular basis (bearing in mind that the results in this kind of study is not generalizable to the larger population). And this might be more reflective of what is actually taking place in Malawi at this time. Thus it is important for researchers and practitioners to take this into account with the reported data related to HIV/AIDS statistics.

Peer Relationships and Social Networks

Participants reflected their connection with social networks, particularly their interconnection with peer relationships. Some of their intimate relationships came about because of peer pressure and the desire to do the same things as their peers. Peer relationships can be positive and negative influences, depending upon the unique individuals in those relationships.

For example one youth described that he used condoms because his friends use them, even at the risk of making his partner upset. The interviewer asked why he still brought condoms when his partner refused to use them; was he not concerned he would upset her? The participant answered that "since some [of my] friends use the condom therefore [I] wanted to be using them too." Other participants also expressed that friends exchanged advice and even gave them condoms.

...he [participant] explained that they say that abstaining is better because you cannot think of someone. In addition, a pupil needs to concentrate much on his education. (*Participant #16*)

[Interviewer:] 'Who gave you condoms most of the time?' He [participant] said he only received condoms from his friends for five times. He said he did not receive more condoms from any friend each one gave him a single condom only. 'Why did they give you condom?' I [interviewer] asked. [Participant:] 'I heard from the people that condoms are important. They help to avoid STI's and pregnancy,' he explained. (*Participant #35*)

[Interviewer] What do you talk about kudziteteza (how to protect yourself)? [Participant:] I always tell my friends not to trust Chishango (condom) but rather just abstain. [Interviewer:] Why say so? [Participant:] We have seen some people who always claim to use condoms but they are dying of AIDS. (*Participant #44*)

He [his friend] encourages me to work hard in class, always advises me to use condoms when I am sleeping with my girlfriend and the danger of AIDS. (*Participant #59*)

But of course, not all adolescents are influenced by peer pressure as was also evident in this group of adolescents. One participant stated that his decision to remain abstinent and focus on his schooling has made him unpopular with his peers and as a result he does not meet with his friends often as they try to talk him into finding a chibwenzi; he stated that he is "despised" but he does not mind at all. It is thus

important to educate adolescents thoroughly and disseminate complete information because they may have the potential to influence more of their peers than a teacher or a parent, or even the church, might.

Churches, schools, and media have also become a part of these adolescents' social networks, informing them of HIV/AIDS prevention methods including well as condom use. Some adolescents indicated that they decided to change their behavior after listening to a public message of prevention via the radio. Some adolescents expressed that condoms were faulty, per advice from teachers and church or other religious institutions' messages. For instance, one participant stated that the "Moslems [say] that condoms cause diseases like cancer, just the same as what the Christians say". Another participant stated the following when asked why he did not have a partner:

..he said that it is because he obeys and follows rather listens to what the radio says. What does the radio say? He said that it says AIDS has no medicine that can cure it but only abstaining from sex is good. (*Participant #2*)

Additional participants also expressed what they have heard from various sources regarding prevention.

He said...they were listening to the radio which it said more of AIDS messages that the youth are the ones who are dying a lot because therefore kulikwambone kupewa (Yao meaning 'it's better to avoid') Asked to whether the message was in Yao language as he said kulikwambone kupewa? He said that the message was in Chichewa language. (*Participant #9*)

'Are you given some advice concerning HIV/AIDS or what you can do with those suffering from it?' I [interviewer] asked him further. He [participant] explained that what they are told at the church is only about abstinence. They are also

advised that, as the youth, they should take care of themselves in order to future leaders of the church. (*Participant #16*)

So where do you hear about AIDS? I [interviewer] asked again. Then he [participant] said that they are advised at the church when they meet on Tuesdays and Fridays. That is why he knows about it. Then I [interviewer] asked to know the kind of advice they are given at the church? He [participant] answered that we are told to abstain. (*Participant #29*)

At night I was listening to the radio and it is when I heard that sex is bad for it can make one get AIDS and that it was better to abstain so that you should not be one of the victims of AIDS. (*Participant #42*)

As a large influence over adolescents, it is important that these public messages of prevention are disseminated objectively. It is natural that people (such as teachers, peers, and relatives) have their opinions and preferred methods of prevention. For example, one participant states that the teacher gives the following advice:

Their teacher said MUKADZISUNGE OSACHITA ZA CHIWEREWERE- Chichewa meaning abstain from promiscuity. (*Participant #2*)

[Interviewer:] Do you mean that your teacher tells you about AIDS, in what way? He [participant] then explained that their teacher advises them to abstain for two reasons: First, they should not fail school after getting pregnant or impregnating and, secondly, they should not fail school because of HIV/AIDS. He also said that their teacher discourages them to use a condom. He said, he says, as students, they should only abstain in order to have a successful future. (*Participant #16*)

The teacher says that the children should not be involved in sexual behavior. He said. 'Amatiuza kuti tisamakonde za chiwerewere kuti tikonze bwino tsogolo lathu.' That is to say 'He tells us that we should not do sex in order to build our future properly'. (*Participant #26*)

He explained that the teacher only focuses on the dangers of STI and AIDS. He discourages sexual behavior and advise them to abstain if they wish to finish school. (*Participant #35*)

Another participant indicated that he did not use condoms much because his parents said that "sweets are tasteless when they are in their wrappers".

If adolescents choose not to be abstinent, the public messages of prevention need to address and disseminate information about the other methods available. Those adolescents who expressed a change a behavior indicated that radio, church, or a doctor was influential in their decision to abstain. Freire (2004) argues this point by indicating that educators (in this case those who are educating adolescents on HIV/AIDS prevention) should not assume that students (in this case these adolescents) are a blank slate with no knowledge of how to make decisions on their own. Adolescents should be viewed as capable of making decisions and needing all the information necessary to make a sound decision.

Freire (2004) emphasized the danger of "false generosity" and creating situations where the power relationship swings from the "oppressor" to the "oppressed", creating just another power imbalance rather than truly improving the situation to create genuine empowerment. "False generosity", according to Freire is the notion that there is an intended generosity by those who have what society deems as power (in this case it is knowledge of a fatal disease) to "inform" and "liberate" those who do not have that power. This appears to be quite applicable to the HIV/AIDS epidemic and its consequences reflected in these Malawian young men's perceptions. Prevention programs and social networks are assuming that they know what is best for adolescents and by not disseminating accurate and thorough information, the power of information remains with the "adults" behind programs and social networks rather than truly empowering the adolescents to take that knowledge and transform their lives.

Additionally, the notion of “false generosity” as described previously permeates the intervention/prevention programs that are briefly mentioned in these interviews by only disseminating a piece of the information. While some participants do not mention any prevention or intervention programs (primarily youth clubs), others have attended youth club programs or even participated in clubs as members. Participants who were active in or attended youth club meetings expressed the following:

We [the drama group] are encouraging those who cannot abstain to use condoms, to those who can manage should abstain in addition all side effects of condoms are given to the people. Only few people are sensitive. Very few manage to abstain, some use condoms but the biggest number of people do not even use condoms. There is still more work to change the peoples behavior.’ He [participant] says that a lot of people do not follow what they are advised about abstinence. ‘We are given information about HIV/AIDS, condoms and how the people live in their social settings. People discriminate against the elders and the disabled. The club focuses on what people should do to solve these problems.’ he answered. I [interviewer] then decided to ask him if he or if the club has done something on its own to encourage the people do it. [Participant:] ‘No we only tell them. We had never done anything. We are the people to share ideas to the community not to do that it’s too difficult,’ he [participant] argued. *(Participant #22)*

[Interviewer:] What can you say about AIDS? Do you remember / know what they [the youth group] discussed about it? Then he [participant] explained that they talk about abstinence and also those failing to abstain are advised to go and receive condoms freely. *(Participant #25)*

... people here do not understand about abstinence or use of condom. They only do sex and say that condoms are useless. They cannot protect themselves. Moreover, they have many partners at once. When we try to advise them to abstain or use a condom, they don't listen at all. *(Participant #32)*

The boy said that the dramas were concerning abstinence. He says ‘Waliji kuwecheta ya kulikanya. Watite wanache wakulijiganya ankatenda yagonana ligongo lakuti chilwele cha Edzi chilumala wandu sambano wanache ankatenda yeleyo. Watesilesoni kut kujigala pa chilu uli wanondi ni kwako goya soni. Kulepela kulijiganya.’ (The expression in Yao says, ‘They were talking about

abstinence. They said pupils should abstain from sex because a lot of people are dying with AIDS so the pupils should abstain it they also said that getting pregnant is also dangerous the result is school dropout'.) (*Participant #33*)

Some participants mentioned the cliquishness of the youth clubs; others mentioned the sexual activity between members of the youth club; and others still mentioned that they no longer attend youth club meetings sometimes due to the distance and time it takes to get there as well as due to the nature of the club being more of a clique rather than to disseminate vital information to youth regarding HIV/AIDS prevention.

