GENDER, RELATIONSHIP POWER, AND HIV TESTING
IN RURAL MALAWI

by

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ABSTRACT

This dissertation considers how relationship power shapes men and women’s decisions around HIV testing, which is the gateway to HIV/AIDS prevention, treatment, and care in sub-Saharan Africa. The study is situated in a high HIV prevalence community in southern Malawi where rapid expansions in HIV testing services provide new opportunities to learn one’s HIV status. I focus on two public health concerns around HIV testing that have been inadequately studied at the relationship level: uptake of HIV testing services and disclosure to primary partners. To accomplish this, I use an iterative, mixed-methods design to: 1) develop a model of relationship power for Malawi, 2) test for associations between power and HIV testing behavior, and 3) explain, validate, or challenge these findings using qualitative data. Quantitative data on 466 couples come from Tsogolo La Thanzi, a study on reproduction and AIDS in southern Malawi. Qualitative data consist of 34 semi-structured interviews and 8 focus group discussions. Using the three social structures of the Theory of Gender and Power—labor, power, and cathexis—I develop and test a preliminary model of relationship power consisting of three domains: economic power, relationship violence, and relationship dominance. Factor analysis revealed two additional constructs of power related to unity and discordance, which were validated as important using qualitative narratives. Next, I use this modified model of relationship power to test hypotheses around uptake and disclosure. Economic power, relationship dominance, unity, and violence emerged as important predictors of testing uptake for men and women. In the disclosure models, economic power, violence, and unity were predictive. Contrary to my hypothesis, young people with higher levels of unity were less likely to test for HIV. This finding was explained by the widespread belief that HIV testing was reserved for times of trouble, such as infidelity, rather than for relationships filled with unity, love, and trust. Study conclusions highlight the need to facilitate theoretical and applied approaches to HIV testing that encompass the couple context—including aspects of unity. Universal HIV testing may provide a promising solution for couples to circumvent exceptionally difficult negotiations by deferring decisions to healthcare providers.
The form and content of this abstract are approved. I recommend its publication.

Approved: Sheana S. Bull
DEDICATION

I dedicate this thesis to the Malawians who suffer unnecessarily from AIDS and to others who live in a state of uncertainty about whether they will become infected with HIV. Your warm hearts, incredible strength and resilience, and receptiveness to my research has given me the fortitude to complete this dissertation and dedicate my professional life to AIDS intervention research in Africa. I can only hope that one day my career will be forced to go in a dramatically different direction after an effective cure or vaccine for AIDS is discovered and made accessible to all.
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To all of you, I say Zikomo Kwambiri.
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CHAPTER I

INTRODUCTION

In a dusty African village on the outskirts of the Balaka town in southern Malawi, Caroline interviews a 23-year old married woman named Ruth about her relationship history. As the interview unfolds, the two women begin to talk about HIV testing, a salient topic of discussion in a setting where HIV prevalence ranks among the highest in the world. Caroline asks Ruth, “So when you went for HIV testing, did you tell husband or did you just go?” Ruth answers, “I told him that there was no reason to be afraid of knowing how your blood is but he refused to go, so I went by myself. He was saying that I was doubting myself.” When Caroline asks Ruth if she continues to plead with her husband to go for testing or if she gave up trying, she responds:

No, I didn’t give up, I always tell him. The first time I went I told him that “you should also go so that we can have proof that we are alright, but if you don’t then I will be having doubts.” Maybe my husband is positive or negative. I will not be sure. The second time I went I told him the same, but to no avail. He says that he can’t go and that those who go for testing are doubting themselves. They don’t trust themselves. It pains me that he is not helping me and the children. (semi-structured interview, female #9)

I present Ruth’s narrative not to bolster support for the powerless woman depiction that is common in gender research and policy on AIDS in Africa (Esacove 2013; Higgins, Hoffman, and Dworkin 2010), but instead to illustrate Ruth’s tremendous agency in her persistent attempts to change her husband’s position on HIV testing. Unlike Ruth’s situation, not all Malawian women are as forthcoming and relentless with their partners about testing. Nor do all husbands refuse to get tested with their wives. Her story does,
however, exemplify one of many different ways that wives and husbands negotiate HIV testing with each other to learn their HIV status.

**Research Aims**

This dissertation seeks to better understand the relationship context around HIV testing behavior, particularly decisions to get tested and disclose test results to spouses or primary sexual partners. Such an examination of heterosexual partnerships requires attention to the everyday relationship dynamics within young couples. In this dissertation, I examine the pathways and mechanisms through which relationship factors, particularly power, influences HIV testing behavior among young couples from rural Malawi. Three specific aims will be addressed with this research:

1. To explore quantitative measures of relationship power for the Malawi context (a) and to evaluate their cultural relevance with qualitative data (b).
2. To test whether relationship power influences two types of HIV testing behavior: uptake of HIV testing services (a) and disclosure of test results to primary partners (b).
3. To understand the meaning of HIV testing within the context of a sexual relationship.

To my surprise, I find that what unites the numbers and narrative in this dissertation is the underlying construct of *unity*: that is, notions of love, trust, intimacy, communication, and reciprocity. At first glance, the idea of *unity* appears antithetical to the term *power*, which has been historically conceptualized as an imbalance between men and women. But to the
contrary, rural Malawians believe that these relationship qualities provide a source of power for them in their relationships. This raises the question, if one has power or unity in their relationship, is it still necessary to get tested for HIV? The qualitative data from this dissertation show that the HIV test does not simply provide a medical diagnosis; instead, people construct meaning around the act of testing and the test result itself within the context of their everyday relationships. At times, this addition of symbolism around testing conflicts with how HIV testing services were designed to function from a public health perspective: to detect HIV infection as earliest as possible in the disease course.

This idea resonates in Ruth’s narrative above. She tries to convince her husband about the diagnostic benefits of HIV testing, i.e., to “learn how their bodies are,” but her husband claims that HIV testing is for those who suspect they are HIV positive or have engaged in promiscuous sexual behavior—as opposed to those who are faithful to their partner and practice safe sex. According to her side of the story, both Ruth’s desire to test and her husband’s refusal make both members question the other’s HIV status and sexual exclusivity, as expressed with the euphemism “having doubt.” Here, an HIV test becomes a symbol of something larger and perhaps more important to some people; it becomes a marker of their relationship status rather than just their HIV serostatus. Thus, an HIV test signifies the absence of unity in the relationship—a characteristic that many couples idealize and strive for in their partnerships.
The Importance of Couple Context

Sexual relationships comprise the social fabric of life in rural Malawi. They are the intimate setting where people get married and children are born, which in turn brings tremendous social status and fulfillment to both men and women. Scholars have even stated that in sub-Saharan Africa, “marriage remains one of the most important individual aspirations and social duties that an individual ever experiences” (Smith and Mbakwem 2007). In a very poor setting complicated by seasonal famines and high unemployment rates, relationships are not only critical for social identity, but for survival. The gendered social norms dictating the division of labor prescribe how husbands and wives are supposed to behave and contribute to the household well being—and it is the economic and social support received through these arrangements that maintains people’s existence and livelihoods. Yet, in sub-Saharan Africa, these ongoing heterosexual relationships are the place where most new HIV infections occur (Dunkle et al. 2008; Maleta and Bowie 2010). Therefore, young people face competing aspirations and needs related to marriage, childbearing, death, and survival while navigating their risk for HIV infection at the same time: a daunting task to say the least, which may force some people to prioritize what is most important to them (Dionne, Gerland, and Watkins 2013).

Young couples are particularly susceptible to HIV infection as they undergo a series of transitions from courtship to marriage and then later, to parenthood. Paradoxically, serious relationships such as marriage in which high levels of intimacy and trust have been established are thought to be more risky than causal, promiscuous encounters (Mkandawire-
Valhmu et al. 2013). This is for several reasons. As young couples begin to form their families, condoms are no longer considered an acceptable preventive measure for HIV/AIDS (Chimbiri 2007). In love marriages, where women rely on ideals of love and intimacy to negotiate relationships with their husbands, condoms are seen as undermining the very thing they wish to preserve (Smith 2006). Low condom use coupled with extramarital partnerships—more notable among men than women (Schatz 2005; Carpenter et al. 1999; Lurie, Williams, Zuma, Mkaya-Mwaburi, Garnett et al. 2003)—provide ample opportunities for new HIV infections to develop during young adulthood.

Despite relatively high rates of HIV infection among young people who are just beginning their sexual and reproductive lives, recent expansions in HIV testing and counseling (referred to as “HTC” from a policy perspective, but also labeled as “VCT”—or voluntary HIV counseling and testing—in the literature and among rural Malawians) services throughout Malawi provide an important opportunity for both individuals and couples alike to learn their HIV status and take action to protect their own and their partner’s health. HIV testing plays a pivotal role in the public health response to the AIDS epidemic and is a vital entry point for HIV prevention services, care, and treatment (VCT Efficacy Group 2000; Painter 2001). Although access to HIV testing has generally improved throughout the region, many people still do not know their HIV status and for those who do get tested, levels of disclosure of HIV test results to sexual partners remain low (Obermeyer and Osborn 2007). Young people confront difficult decisions of whether to be tested and if tested, to disclose the results to their loved ones. They must therefore weigh the advantages
of learning one’s HIV status with the potentially negative consequences of being diagnosed with a life threatening—and arguably stigmatizing—disease in a context where access to antiretroviral therapy (ART) is improving, but still not guaranteed.

In their version of the Social Ecological Model, McLeroy and colleagues (1988) contend that health behaviors are influenced by factors at five different levels: interpersonal (individual level), intrapersonal (includes family and relationship levels), institutional, community, and public policy (the last three categories comprise “structural” levels). With regard to HIV/AIDS in sub-Saharan Africa, Catherine Campbell (2003) argues that the overwhelming focus has been on factors that occur at the individual level and are related to psychological and social considerations. Factors at the interpersonal level are frequently overlooked despite the fact that HIV testing decisions are often made within the context of the dyad, rather than in isolation. Understanding the couple context is important not only for decision-making around HIV testing, but after testing when individuals learn their HIV status—perhaps for the first time—and decide whether to disclose their results to partners. Without more attention paid to the interpersonal level, the current state of research on HIV testing remains inadequate. More research using both partners’ perspectives is needed to more fully understand how the relationship context shapes HIV testing behavior.

The Importance of Relationship Power

Power as expressed through social interactions is not a new concept and has received tremendous scholarly attention by academics from a variety of different disciplines including anthropology, political science, social psychology, public health, and sociology (Connell
1987; Cromwell and Olson 1975; Blanc 2001). Riley (1997) observed that gender affects both “power to” and “power over.” “Power to” refers to the ability to act, whereas “power over” refers to the ability to assert wishes and goals in the face of opposition from another. Some scholars have also stressed that it is not the absolute power of either couple member that matters, but rather their power relative to each other (Blanc 2001). In relation to HIV infection, Wingood and DiClemente (2000) describe power as “having the ability to act or change or having power over others.” In this study, I consider a broad, sociological perspective of gender-based relationship power (shortened to “relationship power”) to refer to the socially constructed gender differences between men and women where “gender” refers to the expectations and norms shared within a society about appropriate male and female behavior, characteristics, and roles (Gupta 2000). This definition allows for more flexibility to study the culturally rooted and more nuanced forms of power that go beyond simplistic notions of male dominance and female submissiveness.

Of the studies that have directly measured relationship power, researchers have conceptualized power—and its association with HIV/AIDS—in many different ways depending upon the context. In 2000, Julie Pulerwitz and colleagues developed one of the first theoretically-based measures of relationship power using the Theory of Gender and Power (Connell 1987; Wingood and DiClemente 2002) and Social Exchange Theory (Emerson 1981) called the Sexual Relationship Power Scale (SRPS) (Pulerwitz, Gortmaker, and DeJong 2000). The SRPS was developed and tested among a sample of Latina women in the US. This single publication sparked a number of HIV-related studies in the West and
also in sub-Saharan Africa, as researchers attempted to adapt the scale to African samples (Harrison et al. 2006; Pettifor et al. 2004; Jewkes et al. 2002; Dunkle et al. 2007). Pulerwitz et al. (2000) defined relationship power as the ability to control a partner’s actions, act independently, dominate decision-making, or engage in behavior against the other partner’s wishes. In their adoption of Pulerwitz et al.’s work to South Africa, Pettifor and colleagues (2004) measured relationship power as a combination of two factors: relationship control and recent experience of forced sex. One important limitation of most of these studies is that they measured relationship power and its effects on behavior and health from the female point of view, resulting in an incomplete representation of male and couple power dynamics. In this dissertation, I contribute to the growing body of literature on relationship power by addressing both couple members’ perspectives, thereby giving a voice to men who are often silenced in this topic of inquiry.

**Summary of Research Design**

The present research uses a sequential mixed methods design with three complementary phases: a *measure development phase* (qualitative and quantitative) to develop a measure and conceptual model of relationship power, a *hypothesis-testing phase* (quantitative) to test whether the measure of relationship power predicts HIV testing behavior, and an *interpretative phase* (qualitative) to offer context for the quantitative findings through the use of grounded theory. In the first phase, I develop a pilot measure of relationship power for the Malawi context and then re-formulate it using a larger set of couple data collected as part of the
Tsogolo La Thanzi (TLT)¹ study. I bring in qualitative data to provide context for the measure and to finalize the conceptual model of relationship power. In the next phase, I test for associations between relationship power and HIV testing behavior. Here, I utilize longitudinal couple data to test hypotheses related to two HIV testing behaviors: HIV testing uptake over a 16-month period and disclosure of test results to primary sexual partners. During the interpretive phase, I use qualitative data to explain, cross-validate, or challenge the quantitative findings from the hypothesis-testing aim. I draw upon focus group discussions (FGDs) and other sources of qualitative data such as semi-structured interviews with young couples, detailed field notes, and informal interviews with young people, HIV testing counselors, and village chiefs.

**Implications for Policy, Prevention, and Public Health**

The results of this research have important theoretical, scientific, and practical implications for the field of public health and the social sciences, and for HIV testing policy in sub-Saharan Africa. Several innovative features of this research advance the study of the relationship context and HIV testing in sub-Saharan Africa. First, this research develops and evaluates a new measure of relationship power that could be used by other HIV/AIDS researchers working in Malawi and surrounding countries. This measure builds upon the SRPS (Pulerwitz, Gortmaker, and DeJong 2000), which has been mostly applied to women’s risk for HIV/AIDS in sub-Saharan Africa (Pettifor et al. 2004; Jewkes et al. 2010; Shannon

¹ Tsogolo la Thanzi (TLT) is a research project on reproduction and AIDS designed by Jenny Trinitapoli and Sara Yeatman, and funded by grant (R01-HD058366, PI Trinitapoli) from the National Institute of Child Health and Human Development (NICHD).
et al. 2012). This dissertation broadens existing measures of relationship power by incorporating the perspectives of both men and women. Second, this study is the first to use longitudinal couple data to explicitly study the association between relationship power and HIV testing behavior (uptake and disclosure). Much of what is currently known about relationship power and HIV relates to risk, not HIV testing behavior. Last, the findings generate new theoretical perspectives on local constructions of relationship power in Malawi, that is, theory that extends our current understandings of power and relationships.