[Interviewer:] And your friend stopped [having sexual partners] as well?

He [participant] said no they are continuing.

[Interviewer:] They don't attend the dramas performance?

[Participant:] They attend.

[Interviewer:] What's their reaction upon hearing the messages?

He [participant] said that they can't stop because those who were performing the dramas have sexual partners as well and married too so they do sex.

(*Participant #4*)

Then I [interviewer] asked him further, 'What do they teach more about HIV/AIDS and condoms? Do they say only about HIV/AIDS?' But the boy [participant] did not give further answers. He said, 'Unejo ngisajalaga kweleko kamokamo. Yeleyo naslileyo ni yakut iunejo mbikene kweleko. Nambo ine nginkuimanyilira.' The expression in Yao says, 'I go there once at a time as takes long time to go there again. What I have told you is what I heard there. I cannot add anything because I don't know.' (*Participant #33*)

Although these youth clubs, primarily set up through NGOs, are designed with the best intentions in mind, the results can be unsuccessful if they do not disseminate comprehensive information about HIV. Youth clubs may be formed out of "generous" intentions to assist in the prevention, and hopeful scaling down, of the epidemic but can

end up being misguided or ineffective when put into action. It may even portray an inaccurate picture of young women and perpetuate the vulnerability of women:

[Interviewer:] Dramas and the poems were only for HIV/AIDS? He [participant] said that were mainly that stressing that if men are continuing the behavior of sleeping with girls the end result is catching AIDS because that girl or girls may happen that they sleep with many other sexual partners and you come to sleep with her and catch AIDS and die. He said because of that he realized that they were saying the truth and then stopped the tendency of having sexual partners. *(Participant #4)*

To be more specific, if these youth club prevention programs were more effective, one would hope to find more than 12 participants consistently using condoms in a sample of 64. Of course this is not to say that youth clubs should be the one and only effective prevention program in the country or that there are no effective youth clubs in the country. It is quite possible that the adolescents in the study did not recall all the information given at the youth club meetings. However, in order to make a more effective impact on the youth as one of the many social networks in an adolescent's circle, there needs to be a closer examination of precisely what information is being given and how these youth clubs are impacting the lives of even these 64 participants in the study, whether positive, negative, or neutral.

Summary of findings from the original study

The original study conducted by Poulin (2006) for which the data was collected had several key findings. First of all, the study found that gift exchange is common among young adolescents; young men will often give their sexual partners money and gifts. However, this is not to be exploitative of their partners but mostly as an

expression of care and love for a woman. Furthermore, the young unmarried women do have considerable control over their relationships and thus are able to manage their own risks of contracting AIDS.

Young women who are in school are found to be less likely to have a partner than those who are not in school, even among their age-peers. This is not due to any AIDS prevention education and activities in the schools but rather due to the weighing of consequences for their potential futures. And as a result, the young women seem to affiliate themselves with peers of the same mindset. Furthermore, the institution of marriage and school are larger contextual factors that define an environment where a woman's agency can be exercised. Results show that African women are not as disempowered as often portrayed. Thus, the study raises the question of why public health models continue to operate on such a paradigm.

Summary of comparative findings from the current study

The findings from the current study supplement the findings from the original study in several ways. Data from the current study support gift exchange between partners, particularly the men to the women. As indicated in the original study, these gifts were not exploitative in nature but rather something that many of the young men had a desire to give. However, with their economic situations, the young men did have difficulty in sustaining some of the gift-giving, and ultimately maintaining their relationships. All the young men in the sample indicated some need to work in casual labor in order to have some money to spend on relationships or things in general.

Young men also express that their partners are sometimes insistent on condom-use or even refuse to use condoms. Thus the nature of gender roles may not be what is stereotypically portrayed in most public health program paradigms, certainly echoing the question of why public health models continue to operate on such a paradigm. This supplements the original study's findings that women are able to exercise choice and control over their potential futures and relationships rather than being submissive to men's demands.

Young men did not seem less likely to have partners if they were in school, although there were those who decided to abstain for various reasons including wanting to concentrate on their studies. And unlike the young women in the findings of the original study, most young men did not seem to purposefully affiliate themselves with peers of the same mindset. However, the reasons for a behavior change or abstinence in the young men did not come from any AIDS prevention education or activities in the schools. This supplements the findings of the original study in that there are some gender differences in overall decisions to engage in relationships while in school which may point to some cultural differences in gender education. It also raises the question of the effectiveness of AIDS prevention education programs in schools if they are being implemented and perhaps the need to monitor and re-evaluate them.

Emerging from the data

Emerging from the adolescents' discussion about their lives and their relationships are several concepts that may account for the discrepancy between

knowledge of HIV and associated behavior change as well as what may be influencing the minimal results of prevention programs and campaigns. First of all, comprehensive knowledge of HIV is not being disseminated to these adolescents, which accounts for the discrepancy between “knowledge” and behavior. It appears that there has been an assumption that “knowledge” meant comprehensive knowledge but in this study “knowledge” was equivalent to “awareness” of AIDS as a fatal disease; beyond that awareness were misunderstandings, myths, and incomplete information. Thus, disseminating objective and comprehensive information about HIV, risk factors, and all prevention methods will significantly contribute to adolescents’ condom use and behavior. This comprehensive knowledge must come from all sources that adolescents encounter, from home to school to public messages of prevention.

Secondly, the young men in this study show that young women are not as disempowered as often portrayed. And young men do not always demonstrate macho attitudes and the need to “prove” themselves to their friends. Thus, empowerment discourse needs to involve both young men and young women in order to achieve a more harmonious equality among the genders. Empowerment discourse also needs to examine the attitudes of adults towards adolescents. Adolescents are capable of processing information and making their own decisions, so if adults and prevention programs really desire adolescents to make the correct choices, they need to be given all the tools to make that choice an educated one.

Thirdly, adolescents are often involved in secret meetings and relationships away from any watchful eyes of parents or extended family members such as aunts and

uncles. Parental involvement does not seem to be present, particularly with advice regarding relationships and safe sex practices. Some adolescents indicate that their sleeping quarters are in physically different buildings from their parents' sleeping quarters. This is an unusual concept for those of us living in Western societies. It is not known whether this is a traditional practice or a more practical option. However, this points to a need for addressing the adult-child relationships and any influence of culture including a culture of silence and traditional perspectives of gender socialization.

Social Forces of Change

So in terms of Portes, where do these results leave us? It will be recalled from earlier that Portes (2006) suggests an institutional framework where society consists of institutional structures (which can be made up of traditions, values and the like) that are arranged into levels of changeability, beginning with a superficial or surface level and progressing to more deep-rooted "institutions" (inherent traditions and ideas that are more difficult to change). Thus forces of change must correspond appropriately to the level of the institutional structure. Portes further distinguishes the cultural and social structural elements within that institutional structure and discusses the various corresponding forces of change (which are different for the different levels of either cultural or social structural elements). So, if we examine the societal structures and levels according to Portes, it is evident that we are not just dealing with superficial beliefs when it comes to examining those ideas, circumstances, and influences around HIV/AIDS in Malawi. There are cultural traditions and values that go beyond the level of superficial norms. These cultural traditions and values include some of the stigma

associated with HIV as well as ideas of sexuality by gender. Some values have been institutionalized (handed down for generations) and may be so deep-rooted that people tend to just live them out without any discussion or question.

All these structural levels of society need to be examined prior to implementing prevention programs making sure we are applying the correct force of change for the appropriate structural level. More specifically, we need to look at the levels of beliefs, norms, values, and traditions that are associated with HIV/AIDS. It is quite possible that programs are presenting preventions and interventions that address superficial changes (or individualistic choices) rather than incorporating the more communal nature of society in Malawi or addressing the deeper held beliefs and traditions. Thus, a mismatch between program and actual beliefs/cultures manifests and the results can only be partially or even totally ineffective. For example, if it is determined that the matter of different dwellings for children and their parents as has come up in this study is a factor that impacts HIV prevention, we must take a look at the reason behind this separate dwelling; is it a cultural tradition or simply a matter of convenience or economics (easier and better to build a few one or two room buildings rather than one entire house)? Depending upon what the reason behind this is would determine how people in practice, prevention programs, and/or policymakers would approach this as it relates to HIV prevention.

Furthermore, it is imperative to note that prevention in Malawian communities may not look the same as prevention in American communities because the factors that make up each structural level of society in Malawi are not necessarily the same as that

which make up each structural level of society in the United States. Returning to the example of an individualistic versus a communal society, this difference alone changes the nature of child-rearing, ideas about education, economics, and the future overall. Therefore, these ideas affect those institutions that Portes (2006) mentions and those institutions in Malawi would not be the same as those institutions in the United States. Consequently, this would mean that, again, prevention programs must consider the ideas, norms, and beliefs that underlie the area in which change is being sought. This also is applicable to the public health paradigm used to create prevention programs which generally stem from the idea that women are disempowered and vulnerable victims of the epidemic; results from this study seem to suggest that African women may not be as disempowered as thought and perhaps prevention programs need to adjust their paradigm to one that acknowledges the agency of women. In the manner of Freire, results of the study also suggest that prevention programs have been operating under the notion of "false generosity" whereby the programs have the best intentions to assist in decreasing the impact of the epidemic but are not really operating from a perspective that facilitates a critical consciousness on the part of those who are affected by the epidemic.

Moreover, the norms of economics in Malawi certainly impact social institutions differently than the norms of economics in a western country. Values of education are certainly different when families have to choose whether to educate their children or send them to the fields to work. Most westerners do not have to make this decision, particularly in places like the United States, where education up to 12th grade is free

and mandatory⁴². Thus the familial institution certainly has a different set of outcomes to consider in Malawi versus the United States. Additionally, with such a large part of its population living in poverty and where there is a large dependence on foreign aid, funding obligations and outcomes differ than those in western countries. And these economic situations then shape the choices being made by adolescents with regards to education, relationships, and their overall futures.

⁴² At least in the United States, school attendance up to 12th grade is mandatory, or at least up to age 18 at which point the student can choose to take classes towards a GED (High School diploma equivalent) without being in the high school setting. And in the U.S. if a child is not attending school, school authorities visit parents in the home to mandate that the child be sent to school. On the other hand, in Malawi there are no such authorities to enforce the policy of compulsory education up to 6th grade.

Chapter 7: Conclusion, Limitations, and Recommendations

There are many factors that affect the AIDS epidemic and prevention programs and these factors complicate prevention and perhaps even intervention. HIV/AIDS can be found to occur concurrently with other public health concerns such as TB and Malaria in Malawi. Poverty impacts prevention and intervention activities while social and cultural ideas in the form of stigmas and taboos create obstacles to widespread awareness and prevention. Figure 5 shows one way to look at a comprehensive picture of HIV/AIDS in Malawi and how other factors impact the prevention and intervention of HIV/AIDS. HIV/AIDS is an epidemic but one that is nestled within larger spheres of concerns and issues. For instance, as stated in the introduction, there are many concurrent illnesses such as TB and Malaria. Economic poverty also impacts the trends of AIDS infection as well as ability to access treatment, VCT services, and preventative programs including access to condoms. Furthermore, stigma, social networks, and cultural taboos also affect how HIV/AIDS and its transmission are viewed in a community, how families choose to deal with those family members living with HIV/AIDS, and the consequences of those stigmas and perspectives which might include people not wanting to be aware of their AIDS status.

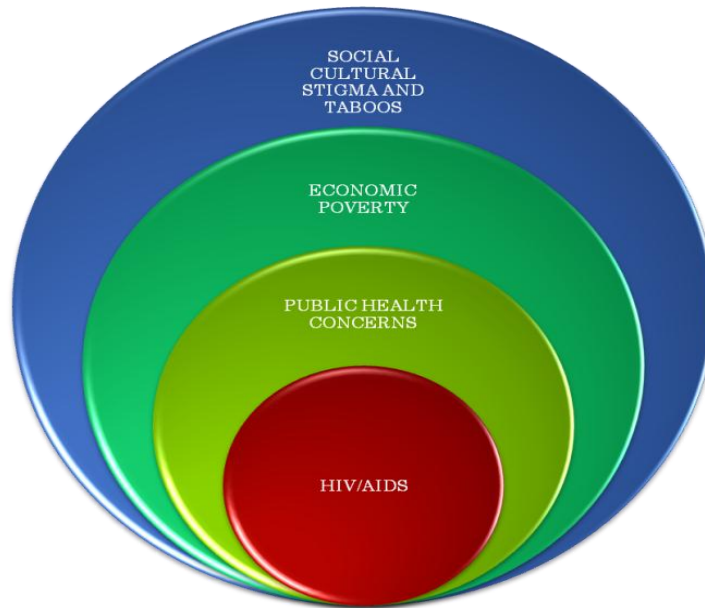


Figure 5. A Comprehensive Picture

Being a qualitative study, the results of this study are certainly not generalizable to the general male adolescent population in Malawi. However, the perspectives of these young men as examined in this study present a picture of what is occurring in their lives; and these results could certainly inform programs, practices, policies, and further research areas.

Results also show the importance of addressing the changing face of gender polarization and include young men in the move to empower young women because in the move to empower young women, young men may feel disempowered, which like Freire (2004) indicates, brings about a vicious cycle of power relations. So it is of crucial importance to facilitate an inclusive method of empowerment rather than focusing all energy on women. It is important to make sure that the empowerment of women does not simply become a disempowerment of men down the road. And it is also important

to ensure that gender roles are accurately represented rather than surmised from stereotypical gender roles.

These young men in Malawi also seem to reflect the same struggles that young adolescent men face in other parts of the world, succumbing to peer pressure and socialization. What sets them apart, however, is a wealth of other issues that most adolescents from the west do not have to face on a daily basis. Lack of resources and economic sustainability forces young men to work, sometimes choosing work over education; this also affects their relationships with young women and often it appears imperative that they work if they want to have and maintain a relationship. In turn, it appears that while young men have the ability to connect with young women, keeping a long-term relationship seems to be at times beyond their control as young women— influenced by the same economic conditions— seem to be shifting the tide of power relations, being able to choose to be with another partner who provides more “bountifully” and making demands. However, these young men do not overtly express an attempt to deal with sentiments of disempowerment nor is there any particularly masculinity scripts such as those mentioned by Izugbara and Undie (2008) where the young men feel that they must prove their virility and manhood among their friends.

The young men also portray the notions of adolescents elsewhere in the world in their preferred social networks and what they choose to do. In this sample, influence seems to come from various social networks and institutions, which makes it noteworthy to ensure that the information they receive is accurate and complete. Every part of society must have 100% accurate information, regardless of what personal

beliefs may be. These adolescents have a right to all the necessary and accurate information, to make informed decisions, and make determinations for their future with respect to HIV/AIDS; yet results have shown that adolescents may not have all the information necessary to make those informed decisions. If adolescents are growing up faster because of the circumstances of their lives, they must be treated as capable of knowing all the information about HIV/AIDS in order to understand the far-reaching consequences of this epidemic. As tempting as it may be to guard adolescents, the prevalence cycle has to be broken in part by empowering adolescents with complete information.