This research also has practical implications. Information on the key factors that influence health decision-making will generate far-reaching conclusions about relationship factors that can be used to facilitate improved approaches for couple-oriented HIV testing programs, which are largely absent throughout the country. In addition, new measures of relationship power for the Malawi context will provide new opportunities to evaluate the effectiveness of public health interventions aimed at improving gender relations and health outcomes within couples.

**Chapter Outline**

The remaining chapters of this dissertation can be summarized as follows. In Chapter 2, I describe the predominant theoretical perspectives used to understand gender and power relations and how this intersects with the background literature on HIV testing. Specifically, I outline the barriers to HIV testing uptake and disclosure in the African context. Chapter 3 presents the mixed methodology I use accomplish the specific aims of this study. As part of this chapter, I provide the details on the measure of power developed for the Malawian
setting. Chapters 4 through 6 provide the main results of this dissertation. In Chapter 4, I use qualitative data to understand what power means in the Malawian context and to investigate how the measure of relationship power developed in Chapter 3 fits with local constructions of power. In Chapter 5, I present the main quantitative findings for this dissertation, specifically, the relationship power factors that influence uptake of HIV testing and disclosure of HIV test results. In Chapter 6, I transition back to the qualitative data to explain the main quantitative findings from Chapter 5. While each results chapter has its own discussion section that links to the findings from the previous chapter, I tie all the findings together in Chapter 7. To conclude, I present the theoretical and public health implications, and future directions of research.
CHAPTER II

BACKGROUND AND CONCEPTUAL FRAMEWORK

In this chapter, I begin with a broad examination of how gender and relationship power have been studied in relation to HIV infection. I then describe what is currently known—and where the literature falls short—regarding the association between relationship power and two types of HIV testing behavior: uptake of testing services and disclosure of test results to sexual partners. As I review the literature, I incorporate discussions of how social science theory has been and could be applied to inform research on HIV testing behavior. I conclude with a description of the rural Malawian context: the historical, social, economic, and cultural landscape, the HIV/AIDS epidemic, and the state of existing HIV prevention programs and policies.

Gender, Relationship Power, and HIV/AIDS

On a June afternoon in 2009, we respectfully approached a couple’s home in the Mponda village to conduct the fifth interview of the project. After formally greeting each member of the household according to Malawian customs, our intention was to learn about the couple’s relationship history. But their stories were already imprinted on their bodies and immediately revealed through a single glance at the couple’s physical appearance. The man was tall, very thin, and had what appeared to be sores on his face; the wife suffered from a bad cough, later determined to be tuberculosis. In a private conversation, the wife explains how she was previously a bar girl (akin to a prostitute in this case) and her current husband made her an offer she couldn’t refuse: to marry him and gain the chance to build a respectable life for
herself as a wife and mother. The husband was older, had several ex-wives, and his steady job at a local factory afforded him the opportunity to have multiple sexual partners. Despite the presence of these clear “risk factors” for HIV, it was only after the couple lost their young child to AIDS that they decided to get tested themselves and were discovered to be HIV positive.

Times are still dangerous for Africans living amid a generalized AIDS epidemic. The common phrase in Africa that “you are either affected or infected with HIV/AIDS” reflects the hard-hit reality that almost everyone knows someone currently living with HIV or who has recently died of its complications. Despite valiant and well-intentioned efforts by global health institutions to prevent new HIV infections, children, adolescents, and adults continue to become infected at relatively high rates. Sub-Saharan Africa is home to approximately 22 million individuals currently living with the HIV virus (UNAIDS 2010). In 2009, an estimated 1.8 million people were infected with HIV in this region alone. HIV incidence is gradually declining in many regions of sub-Saharan Africa, but the number of people living with HIV continues to rise, largely due to ART expansion (UNAIDS 2010).

Although estimates differ by country, women in sub-Saharan Africa now make up nearly 60% of all HIV infections (UNAIDS 2010). These gender disparities in HIV infection persist across adults and young people (UNAIDS 2010; National Statistical Office & ORC Macro 2011). Gender-based relationship power is one of the most widely cited reasons used to explain gender disparities in infection rates. Many social epidemiologic studies from southern Africa demonstrate that relationship power imbalances are associated with key risk
factors for HIV, including less condom use, increased number of sexual partners, coercive sex, transactional sex, increased physical violence, and alcohol and drug abuse (Dunkle et al. 2004; Pettifor et al. 2004; Jewkes, Levin, and Penn-Kekana 2002; Blanc et al. 1996; Harrison et al. 2006; Dunkle et al. 2007). In several studies, a direct association has been established between power imbalances and HIV infection (Dunkle et al. 2004; Pettifor et al. 2004).

**The Theory of Gender and Power**

In 1987, R.W. Connell developed the first systematic conceptual framework for the social analysis of gender called the Theory of Gender and Power or “TGP” for short (Connell 1987). Wingood and DiClemente (2002; 2000) later adapted Connell’s theory to specifically study women’s social exposure and risk for HIV/AIDS. One unique feature of the TGP is its potential to study HIV risk beyond the individual-level by examining the broader context of relationships that perpetuate risk. The TGP proposes that power inequities arise from three overlapping social structures that interact to generate different exposures and risk factors for HIV/AIDS: the sexual division of labor, the sexual division of power, and social norms related to gender (also known as “cathexis”). Because these three social structures are so closely intertwined and often inseparable, it is difficult to label an exposure or risk factor as the result of one structure over another; rather, it is often the intersection of these factors together that creates a risky environment.

The sexual division of labor functions at the societal level through the allocation of men and women to certain occupations (Wingood and DiClemente 2002). Women are often relegated to jobs and responsibilities deemed to be “women’s work”, such as those that exist
in the domestic sphere. The inequities resulting from the sexual division of labor are manifested as economic exposures and socioeconomic risk factors for HIV/AIDS. In sub-Saharan Africa, there is evidence to support the sexual division of labor’s role in HIV risk for women. Traditional breadwinner-homemaker marriages constrain women’s earning potential and mobility while at the same time providing men with more access to wealth, opportunities, and sex partners. A number of studies from the region support the view that men’s mobility is a risk factor for HIV (Voeten, Vissers, and Gregson 2009; Vissers et al. 2008; Kishamawe et al. 2006; Lurie, Williams, Zuma, Mkaya-Mwaburi, Garrett et al. 2003).

In addition, many African societies are organized according to patrilineal systems of decent and inheritance that allowed men to control economic resources in the household (Caldwell, Caldwell, and Orubuloye 1992). Resource theory (Foa and Foa 1980) helps to elaborate on the TGP’s structure of labor by extending the idea of economic dependence. According to resource theory, women with less access to and control over resources as compared to their partners become economically dependent on men. This dependence is thought to limit their negotiating power over sex, potential to mitigate violence, and ability to leave a risky relationship.

Although sex linked to subsistence is critical for the survival of many marginalized African women (Leclerc-Madlala 2003; Wojcicki 2002), capital-led globalization has created a new form of dependence in the form of luxury items that are becoming increasingly desired by women from their more wealthy sexual partners (Hunter 2010, 2002; Epstein 2007; Wamoyi et al. 2011). Receipt of money, gifts, or financial assistance from men, sometimes
referred to as material transfers, has been shown to decrease women’s bargaining power in the sexual realm, including condom use and frequency of sex (Luke et al. 2011; Dunkle et al. 2004; Luke 2006).