The breakage of the cycle has to begin with the adolescents as we have seen that the issues surrounding HIV/AIDS does not find its source just with the individuals but also with the institutions that are a part of the adolescents' daily lives. Some of the necessary forces of change, according to Portes (2006), may take some time to manifest but it is hoped that with the empowerment concepts of Freire the adolescents can accelerate these changes in order to impact their lives sooner rather than later.

Limitations of the study

There are several limitations to this study to be mindful of. First of all, as previously mentioned, due to its qualitative nature, it is certainly not generalizable to the entire adolescent male population in Malawi. Second, being a secondary analysis, further probing of a participant's answer to obtain further information or clarification of a topic or statement was not possible. This inhibited some interpretation of the

participants' statements because without the ability to probe, some of the participants' statements remained inconclusive. However, having a larger qualitative sample enabled enough participants' provisions of clear statements that supported common themes and patterns. A third study limitation was also tied to the study being a secondary analysis; interview questions were focused for a different exploratory study and thus did not delve into those topics and patterns that arose as much as one might hope or achieve in an original study. This would also include more health intervention issues such as circumcision in addition to other areas that could be expanded upon but were not. And finally, it is important to emphasize again the potential for over-reporting of condom-use by these adolescents and thus it may be more probable that some of those who say they use condoms consistently either do not or may only use it on an occasional basis.

There is also the topic of researcher bias in that it is difficult to separate the researcher from the topic of study particularly as this is a qualitative study utilizing a constructivist approach. In all the past years of reading and discussing issues related to the epidemic with others as well as a personal connection to the country and its people, it is through a particular filter that this secondary qualitative analysis is conducted. However, acknowledging the personal connection to the study, all attempts were made to ensure the concepts and ideas in this study emerged from the data and were supported by the data.

Recommendations for Policy, Practice, and Further Research

The results of the analyses conducted in this study and the interpretation of those results can be summarized into several key findings: comprehensive, objective knowledge of HIV must be disseminated; young women are not as powerless as portrayed; economics impact the decisions of these young men—whether it be related to condom use or education; and familial relationships also need to be examined as most parents are unaware of their children’s activities, even if this unawareness may be culturally influenced and gender-based. Most adolescents are aware of HIV as a fatal disease; however, some previous studies and the current study indicate a disparity between knowledge and behavior. As discussed in an earlier section, even the MDHS 2010 reported that less than half of both men and women ages 15 to 54 in the survey had comprehensive knowledge about AIDS. Knowledge is not merely an awareness of HIV and its transmission but a comprehensive knowledge of risk factors and protective methods. This comprehensive knowledge can be defined using the already existing description from the MDHS 2010 which states the following:

knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention –that HIV can be transmitted by mosquito bites, and that HIV can be transmitted by supernatural means. (National_Statistical_Office & ICF_Macro, p. 168)

This comprehensive knowledge must be disseminated to both young men and young women equally as young women are able to exercise choice and control in sexual relationships more often than is commonly portrayed in most articles. While women are still vulnerable and empowerment is necessary, findings in this study and the original

study have shown that young women are capable of initiating and engaging in safe or risky behaviors independent of the dictates of their male counterparts. Not only that but each adolescent has the potential to influence the choices and decisions of other adolescents, whether it be through friendship or partnership. And most of these decisions, whether made by young men or young women, are usually influenced by economics. In a country where half the population lives at or below the poverty line, each decision made is influenced by the availability of money or the gain of money. Young men in this study mentioned that they worked to pay for their school fees, to afford things for their girlfriends, to provide for their families, and sometimes to budget for condoms. They also mentioned that sometimes their girlfriends would be found talking with other men and the assumption was because of monetary provision. Economics also influenced secondary school attendance, and some young men had to drop out because of the lack of money for fees. Most of these young men who dropped out may not return to school for various reasons thus impacting the overall educational status of young men in the country. Economics as well as culture may also influence family dynamics and a culture of silence or a culture of openness between parents, extended family members, and children. It is important to involve adults to obtain their perspective on what is happening with the adolescents in their families and communities.

The findings of this study lead to several points of consideration for practice, policy, programs, and further research. These points can be grouped into broad topics:

HIV/AIDS awareness education and prevention programs; economics; education; and further research.

HIV/AIDS Awareness Education and Prevention Programs

With respect to HIV/AIDS awareness education, results show that information dissemination needs to be thorough. It is well understood that churches are reluctant to present and support the entire “ABC” prevention campaign; so there must be counterparts that fill in those gaps—i.e. public media, hospital, government, public education. This means that those who disseminate information (i.e. teachers and health care workers) must also be thoroughly informed and educated, and committed to passing on *all* information *objectively* rather than solely speaking about those preferences that are subjective to the person or the institution. This also means that accurate information about condoms must be conveyed.

The results of this study indicate that adolescents do not consistently use condoms to protect themselves during sexual intercourse, which with an epidemic such as AIDS can be cause for alarm. However, condom use is critical and must be conveyed as such to the adolescents—both male and female—in practice and in policies. Condom use is not only critical to the prevention of AIDS but also in the prevention of unwanted pregnancies. Thus, it behooves prevention programs and those in practice to convey the usefulness of condoms for both the prevention of AIDS and of unwanted pregnancies. Results show that some adolescents already understand the purpose of condoms for the prevention of pregnancy but may not necessarily understand that it can significantly decrease risk of HIV transmission; as such, those in practice and

prevention program messages can build on that knowledge. Perhaps there needs to be more comprehensive condom education, teaching adolescents that it helps prevent both unplanned pregnancies *and* sexually transmitted diseases including AIDS.

In recent years, there has been a call to discard the familiar “ABC” campaign and in its place the “SAVE” approach to HIV prevention⁴³ has been increasingly receiving attention as AIDS continues to remain at the forefront despite decades of funding and efforts poured into fighting it. The SAVE approach appears to be more appropriate considering the model originates from the perceptions of African leaders finding that the ABC campaign promoted by PEPFAR along with other international organizations (and a Western viewpoint) has not been adequate in covering all the complicated aspects of the epidemic. The perspectives from the adolescents in this study support the use of this new intervention as results have indicated that the ABC campaign has not been as successful as hoped. An approach like SAVE may also help reduce the stigma associated with AIDS and enable more open and honest responses to questions about HIV, which would in turn reduce the impact of social desirability in future studies and the potential for over-reporting of condom use.

With a more appropriate and comprehensive approach, prevention programs and HIV/AIDS education programs must also emphasize passing along thorough and complete information to the adolescents. It is understood that HIV/AIDS is associated with stigma and is culturally a taboo topic; however, as discussed results of this study indicate that some adolescents make choices based on incomplete information. The

⁴³ SAVE stands for Safer practices, Access to treatment, Voluntary counseling, and Empowerment. The approach was originally formulated by the leaders of the African Network (ANELA+) as a response to the shortcomings of the ABC campaign. See http://manerela.org/SAVE_Model.html for more information.

choices that adolescents make can result in negative and undesired consequences. Empowering them to take charge of their future means giving them all the information that is necessary to enable them to make the best decision for their lives, rather than deciding what information they need and do not need. Decisions based on incomplete information, on the part of both genders, can be detrimental and contribute to the epidemic consequences of HIV/AIDS.

The family and village/community in which adolescents live must not, however, be bypassed in this issue. Adults must be informed that there is such evidence that adolescents are making decisions based on incomplete information; thus results such as those from this study should be shared with adults in the community to encourage the participation of the adults in the educational process and ultimately in their children's future with respect to the epidemic. Empowering adolescents alone will not work if there is a conflict in the adolescent-adult relationship, however small or large the scope of that relationship (i.e. between parent and child or between children and tribal traditions).

HIV prevention and intervention programs must start with the communities in which adolescents live. Families need to be involved and cultural traditions of parent-child communication must be examined. Granted that it is understandable adolescents can be reluctant to speak to their parents about personal issues, adolescents are carrying out their relationships in secret, sneaking away from the house at night or coming home late as some of the adolescents have indicated in this study. Thus it is conceivable that parents have no idea that their children are demonstrating risk-taking

behaviors with the possibility of contracting a deadly disease. If they do have an idea but do not interfere due to cultural ideas regarding the socialization of adolescents, these too must be examined and addressed with the parents to promote discussion as to how to move forward together.

Youth intervention and prevention programs have to be cognizant of "cliques". Adolescents can be inclusive but can also be driven to exclusivity; youth club organizations will not be effective if the adolescents themselves view the members as cliquish and hypocritical. Administrators of these programs need to involve club leaders and members in training on a frequent basis, not just in HIV issues but in tolerance and acceptance of all. Otherwise, it seems the youth clubs may be in a position to perpetuate the incidence of new HIV infections.

Additionally, youth programs must also be sure to reach as many areas and regions as possible. Although there are myriad reasons for conducting youth programs in certain areas, it is important to ensure that youth are being educated in all regions of the country. Not having equal information distribution may affect the results of the epidemic and the prevalence rate for HIV/AIDS. Results of this study showed that not all students in this sample population attended youth club programs or knew of youth club programs they could attend. For those adolescents who were attending youth club programs, success of their prevention programs appeared to be difficult to assess.

Finally, results of the study showed that although not many adolescents in this study participated in VCT those that did either changed their behavior or learned not to

be fearful of AIDS as long as both parties knew their HIV status prior to sexual activity and shared that status with one another. Thus this provides insight into the campaign to promote VCT as VCT would promote empowerment among the adolescents. Knowing one's status will help one safeguard it and also be aware of how that status might change due to one's future decisions regarding sexual activity. As a result, in practice and policy, stressing the importance of VCT and knowing one's status would be helpful in promoting behavior change in adolescents as well as spurring them on to really make better decisions for their future.

Gender Issues

As far as gender roles go, the results of this study paint a different picture of gender relations where young women are initiating and exerting choice rather than submitting themselves to young men's wishes. Although it is not a comprehensive indicator of gender equality, it does appear to be a positive shift in that direction. And as a result the evidence of women's assertion in relationships points to the continued importance of educating women, in this case in the comprehensive knowledge of AIDS so that when they exert or initiate a choice, it is one that will be in the direction of decreasing HIV transmission rather than in the direction of refusing condom use. However, it is also important to keep in mind that in emphasizing only the empowerment of women while excluding the men might result in a less-than-ideal achievement of gender equality. The empowerment of women must also involve the

buy-in of their social counterparts: men⁴⁴. The onus of empowerment should not solely rest on the shoulders of women nor should the prevention of HIV or the decrease of prevalence rates, despite there being numerous public health studies that suggest educating women increases the health of a population. A majority of the infected population in southern Africa is among those who describe themselves to be in a *heterosexual* relationship (as opposed to IV users, prenatally transmitted, etc.). Thus, research in HIV/AIDS must be inclusive of the male perspective in this epidemic so as to ascertain the bigger picture of what is going on and what is being overlooked in the struggle against HIV/AIDS. It is also important to ensure that, as Seeley and colleagues (2004) mention, stereotypical gender roles, such as masculinity and macho attitudes of men over women versus the helplessness and so-called weakness of women, are indeed the accurate representation of the genders in a community or population being studied. It would seem that in this case, those stereotypical gender roles may not be an accurate representation of the young men and women in Malawi.

There is also the need to address men having sex with men as it is not a topic that has come up in the original study or this study and how that fits in to the comprehensive picture of the AIDS epidemic. Albeit this is a difficult and taboo issue in Malawi considering the legal ramifications, it is a viable concern with respect to the fight against AIDS. Just because people do not mention homosexuality does not mean it does not exist; however, due to it being considered "illegal" in Malawi, it is

⁴⁴ This is not to say that there are no homosexual relationships in Malawi, let alone Africa, but for the purposes of this dissertation it will be noted that the majority of infected persons in Malawi are those who *describe* themselves as being heterosexual and relationships are discussed as heterosexual albeit this is not being prescribed as the only "normative" relationship.

understandable that homosexuality would be hidden and thus make it less likely for them to access HIV services. Practice has to be inclusive of those who may be homosexual to ensure they can access prevention services in a safe environment as indicated in Malawi's National AIDS Policy (National_AIDS_Commission, 2003).

Economic Issues

Economic situations have to be addressed as it makes things complicated in a variety of ways as evidenced by the results of this study. Economics influences relationships and choices of relationships, the need for work, access to condoms and antiretroviral treatment in many situations, and in particular, education. Some of the adolescents in this study expressed that they could not afford to complete their secondary education because of the school fees. They also expressed that they could not afford to purchase condoms or find the time to go to the health center in order to obtain the free ones or get tested for HIV. Thus prevention programs that emphasize condom use need to also consider the economic factor in obtaining these condoms; perhaps methods of delivery, such as condom distribution and access to VCT, must be re-evaluated.

Furthermore, some young men see work and the need for economic stability and gain as a way to keep their partners. Young women on the other hand cannot help but remain dependent on male partners for provisions and supplies, making the economic potential of a partner an important factor in their relational choices. Thus providing

economic opportunities as well as improved access to condoms and prevention programs is an important aspect of overall HIV/AIDS prevention.

Education

Education as a whole, not just education in HIV/AIDS awareness, is a critical issue for these adolescents. Quite a few adolescents in this study wanted to complete their education, particularly secondary education, but could not afford to do so due to the school fees. Thus, they dropped out to work in order to save up for school fees. When they found themselves in a position to return to school they found that they were a year or two behind their peers and faced being teased by their younger classmate. For this reason some adolescents in this study have indicated that they become discouraged in returning to school and completing their education; as a result they dropped out permanently. It is important to evaluate how widespread this issue may be and find solutions to encourage the completion of adolescents' secondary education. Options to complete their education should be available to these adolescents, perhaps in an alternative setting so they are not ridiculed and thus less motivated to attend school. Free secondary education might also want to be considered so that these adolescents do not have to drop out due to monetary problems. These are important issues to address as secondary education is crucial to the overall development of the country and its workforce.

Further Research

The results of this study, being only focused on a small part of the overall population, point to more areas for future research to undertake. Future research is needed to examine what factors might better engage adolescents in consistent condom use. Research needs to continue to address the issue of gender perspectives and how women are exerting their voice in order to understand how the empowerment of women is influencing the dynamics of relationships. These dynamics then need to be incorporated into new programmatic discussions and policy implementations as well as empowerment dialogues. Research also needs to further address accurate representation of gender roles in Malawi, and then in other sub-Saharan countries, in order to subsequently research how prevention programs might be operating on a different paradigm of gender role assumptions and therefore contributing to the lack of success in prevention programs.

Future research might also want to attempt to address homosexuality in Malawi. As indicated previously, despite it being illegal, it is a piece of the bigger picture in the fight against AIDS. Due to the legal ramifications of disclosing one's homosexuality, people in this population are less likely to be visible and less likely to self-disclose in a personal interview. However, it is important to know and understand if and how this population contributes to the prevalence rate in Malawi and perhaps to use those results in advocating for policies and practices that enable these individuals to access HIV services in a safe environment without fear of repercussion.

Research is also needed in communities trying to implement the SAVE approach to HIV prevention to provide more documented support for a holistic approach to

HIV/AIDS prevention in Malawi and in sub-Saharan Africa as whole. Results in this study support the move towards such an approach. It is crucial to not only gather more data on this approach but also to portray a more accurate picture of condom use and prevention activities as they relate to high prevalence rates.

Further research may also want to examine attitudes of adolescents prior to VCT and after VCT. Because the number of adolescents in the current study sample that actually participated in VCT was only a few, it would be helpful to see if there is a pattern as far as behavior change after participating in VCT. The findings of such a study would help influence practice and policy on a wider scale. And future studies can also address the use of male circumcision as part of a preventative measure in Malawi—whether it is being promoted and implemented as a strategy and how it is being viewed and/or received by people.