The TGP’s sexual division of power is maintained by social mechanisms such as the abuse of authority and control in relationships (Wingood and DiClemente 2002). Gender-based violence is one manifestation of these power imbalances and an important risk factor for HIV in sub-Saharan Africa (Dunkle et al. 2004; Jewkes, Levin, and Penn-Kekana 2003; Jewkes et al. 2010). Multiple direct and indirect pathways have been proposed to link power imbalances, women’s experience of violence, and HIV infection (Jewkes et al. 2010). Direct effects occur through violent, unprotected sexual encounters with abusive men who are more likely to engage in risky sex and to be HIV infected themselves (Jewkes et al. 2009). Indirectly, the threat of violence may prevent women from negotiating the circumstances of sex, resulting in more frequent sex and less condom use (Jewkes et al. 2006; Pettifor et al. 2004). Large age and economic differences between partners such as those characterized as “sugar daddy” relationships may also place adolescent women at increased risk for violence (Luke 2003) and HIV infection (Kelly et al. 2001) through their limited power to negotiate safe sexual behavior with older, wealthier men (Luke 2005; Luke and Kurz 2002).

According to the TGP, social norms surrounding gender and sexual behavior (or “cathexis”) add a third dimension of risk for HIV. In many African societies, traditional gender roles and socialization patterns implicitly or explicitly dictate what men and women do and how they behave (Shettima 1998). A husband’s right to punish his wife or demand
sex are often condoned and considered socially acceptable (Jewkes 2002). The presence of a “sexual double standard” (Hunter 2010) that makes it more socially acceptable for men to have extramarital partners also places women at increased risk for HIV through their partners’ behaviors. Women, on the other hand, in order to meet the ideal qualities of a respectful wife, may avoid topics that could create conflict in the household, for example, condom use or extramarital affairs. Longitudinal studies have demonstrated that women are more likely to become infected by their husbands, while men are more likely to become infected through their own extramarital affairs (King et al. 1993; deZoysa, Sweat, and Denison 1996; Heise and Elias 1995; McKenna et al. 1997).

Though typically not applied to men, men’s health is similarly affected by the three social structures of gender and power. There are many pathways to HIV infection for men in sub-Saharan Africa; I highlight just a few examples. Through the sexual division of labor, dominant masculine ideologies surrounding fatherhood and the provider role keeps men out of the household and in the labor force. Men’s mobility and freedom in the public space facilitates their engagement in HIV risk behaviors, particularly, having multiple concurrent sexual partners. Through the sexual division of power, male dominance over the timing and circumstances of sex directly places men at risk for HIV as well. Finally, through the third structure of social norms and affective attachments, men’s desire for multiple sexual partners and the elevated social status that comes with this practice creates exposures to HIV infection (Swidler and Watkins 2007; Smith 2009).
HIV Prevention and Testing in Sub-Saharan Africa

This dissertation attempts to translate what we know about the power/sexual risk nexus to non-sexual behavior related to HIV testing (namely, uptake and disclosure). Before outlining how we might apply this knowledge to HIV testing, I will first discuss the predominant approaches to HIV prevention in this region and why HIV testing is an important area of inquiry.

Current HIV prevention strategies center on the “ABC” approach or Abstinence, Be faithful, and Condoms. For young adolescent couples, abstinence has been promoted as an idealistic HIV prevention strategy by forgoing or delaying sex until marriage. While by far the most effective strategy to prevent HIV/AIDS when practiced, its high failure rate has often been attributed to a morality-driven agenda that lacks rigorous scientific support (Santelli et al. 2006). For those who fail in “A”, or abstinence, albeit under circumstances that make it difficult to be successful, “B” encourages people to stay with one sex partner. If neither “A” nor “B” is feasible or possible, consistent condom use or “C”, is recommended as a fallback strategy. However, for young couples just starting their families, condoms interfere with childbearing intentions. In addition, public health messages continue to perpetuate the association of condoms with high-risk or causal sex, thus limiting their use within serious partnerships if people perceive them to interfere with intimacy and trust. Condoms can also diminish women’s sexual pleasure and interfere with intimacy (Higgins and Hirsch 2008; Chimbiri 2007; Tavory and Swidler 2009). As an alternative to condoms, married couples are advised to remain faithful to each other through widely disseminated
public messages on fidelity (for example, Uganda’s “zero grazing” campaign). The objective here is to minimize exposure to sexual networks that ostensibly act as superhighways to transmit HIV infection—a phenomenon referred to as concurrency (Epstein 2007).

While the predominant prevention approach for HIV/AIDS in sub-Saharan Africa emphasizes the “ABCs”, the continued spread of the disease signifies that knowledge alone is not sufficient and thus other approaches are warranted. Policy makers and international health experts have promoted HIV testing and counseling as one such alternative for HIV prevention (CDC 2006; UNAIDS 2006; WHO 2007). Two main terms are used to refer to HIV testing: “HTC” (HIV testing and counseling) and “VCT” (voluntary HIV counseling and testing)\(^2\). The term HTC recently replaced the term VCT in official AIDS policy, although much of literature that I reference in this dissertation reflects on VCT. From a public health standpoint, HTC serves to reduce HIV transmission through its complementary risk reduction counseling and timely access to care, treatment, and other HIV prevention services (Painter 2001; VCT Efficacy Group 2000).

Tremendous efforts have been made to increase the number of people who know their HIV status in sub-Saharan Africa. Public health slogans such as “Know Your Status”

\(^2\) In the past, the term VCT was used to refer to walk-in testing services located within health facilities or as standalone testing sites—or client-initiated testing. The Ministry of Health in Malawi recently replaced the term VCT with HTC to reflect revised standards set forth by the WHO and UNAIDS. Provider-initiated HIV testing and counseling is now considered the international standard of care. Health care providers are encouraged to offer an HIV test paired with complementary risk reduction counseling to their patients during all medical encounters (WHO, 2011). Therefore, the term HTC encompasses both provider-initiated and client-initiated services offered at a wide range of testing sites including mobile clinics, the home, and at the workplace.
(featured in Figure 2.1) are omnipresent in Malawi, carefully placed in high-traffic public spaces and outside HTC clinics in an attempt to normalize the act of testing and promote the individual right, freedom, and entitlement to knowledge of HIV status. The marketing of HIV testing is clear, concise, and appeals directly to testing consumers as if the act of testing is as simple as just showing up (i.e., “Let’s go!”).

![Image](image.png)

*Figure 2.1: Example “Let’s Go” Slogan Promoting HCT*

(Photograph taken by Amy Conroy in Cape Maclear, Malawi, 2009)

Despite substantial economic and human resources dedicated to promoting HIV testing in sub-Saharan Africa, testing programs continue to fall short. An extensive body of literature from sub-Saharan Africa cites three main areas of concern: uptake of testing is relatively low in many settings (Denison et al. 2008; Obermeyer and Osborn 2007), disclosure of test results to primary partners is less than ideal (Obermeyer and Osborn 2007), and sexual behavior change, particularly among those who test negative, is modest at best (Shelton 2008; Yeatman 2007). This dissertation focuses on the first two areas of concern:
uptake and disclosure.