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http://www.unctad.org/sections/lcd_dir/docs//ltdc-mlw.pdf

Appendix 1

Map of Malawi



Source: <http://www.norwich-dedza.org/images/malawi.gif>

Appendix 2

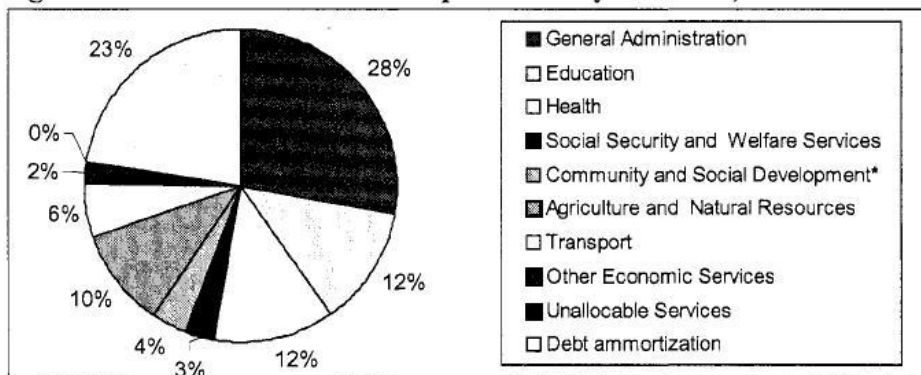
Population Growth Demographics for Malawi

Year	Births per 1,000 population	Deaths per 1,000 population	Net number of migrants per 1,000 population	Rate of natural increase (percent)	Growth rate (percent)
1977	53.70	22.92	0.00	3.078	3.078
1979	53.62	22.44	0.00	3.118	3.117
1981	53.51	21.79	0.00	3.172	3.171
1983	52.54	20.86	0.00	3.168	3.167
1985	50.80	19.60	0.00	3.120	3.120
1987	49.22	18.46	38.38	3.076	6.914
1989	48.32	17.40	24.18	3.092	5.510
1991	47.87	17.12	5.52	3.075	3.628
1993	47.28	17.61	-32.94	2.967	-0.328
1995	46.46	18.84	-8.70	2.762	1.893
1997	45.83	20.12	0.00	2.571	2.571
1999	45.33	20.92	0.00	2.441	2.441
2001	44.21	21.01	0.00	2.320	2.320
2003	43.40	20.52	0.00	2.288	2.288
2005	42.73	19.36	0.00	2.337	2.337
2007	42.09	18.25	0.00	2.384	2.383
2009	41.48	17.60	0.00	2.388	2.388
2011	40.79	17.15	0.00	2.364	2.364
2013	40.01	16.79	0.00	2.322	2.322
2015	39.19	16.50	0.00	2.269	2.269
2017	38.25	16.21	0.00	2.204	2.204
2019	37.25	15.93	0.00	2.132	2.132
2021	36.25	15.64	0.00	2.061	2.061
2023	35.23	15.35	0.00	1.988	1.988
2025	34.21	15.07	0.00	1.914	1.914

*Source: U.S. Census Bureau, International Data Base.

Appendix 3

Figure 1.5 Allocation of Public Expenditure by Function, 2004/05



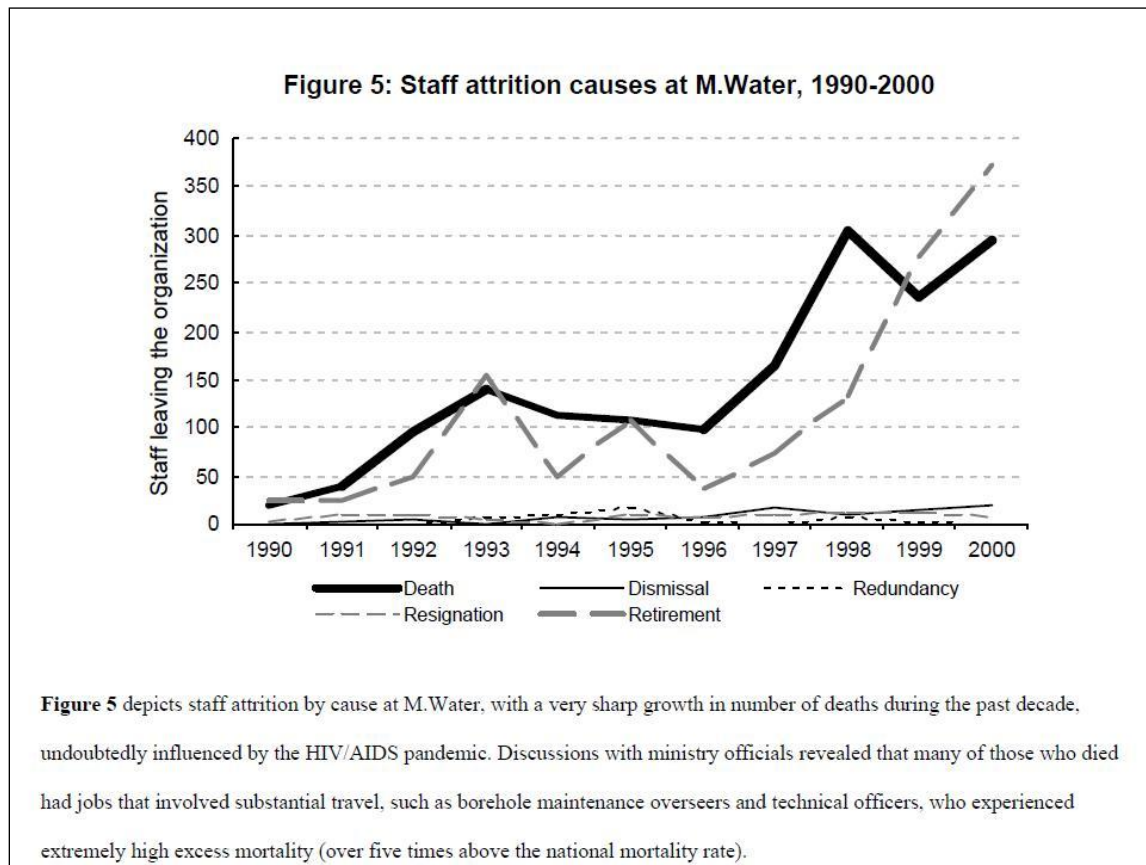
Source: GOM Economic Report, various years.

Note: 'General Administration' includes a large number of smaller votes: State Residencies, National Audit Office, National Assembly, Office of the President and Cabinet, Human Resources Management and Development, Directorate of Public Procurement, Defense, Malawi Defense Force, National Statistical Office, Foreign Affairs, Malawi Revenue Authority, Home Affairs, Police, Prisons, Immigration, Justice and Constitutional Affairs, Directorate of Public Prosecution and State Advocate, Registrar General, Human Rights Commission, Electoral Commission, Anticorruption Bureau, Law Commission, etc.

Public Expenditure by Function for 2004-2005⁴⁵

⁴⁵ Source: World Bank (2007), *Malawi Public Expenditures Review*, Washington, DC: World Bank

Staff attrition at the Ministry of Water⁴⁶



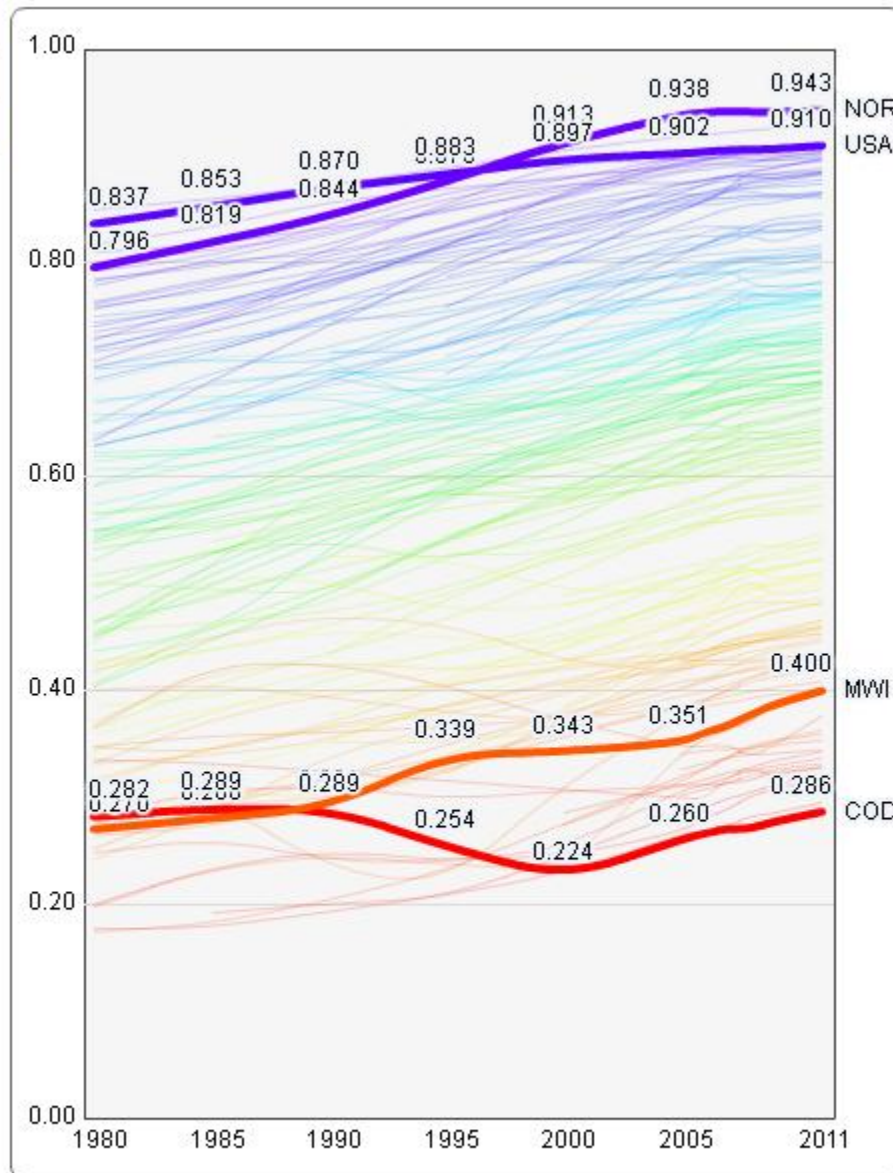
⁴⁶ Source: World Bank Report (2008), *HIV/AIDS, Climate Change, and Disaster Management: Challenges for Institutions in Malawi*, May

Appendix 5

HDI Trends for Malawi from 1980 to 2011, compared to selected trends of other countries⁴⁷



Human Development Index (HDI) value



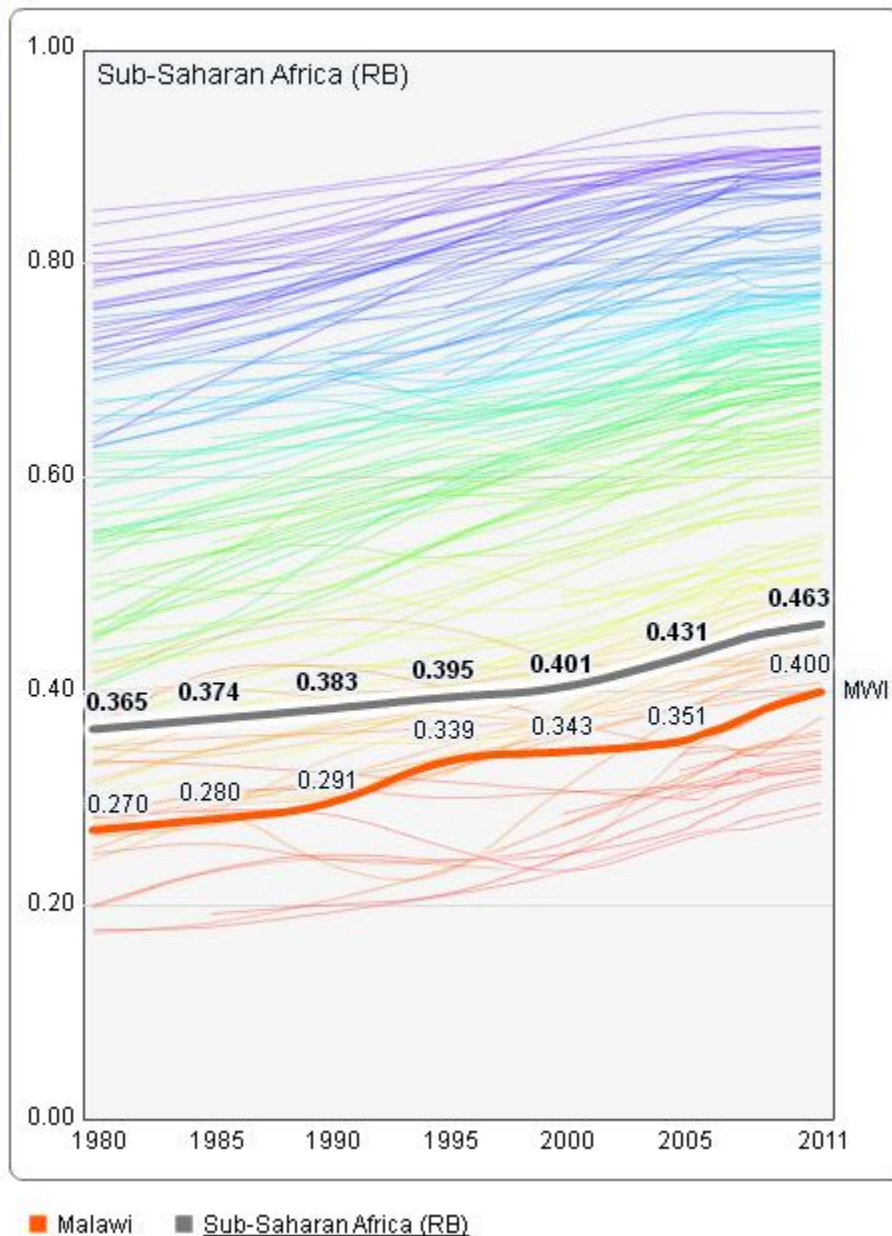
■ Congo (Democratic Republic of the)
 ■ Malawi
 ■ Norway
■ United States

⁴⁷ Source: <http://hdr.undp.org/en/data/trends/>; Norway is ranked #1 in the world; Congo (Democratic Republic of the) is ranked last (#187). The United States is ranked #4 and Malawi is ranked #171.

HDR Trends from 1980 to 2011, comparing Malawi to that of Sub-Saharan Africa⁴⁸



Human Development Index (HDI) value (Sub-Saharan Africa (RB))



⁴⁸ <http://hdr.undp.org/en/data/trends/>

APPENDIX 6

AN INVESTIGATION OF UNMARRIED ADOLESCENTS' PARTNERSHIPS IN RURAL MALAWI *Training Guide for Rumphi Site*

I. Introduction and Quantitative vs. Qualitative research: A General Overview.

The main advantage of qualitative research is that it allows us to get at more detailed, complex information that we simply cannot capture with structured, close-ended questions most often found in survey questionnaires. While surveys are great at capturing a wide variety of data about large numbers of people, qualitative methods are better equipped at getting "in-depth" information about more specific topics. While there are other types of qualitative methods, such as focus groups, in this project we will use the 'in-depth interview' as our main methodological tool. The in-depth interview in this project is largely unstructured, and will

II. The aims of this project.

The overall aim of this qualitative research project is to understand the various aspects of relationships and partnerships that young people engage in. We want to know detailed, in-depth information about who the (sexual) partners—both short-term and long-term—of unmarried girls and boys (ages 15-24) are, and about the sexual behaviors that occur within them. This is a broad topic, and we want to know a lot about it, so the in-depth interview that is conversation in style is really the best way to go about getting at this information.