Recent estimates based on surveys in 12 high-burden countries in sub-Saharan Africa indicate that a median of 12% of men and 10% of women in the general population have been tested for HIV and received the results (WHO 2007). If this is accurate, then improving the use of HIV testing services would require an understanding of the barriers and facilitators to uptake in the general population. The benefits of HIV testing are also predicated on the assumption that couples first disclose their HIV status to each other. Disclosure may reduce HIV transmission by increasing awareness and decreasing risky sexual behavior (Medley et al. 2004). It is difficult to generalize about disclosure rates at the population level. Most studies utilize convenience samples of HIV clinic patients or pregnant women (Kilewo et al. 2001; Antelman, Fawzi, and Kaaya 2001). However, aggregate estimates from multiple countries show that an average of 52% (range: 16-86%) of HIV positive women disclosed their status to sexual partners (WHO 2003). Recent studies that include men—both HIV positive and negative—indicate that upwards of 70% of men from Malawi, South Africa, and Kenya disclosed their status to sexual partners (Anglewicz and Chintsanya 2011; Katz et al. 2009).

The Social Ecological Model of Health

The Social Ecological Model of health provides a useful framework for examining how determinants of HIV testing behavior (uptake and disclosure) have been studied and where gaps in the literature remain. According to the Social Ecological Model, multiple levels of factors influence health behaviors including intrapersonal, interpersonal, institutional,
community, and public policy (Sallis, Owen, and Fisher 2008). In the discussion that follows, I present how factors at the individual (intrapersonal) level and relationship (interpersonal) level have influenced HIV testing behavior. I also consider structural level factors related to economics, but only as they are manifested within the context of the relationship. I hypothesize that a lack of understanding of and consideration for relationship factors, specifically power, contributes to limited HIV testing success at the programmatic level.

**What It Takes to “Know Your Status” in Africa**

**The Individual Level**

At the individual level, a variety of different psychosocial factors are thought to influence the uptake of HIV testing services in sub-Saharan Africa. The most widely documented barriers include stigma and discrimination (Berendes and Rimal 2011; Kalichman and Simbayi 2003; Weiser et al. 2006; Hutchinson and Mahlalela 2006), confidentiality concerns (Bwambale et al. 2008; Weiser et al. 2006), and low HIV-related knowledge3 (Jean et al. 2012; Gage and Ali 2005; Berendes and Rimal 2011).

One particularly important individual-level factor is *perceived risk*. This construct is one of the most widely applied components of the Health Belief Model or “HBM” (Becker 1974), especially for studying HIV/AIDS. The underlying idea is that beliefs about the likelihood of contracting a disease or condition will motivate people to adopt a certain preventative

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3 Though knowledge is cited as a barrier to testing in recent studies, it is important to point out that it is generally understood that a lack of “HIV-related knowledge” is no longer a major driver of the AIDS epidemic in Africa. People are well aware of AIDS, how the virus it is transmitted, and the precautionary measures to help avoid HIV infection—though this knowledge is not perfect and nuanced understandings still exist.
behavior (Champion and Skinner 2008). Indeed, previous research demonstrates that low perceived risk for HIV may limit uptake of testing (deGraft-Johnson et al. 2005; Weiser et al. 2006; Creel and Rimal 2012; Sambisa, Curtis, and Mishra 2012). There exists some inconsistency, however, about the direction of this association; other studies have found that individuals who perceive themselves to be at high risk for HIV may refuse testing out of fear of the consequences (MacPherson, Corbett et al. 2012; Pool, Nyanzi, and Whitworth 2001). Because the HBM construct of perceived risk has been such an influential variable in the HIV testing literature, I consider it in my quantitative analysis. By doing so, I also hope to resolve some of the inconsistency regarding direction of the association between perceived risk and HIV testing uptake.

Less research has focused on the relationship context of risk perception. This is despite the fact that evaluation of risk for HIV is often made in a dyadic context, that is, risk assessments are based not only on self, but also on partners’ sexual backgrounds. In Malawi, women are most worried about getting HIV from unfaithful husbands, while men are most worried about getting HIV from their extramarital partners (Smith and Watkins 2005). There is mixed evidence on whether perceived partner infidelity is positively or negatively associated with testing uptake. Several studies from South Africa and Zimbabwe demonstrate that women who suspect or know that their partners have other sexual partners are more likely to get tested for HIV (Luseno and Wechsberg 2009; Morin et al. 2006). In contrast, a study from Malawi finds no association between perceptions of a partner’s infidelity and ever having tested for HIV (deGraft-Johnson et al. 2005). In this dissertation,
I extend the research that focuses mostly on individual-level perceived risk to include a partner’s perceived risk as a predictor of HIV testing uptake.

The Relationship Level

Though the literature centers on individual-level determinants, an investigation of the relationship level is critical in order to better understand the social environment in which HIV testing decisions are made. A broader body of health literature posits that serious intimate relationships play an important role in couple health and consequently, there have been growing calls to study how partners mutually influence each other’s behaviors (Lewis et al. 2006). The Theory of Interdependence suggests that behaviors within dyads are interdependent; each couple member has a certain amount of influence over the interaction they have together (Kelley and Thibalt 1978). Therefore, an understanding of the effects of couple interactions on health requires that both partner’s perspectives be taken into account. Unlike certain behavioral outcomes such as sex that cannot occur without the participation of both partners, decisions to test for HIV and disclose test results can, in theory, be made independently (unless the behavior under investigation is couples testing, which clearly requires both couple members). However, the literature suggests that HIV testing behavior does not occur in isolation; men and women make HIV testing decisions using information about their relationship (Luseno and Wechsberg 2009; Morin et al. 2006). Thus, I posit that the Theory of Interdependence can still provide the rationale for why it is important to examine how partnership context influences individual decisions to test or disclose.
The Theory of Gender and Power (TGP) may provide a useful theoretical lens to study how the relationship context—particularly power—shapes HIV testing behavior (uptake and disclosure). To briefly recap, the TGP argues that three social structures, *sexual division of labor*, *sexual division of power*, and *cathexis* or social norms around gender, shape sexual risk for HIV/AIDS. Of the studies that have examined the association between relationship power and HIV testing uptake, many have centered on male control over their female partners’ decisions to test. The three social structures of the TGP are implicitly involved here, although they are rarely—if ever—directly referred to in the literature. Studies suggest that decision-making power imbalances related to the *sexual division of power* constrain women’s use of testing services. For example, a common reason provided by women who refuse testing is the need to discuss the issue with their husband or because the husband refused testing himself (Kranzer et al. 2009; Dahl et al. 2008; Perez et al. 2006; Baiden et al. 2005). Issues related to *cathexis* may also play a role; qualitative research suggests that a double standard may exist around HIV testing such that women need to request permission from their husbands, but men are free to make testing decisions on their own (Maman, Hogan, and Kilonza 2001). Finally, women’s reported obligation to seek permission from their partners may be reinforced by the *sexual division of labor* through male control over economic resources. For example, Morin and colleagues (2006) note that women inform their husbands before testing in order to obtain money to travel to testing sites. More importantly, this reinforces women’s inability to access money and resources in the future.
Wingood and DiClemente (2000) argue how being involved in an abusive relationship creates physical exposures to HIV through the *sexual division of power*. The authors provide an example of how Latina women in the US who feared a partner’s anger in response to requests to use condoms were less likely to use them (Marin et al. 1993). The same logic parallels existing research on use of HIV testing services for women in sub-Saharan Africa. Worry about physical abuse has been found to hinder the ability to test if individuals suspect that they could be HIV positive (MacPherson, Corbett et al. 2012; Pool, Nyanzi, and Whitworth 2001). The TGP structure of *cathexis* is inextricably linked to these manifestations at the division of power. At the societal level, the structure of *cathexis* dictates appropriate sexual behavior for women and reinforces cultural taboos regarding female sexuality (Wingood and DiClemente 2000). Therefore, women may suffer abuse after testing for reasons related to *cathexis*, for example, because they failed to inform their partner of their intentions to test and thus violated social norms around male permission or because the act of testing implies guilt from infidelity or past promiscuous behavior—regardless of whether women engaged in these behaviors.