More specifically, we are interested in knowing the following things about partnerships, and the following six topics are the general themes you will need to ask each respondent about:

- 1) *School.* Is the respondent in school? Why or why not?
- 2) *Partnership beginnings and endings.* Things relating to this that you could ask the respondent about are: How did you meet your girlfriend or boyfriend?
- 3) *Who are these partners?* Are they schoolmates? Someone who is married? How old are they?
- 4) *Gifts and money given.* If and how gifts and money are exchanged within those partnerships,
- 5) *Sexual behaviors* various aspects of that take place within partnerships,
- 6) *Marriage hopes and expectations.* Whether the respondents have hopes for marriage, and, if so, what are those hopes.
- 7) *Friends*

See Interview guide for more detailed examples.

III. Qualities of the qualitative interviewer.

In many ways, the qualitative interviewer requires certain skills that go above and beyond what is required of the quantitative interviewer. It is essential that a good qualitative interviewer to have excellent conversational and listening skills. The qualitative interviewer, like all good researchers carry themselves in an interview, is never judgmental. They do not impose any "morality" onto the respondent. You should not end an interview by telling the respondent what he or she did wrong! You should never tell a respondent, for instance, that she should go to church more, or that he really should abstain from sex. Remember, this research is not a

public health campaign. We never want to make the respondent feel bad about his or her behavior. Why? For two main reasons:

- 1) By making the respondent feel uncomfortable, it could seriously alter any further responses given. The respondent simply may not want to tell the qualitative interviewer the truth, if he or she feels as though her answers will somehow not meet the approval of the person to whom she is telling.
- 2) This project is a longitudinal study. We will be back to follow-up and re-interview these same respondents. Therefore it is important that we maintain good rapport with each for the future.

IV. *The Interview.*

Social science research is generally concerned with the comfort level of the people involved in the research. This is true in for all population groups—whether they are men or women, young or old, those who live in rural areas or in more urban settings. In this project, our population is a group of young people in rural Malawi, and because they are young and we want to know about things they may want to keep hidden, your task is particularly challenging. You were all selected not only because of the skill you have demonstrated in the past, as good interviewers, but also because it is important to match interviewer and respondent on certain characteristics. For instance, we want the interviewers and respondents to be closely alike in terms of age, sex, ethnicity, and place of residence. Thus, a young boy 16 years of age who lives in a far-away village may be less likely to talk about private information about his *chibwenzi* with a 35 year old woman who lives in Lilongwe as he would with someone who is a boy of 19 and lives in a nearby village.

This qualitative project has special requirements of each interviewer. Because much of what you will be discussing will be about partnerships and sexual behavior, the interview may take on a different meaning and be different in tone than other projects that focus on areas that are less private (e.g. a project that asks wants to know about a family's religion). So remember, **sexual behavior is a very sensitive topic!!** Keeping this in mind, it is a good idea to think about how this sensitivity may affect the interview itself, and how you—the skilled qualitative researcher—can accommodate the respondent in these situations.

Consider the following: How can the interviewer be sure that the respondent is being truthful with his or her responses or stories? Answer: She cannot!! But, she can look for clues during the interview which might tell her that the respondent may not be saying things as they really happened. For example, the interviewer may find that there are inconsistencies in the respondent's stories. In addition, the skilled interviewer can do her best to make the respondent feel as comfortable as possible, much like the respondent would feel if she were confiding in a close friend or a sister.

Imagine the following situation: One of our respondents is a 15 year old girl. She and her parents give consent to an interview, but mostly because they are offered a packet of sugar. In comes a stranger (the interviewer), who represents a large research project, and proceeds to ask her questions about sexual behavior. Maybe the interviewer, the stranger with a fancy T-shirt, wants to know all about the first time the girl had sexual intercourse. How might this situation and this type of question feel like to the young respondent? If she did have sex, why

would she want to tell the stranger? What if the sexual act was forced? Do you think she will want to tell this information to the interviewer? It is important, then, that the skilled interviewer, think about this situation and what she can do to allow the respondent to feel comfortable enough to be truthful in her answers. Another example of something the respondent may not want to tell is with other partners outside of boyfriend/girlfriend, or if the respondent has more than one. They may be hidden partners, so that no one knows about them. How do you think you can get the respondent to talk about these?

Also keep in mind, this style of research, unlike the quantitative or survey research, is conversational. One word answers or very short sentences will not sufficiently capture the detailed information I am looking for. You, as the skilled interviewer and conversationalist, must quickly learn to make the respondent feel comfortable and open with you. Your aim is to capture the stories told by each respondent. Use each of the six themes listed in the interview guide as starting points. Each theme refers to the main points I want to know about, and I want as much detail about each as possible for each and every respondent.

It is very important that you write down the stories told by the respondents in the words in which they chose themselves, to the greatest extent possible. I DO NOT want you to change their wording into something that may be, in your mind, more correct. For example, it is not likely that these respondents will know that the new language of STDs is commonly expressed as sexually transmitted infections, or STIs, by research organizations. I will be very suspicious if the phrase 'sexually transmitted infection' comes up in an interview repeatedly.

Where and when to probe: In general, you want to follow up on the topics and questions indicated in the interview guide. However, the following items may come up at times spontaneously, but if they do not, or do a little, probe to find out more: school, marriage, sexual behavior, exchanges, the relationship/partnership itself.

Note: We will be cross-checking with some of the interviewers. We will re-interview 5 respondents in each site.

Finally, please refer to the other two relevant documents: 'notes on note-taking' and 'problems during an interview' for further, helpful information.

In-Depth Interview Guide
Balaka and Rumpfi, Fall/Winter 2004

The following seven topics are those you should ask about and discuss with each respondent. Keep in mind that these topics need not be brought up in the order in which they appear in this guide; it is likely that some will come up spontaneously over the course of the conversation. Also keep in mind that the bullets under each are suggestions, they are not the only possible areas to chat about.

For each respondent, we want to gather as much information about each topic as possible. Remember to probe and explore these areas "in-depth", as we discussed during the interviewer training. Before you end each interview, you should ask yourself if you have thoroughly covered each of these topics. It is very important to know the "whys"!! (e.g. Why are you no longer schooling? Or, why did you accept this *chibwenzl's* proposal?) Please try to keep the conversation going for as long as the respondent feels comfortable. As identified in the consent, remember that if at any time the respondent feels uncomfortable during the interview, he or she may stop.

(1) SCHOOL

- Is the respondent currently in school?
- (If yes), talk to the respondent about school.
- (If no), talk to the respondent about why he or she is no longer in school.
- (If the respondent is finished, and/or has a secondary school certificate), talk with the respondent about what he or she is doing now (for work).

(2) PARTNERSHIP BEGINNINGS AND ENDINGS

- Ask the respondent about how did she or he met your *chibwenzi* (or *chitomelo*).
- If they do not have a boyfriend or girlfriend, ask if they did in the past.
- If they still say they did not, ask why, and whether they want one.

- Did he propose to her? Was she proposed to?
- Be sure to get a full story about the *chibwenzi* or *chitomelo*.

(3) PARTNER AND PARTNERSHIP CHARACTERISTICS

- Who are these partners?
 - Are they schoolmates?
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- How long did the relationship last?
 - Is the partner/s married?
 - What is their age?
 - How do you spend your time together?
 - What else?

(4) MONEY AND GIFTS

- If and how are gifts and money exchanged between *zibwenzis*?
- What was given and what was the amount given?
- When are they given?
- Were the gifts somehow different in the beginning of the relationship or are they the same?
- What else?

(5) SEXUAL BEHAVIOR

- How often does the respondent have sex with his or her partner/s?
- Do they use condoms?
- Why or why not?
- Does the respondent have another partner?
- Does the respondent's partner have other partners?
- What else?

(6) MARRIAGE HOPES AND EXPECTATIONS

- Does the respondent have hopes for marriage?
- What are those hopes?
- What else?

(7) FRIENDS

- Does the respondent have friends he or she likes to chat with?
- Who are these friends? Are these friends in school, in the same church, and/or in the same village?

- When they chat with their friends, what do they chat about?
 - Do their friends have *zibwenzis*? Why or why not?
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