Women have also reported fears of divorce or partner abandonment as barriers to testing (Mlay, Lugina, and Becker 2008; Irungu et al. 2008). I suspect that these findings operate through the pathway of financial resources. Through the *sexual division of labor*, women generally have less access to economic resources than men. According to the theory, women who are unemployed or underemployed may be forced to rely on their male partners for economic assistance, which in turn limits their agency in the relationship (Foa and Foa
1980; Wingood and DiClemente 2000). As the theory implies, women with less access to economic resources may be more susceptible to the effects of relationship dissolution should they test positive, especially if they perceive few alternatives to the current relationship. Thus, the risk of losing a relationship—and the financial support that accompanies it—may overshadow any of the perceived benefits of HIV testing. But also, women’s economic dependence on men may limit their negotiating power over HIV testing if their partner is reluctant to test.

Up until this point, I have focused my theory and review of the literature and relevant theory on relationship factors that may influence women’s uptake of HIV testing, but what may explain men’s behaviors and how might this differ from women’s? While the TGP proposes that three social structures limit women’s uptake of HIV testing, these same social structures provide men with a surplus of power which provide men with a surplus of power may ultimately prevent them from testing as well.

During an informal interview in 2011 with a male VCT counselor named Joseph, I frankly asked him if and why men were scared of testing.

Men are more reluctant to come in for testing. Joseph says they are “running away from their responsibilities.” He also says that men are often blamed (he said “victims” in English) for transmitting HIV to women through extramarital affairs. Consequently, many will refuse to get tested out of fear. It takes a long time for women to convince their husbands to get tested as well. When a married woman comes in for testing, Clinic staff will “invite” the husband to come too by going out to the home using maps of the area and then asking them to come in for VCT. Wives blame the husbands for bringing in HIV since they are at home with the children while the men are free to move around with other women. (Interview and field notes dated October 18, 2011)

I previously suggested that women’s fear of being blamed for infidelity might limit their uptake of HIV testing (i.e., cathexis). In the above quote, Joseph suggests that it is the women who are doing the blaming, not the men—hence, men become “victims”. Men are
very much aware of the global AIDS discourse that faults men for higher rates of HIV infection among women; this emphasis on female vulnerability to HIV/AIDS may have unintended consequences on men’s testing behavior.

Anthony Simpson’s (2009) research on masculinities and AIDS in Zambia—a country that shares its borders with Malawi—documents that men are indeed having extramarital affairs and are well-informed about the risks of having these relationships. But in order to circumvent an admission of guilt that comes with the act of going for HIV testing, men will avoid it even if they are clearly dying of AIDS (Simpson 2009). In fact, there may be real consequences for men who are found to be cheating on their wives during an AIDS epidemic. Evidence from the region shows a growing intolerance for men’s sexual indiscretions. Several studies from Malawi point out that women will bring in marriage mediators, confront his mistresses directly, and may ultimately leave a partner who refuses to reform his sexual behavior (Watkins 2004; Schatz 2005). In nearby Uganda, new legislation allows wives to divorce husbands for infidelity (Parikh 2009). Taken together, this research indicates that men may internalize some of the same worries around infidelity accusations and divorce when making decisions to test—and later, to disclose.

Beyond these affective attachments that link HIV infection to infidelity (aspects of cathexis), questions remain around how the other social structures of TGP limit or facilitate men’s rates of HIV testing. Through the sexual division of labor, men’s breadwinner role and the income that accompanies it may buffer the potential negative consequences of testing positive, thus making testing seem like a more risk-worthy venture. At the same time, being
employed means that men have less time to wait in long lines at crowded health centers to receive testing at the cost of losing out on wages. Of the fewer studies that include men, the findings show that migration for work (Weiser et al. 2006), logistical barriers around VCT including access (Bwambale et al. 2008), and testing service characteristics (Kranzer et al. 2009; Hutchinson and Mahlalela 2006) may be important factors for men’s uptake.

Through the intersection of the sexual division of power and cathexis, men involved in male-dominated relationships who perhaps adhere to stronger patriarchal ideals around masculinity may be more likely to avoid overly feminized health care spaces. A large body of literature on masculinities has established a relationship between lower rates of health service utilization and poorer health among men who adopt these gender ideals. In Zimbabwe, Skovdal and colleagues (2011) discovered that hegemonic masculinities that require men to be strong, informed, resilient, disease-free, and highly sexual and economically productive, may serve as a barrier to HIV testing. Here, these ideals of masculinity conflict with the ‘good patient’ perspective that expects patients to be concerned about their health, regularly seek care at what men largely perceive to be female-dominated spaces, take instructions from health care providers, and engage in health promoting behaviors. In Malawi and Uganda, Izugbara and colleagues (2009) found that young males resisted testing because they perceived the act to signify a lack of self-confidence and vulnerability to HIV—traits that conflicted with their male youth identity. To conclude, men face similar social barriers around gender and power that limits their uptake of HIV testing, however, their position has largely been neglected in this body of research.
What it Takes to Disclose Your HIV Status

The Individual Level

It is widely acknowledged that individuals face great difficulties when making decisions to disclose their HIV status. Decisions to disclose test results to sexual partners are often made using a complex calculus that involves weighing the many advantages and disadvantages of the behavior. In the literature, two particular constructs of the HBM have been widely studied with regard to disclosure: the perceived barriers (or “costs”) and the perceived benefits. The HBM constructs offer explanations of behavior in relation to the threat of a particular disease or health condition—or in this case, the perceived outcomes of sharing personal health information with sexual partners.

Given that decisions to test for HIV often include whether individuals anticipate disclosure, many of the same barriers and benefits of testing uptake apply to disclosure. At the individual level, demographic barriers include lower socio-economic status (SES), being unmarried, and younger age (Anglewicz and Chintsanya 2011; King et al. 2008; Antelman et al. 2001; Farquhar et al. 2004; Wong et al. 2009). Combined, the findings suggest that these individuals may be more vulnerable to the negative consequences of disclosure: simply put, they have more to lose than their older, married, and higher SES counterparts. Risky sexual behavior such as having unprotected sex and multiple sexual partners has also been cited to constraint disclosure among HIV positive samples (Antelman et al. 2001; King et al. 2008), perhaps because these individuals expect to be blamed for “immoral” sexual behavior.
HIV serostatus is another individual-level factor thought to play a role in decisions to disclose test results with sexual partners (Maman, Hogan, and Kilonza 2001). Unsurprisingly, HIV negative individuals are more likely to disclose than HIV positive individuals (Anglewicz 2008). Katz and colleagues (2009) found that HIV positive men had a more difficult time disclosing to their partners than HIV positive women. Research on stigma and discrimination in South Africa shows that HIV positive individuals are more susceptible to negative social and economic consequences such as loss of employment, increased poverty, and rejection by family members and friends (Simbayi et al. 2007). While HIV status at the individual level is highly relevant, little research has explored it within the context of the relationship—that is, whether or not HIV status couple concordance (both partners are either HIV positive or HIV negative) and discordance (one partner is HIV positive, one partner is HIV negative) plays a role in decisions to disclose to sexual partners.

The Relationship Level

While a variety of relationship-level barriers are hypothesized to hinder HIV disclosure, the main obstacles center on fear: fear of stigma, fear of relationship dissolution and the accompanying loss of economic support, and fear of physical and sexual violence (Medley et al. 2004; Kilewo et al. 2001; Maman, Hogan, and Kilonza 2001; Maman et al. 2003; Farquhar et al. 2004). Fear-based barriers are more salient for women than men, which reflect the unequal and limited power that many women have around HIV infection (Maman, Hogan, and Kilonza 2001). In Malawi, a study on couples found that AIDS-related stigma was a more salient barrier to disclosure for women than men (Anglewicz and Chintsanya 2011).
Similar to HIV testing uptake, disclosure-related behavior can be explained by the three social structures of the TGP. Regarding *cathexis*, some qualitative research suggests that women who choose to disclose a positive test result to their spouses are blamed for bringing HIV into the family (Lugalla et al. 2008), especially if men were not informed that their partners went for testing (Maman, Hogan, and Kilonza 2001). At the *sexual division of power*, other studies show that women who disclosed their HIV test results experienced negative outcomes such as violence (Maman et al. 2002; Maman et al. 2001; Maman et al. 2003). In a study from Tanzania, Maman et al. (2002) reported that partner violence was 10 times greater among HIV-infected women as compared with their uninfected counterparts.

However, there are conflicting accounts about whether women experience high levels of adverse consequences after disclosure. In fact, many studies report that violence is a rare outcome of disclosure for women (Medley et al. 2004; Desgrees-Du-Lou 2005; Keogh et al. 1994; Vissers et al. 2008) and tends to occur more in serodiscordant couples (Maman et al. 2003). Interestingly, in Tanzania, less partner violence was reported among women who disclosed their serostatus to their partners than among women who did not (Maman et al. 2001). It is possible that individuals who tested and then later disclosed are a biased sample since they tested for HIV in the first place, as compared to those in violent relationships who delay or forgo testing altogether out of fear. Regardless, these studies suggest that violence after disclosure is situational and depends on the relationship context.

Inequities resulting from imbalances at the *sexual division of labor* may also shape women’s decisions to disclose—especially if the woman is the HIV positive partner. Fears of loss of
economic support due to partner abandonment may drive some women to hide their status from their partners. These fears may be justified. In Uganda, discordant couples with an HIV positive woman were more likely to dissolve than seroconcordant or serodiscordant (positive male, negative female) couples (Porter et al. 2004). It is important to point out that adverse consequences may be biased if women who suspect that their partners will react negatively are less likely to disclose in the first place.

**Limitations of the TGP**

Several limitations of the TGP are noteworthy. First, the TGP is rooted in the so-called “vulnerability paradigm,” which overemphasizes women’s lack of power in society and their inability to protect themselves from HIV/AIDS. Globally, contemporary AIDS discourse perpetuates portrayals of women as biologically and socially vulnerable to HIV, victims of men’s abuse, and innocent bystanders in the global HIV/AIDS pandemic (Higgins, Hoffman, and Dworkin 2010). Not all women are victims, nor are all men overly dominant and controlling. These popular depictions of female vulnerability serve an important and valid purpose by reinforcing the evidence that women are indeed disadvantaged by HIV/AIDS; however, at the same time, may restrict our understanding women’s agency and resilience.

Second, the female vulnerability paradigm is historically grounded in western feminism and centers around individual human rights and freedoms that are defined and socially celebrated in the West—a setting very different from rural Africa where the model is frequently applied. It is possible that women’s power in Malawi may be overlooked because
of the ways it is expressed within the context of culture. From a western perspective, it may appear that women succumb to their partner’s dominance; yet, in reality, they may be using “backstage” techniques (Goffman 1959) to maintain control over their lives. Sociologists working in rural Malawi have started to tap into the subtleties of female agency and how this agency is invoked to avoid HIV infection. For example, researchers have found that wives sometimes use subtle and gendered communication to encourage fidelity in their marriages (Watkins, Rutenberg, and Wilkinson 1997; Zulu and Chepngen 2003) and other locally-formulated strategies, including approaching husbands about their behavior, bringing in marriage mediators, confronting his mistresses, and leaving a partner who refuses to reform (Watkins 2004; Schatz 2005). By relying solely on the TGP—and its female vulnerability orientation—we may miss the important graduations of female agency that could be harnessed to improve HIV/AIDS interventions among others who are truly powerless.

Third, a female vulnerability emphasis detracts attention away from heterosexual men’s social disadvantages and needs around HIV. It assumes that men are active transmitters of HIV infection, but not active agents of prevention (Higgins, Hoffman, and Dworkin 2010). In response to this, there have been growing calls for new scholarship on masculinity and the ways in which men’s own limited life choices relate to global patterns of power (Hirsch et al. 2009).

To summarize, the TGP’s underlying emphasis on female vulnerability restricts our understanding women’s agency and resilience, men’s position, and the broader dyadic context for HIV risk. In this dissertation, I hope to illuminate areas of nuance regarding the
gender/power/HIV testing nexus in order to move this body of research in new directions that consider these important gaps. To accomplish this aim, I invoke the strengths of grounded theory as a method to more fully capture the construct of relationship power and its intersection with HIV testing. By listening to the perspectives of rural Malawians’ who are the true cultural experts on these issues, I hope to broaden our knowledge of how relationship factors intersect with the act of HIV testing.

**Symbolic Interactionism and HIV Testing Behavior**

As one could imagine, the act of testing is not a straightforward process; HIV/AIDS and its interventions carry symbolic meanings that are deeply embedded within the social and cultural milieu and strongly shape people’s decisions to test. According to Herbert Blumer’s (1969) perspective on social interactionism: (1) people act on the basis of meanings that things have for them; (2) these meanings derive from social interaction; and (3) these meanings are modified by their interpretations in practice. The basic research assumption consistent with this view is that if one desires to understand human interactions and how they shape behaviors, one needs to study people’s experiences as they perceive them (Jeon 2004).

By doing so, a symbolic interactionism perspective gives agency to the rural Malawians living amongst an AIDS epidemic rather than assuming they are mindless beings to be fashioned by western AIDS policy. Indeed, research on HIV/AIDS interventions designed in the West but implemented in Africa shows that local interpretations and responses may differ substantially from how these programs are intended to function from a public health
perspective (Kaler and Watkins 2010; Angotti, Dionne, and Gaydosh 2010; Tavory and Swidler 2009). In rural Malawi, Kaler and Watkins (2010) use qualitative data to understand local perceptions of HIV testing and find that the reluctance to test is connected to the perception that testing inevitably leads to a positive diagnosis and subsequent death. Rural Malawians describe how testing is analogous to “asking God about the day you will die” and many would prefer not to live with this uncertainty (Kaler and Watkins 2010).

The disconnection between AIDS policy and local responses resonates in the condom literature as well. In love marriages, where women rely on ideals of love and intimacy to negotiate relationships with their husbands, condoms are seen as undermining the very thing they wish to preserve (Chimbiri 2007; Tavory and Swidler 2009). Given their strong association with high-risk sex and immorality, condom use within serious partnerships symbolizes a relationship characterized by mistrust, instability, and immoral sexual behavior (Smith 2009). Bringing up condoms unexpectedly raises concerns about a partner’s HIV status or faithfulness and symbolizes a partnership filled with uncertainty. The rationale is simple and logical: why use condoms with a partner you trust and love? I suspect that the same premise might be true with HIV testing.

Other scholars have used a symbolic interactionist approach to examine HIV testing within the context of a relationship. Kathryn Rhine (2009), for example, discovered that an HIV test is not simply a tool employed to measure immunological malfunction. She says, “A diagnosis also illuminates a set of social facts. The virtues and fears embedded in the act of taking a test are related to larger questions of how families and relationships might change in
light of a positive result.” Deborah Lupton and colleagues (1995) add that HIV test results have meanings that are tied to relationships, faithfulness, and trust. Individuals often take HIV tests when they are ending a relationship or starting a new one and thus testing serves to mark these important life transitions. In Tanzania, Maman and colleagues (2001) found that couples used testing as a means to reaffirm one’s commitment to the relationship. Thus, for some people, the act of testing may be more of a symbolic gesture than an attempt to confirm perceptions of risk. Through a symbolic interactionist approach, I hope to understand how beliefs, perceptions, and experiences of HIV testing created through social interactions at the relationship level ultimately shape people’s reactions to HIV testing programs in Malawi. This approach will supply locally rooted evidence for the applicability of the TGP and illuminate areas of contradiction, confirmation, and further exploration.

Study Hypotheses

This dissertation seeks to investigate how relationship power may act as a barrier or facilitator to HIV testing behavior (uptake and disclosure) in southern Malawi. Based on the TGP and background literature, I hypothesize that relationship power will consist of the following domains: socio-economic power within the relationship, decision-making dominance, and relationship violence—each of which will be independently associated with the two outcomes of HIV testing behavior. For both women and men, having less socio-economic power as compared to a partner (sexual division of labor), being in a male-dominated relationship (sexual division of power), and having a history of relationship violence (sexual division of power) will indicate low power in the relationship. Given the background theory and
literature, I hypothesize that the following conceptual model will explain HIV testing behavior within rural Malawian couples (see Figure 2.2).

Figure 2.2: Conceptual Model for HIV Testing Behavior Hypotheses

**Hypothesis #1**

I hypothesize that each power variable will be associated with uptake of future HIV testing over a 16-month period. In addition, I hypothesize that the perceived risk construct from the HBM will be associated with HIV testing uptake. Four sub-hypotheses will be tested:

A. *Socio-economic inequality (division of labor):* Individuals in a lower socio-economic position relative to their partners will be less likely to get tested since they will have stronger fears around divorce or abandonment—and loss of financial support—that may come with
HIV testing. With less economic power, these individuals may also be in a more disadvantaged position to negotiate testing with their partners.

B. *Relationship dominance (division of power):* Women in a male-dominated relationship compared to an egalitarian or female-dominated relationship will be less likely to test for HIV due to male control over testing decision-making. Male-dominance will also be negatively associated with testing among men. These men may be more likely to adhere to traditional beliefs about masculinity and therefore feel disinclined to test.

C. *Relationship violence (division of power):* Having a history of relationship violence (physical and sexual) is a proxy for fear of abuse, which has been shown to be a barrier to testing. Individuals in violent relationships will therefore be less likely to test for HIV. Having a history of violence (sexual or physical) could also operate through the pathway of risk, thereby decreasing the likelihood of testing (assuming people are higher risk are less likely to test).

D. *Perceived risk (self and partner).* For women, those who believe they are at higher risk for HIV will fear the negative consequences of testing and therefore be less likely to test. For men, those who believe they are at higher risk for HIV will fear being blamed for infidelity and therefore be less likely to test.

**Hypothesis #2**

I hypothesize that each power variable will also be associated with HIV testing disclosure to a primary sexual partner. In addition, I hypothesize that perceived HIV status
concordance will be associated with HIV testing disclosure. Four sub-hypotheses will be tested:

A. *Socio-economic inequality (division of labor):* Individuals in a lower socio-economic position relative to their partners will be less likely to disclose their test results since they will more likely to fear divorce or abandonment—and loss of financial support—as a consequence of disclosing test results.

B. *Relationship dominance (division of power):* Being in a male-dominated relationship as compared to an egalitarian relationship will make women less likely to disclose out of fear of the violence that is associated with dominance.

C. *Relationship violence (division of power):* Having a history of relationship (physical and sexual) violence will reinforce fears of abuse, thereby decreasing the likelihood of HIV test disclosure. Even if they tested negative, individuals in violent relationships may still avoid disclosure if they did not inform their partners of their plans to test.

D. *Perceived HIV status concordance:* HIV positive individuals will be less likely to disclose their test results if they perceive their partners to be HIV negative as compared to HIV negative individuals who also perceive their partners to be HIV negative.

**Study Innovation**

This study advances our knowledge of HIV testing uptake and status disclosure in sub-Saharan Africa in the following ways.

1. *A one-time test is not enough to prevent HIV.* Despite the fact that HIV testing rollouts have increased the number of people who know their HIV status, a large majority of studies
on HIV testing in sub-Saharan Africa examine whether people have ever tested or recently tested for HIV as if it is a one-time event (Berendes and Rimal 2011; deGraft-Johnson et al. 2005; Irungu et al. 2008; Jean et al. 2012; MacPhail et al. 2007; Weiser et al. 2006). Reliance on cross-sectional data where predictor variables and testing history are collected alongside each other makes it difficult to draw conclusions about causation or temporality. Additionally, a single HIV test is not enough to prevent HIV, especially in a setting where dense sexual networks of concurrent partnerships are common and riskier than serial monogamy (Morris and Kretzschmar 1997; Morris and Kretzschmar 2000). As more people begin to learn their status and as testing shifts to a more normative practice, it is likely that a substantial proportion of HIV testing clients will have tested before (Bradley et al. 2011). Thus, it becomes imperative to study the factors that influence regular uptake of HIV testing throughout young people’s reproductive years. This dissertation will examine a 16-month period of testing activity.

2. **Studies that use data from both partners strengthen the evidence.** Given the important role of marriage on couple health, there have been growing calls to study how spouses mutually influence each other’s behaviors using data from both partners (Lewis et al. 2006). A couples’ dataset allows for the ability to predict respondent outcomes (i.e., the dependent variable) using both the respondent and their partner’s independent variables—yielding more information that if the respondent was studied in isolation.

3. **Men receive less attention in the HIV testing research, particularly on disclosure, from sub-Saharan Africa.** This may be for a number of reasons and partially attributed to the ease of access
to pregnant women through clinic recruiting and the feminization of the AIDS epidemic. Lower rates of testing among men in Malawi (National Statistical Office & ORC Macro 2005, 2011) underscores the need to focus on issues that are pertinent to men as well.

4. *Studies on relationship-level factors and HIV testing in Malawi are generally lacking.* Decisions to test and disclose are often made in a dyadic context. Therefore, improvements to testing services requires a better understanding of the relationship-level barriers and motivating factors that affect whether people get tested and disclose their results to sexual partners.

5. *Few studies examine factors that influence disclosure among people who test negative.* From an HIV prevention perspective, it is certainly understandable that greater attention would be directed towards HIV positive people who choose to disclose. However, an understanding of the drivers of disclosure among HIV negative people is also important so that young people can more accurately assess their HIV risk. Furthermore, increasing the rates of disclosure among those who are negative is important for establishing positive relationship behaviors that may facilitate disclosure of a positive test result if the time comes in the future. Thus, an understanding of the relationship factors that influence disclosure of a negative status is also warranted.

**The Malawi Context**

Present-day Malawi is a small, landlocked country located in southeastern Africa whose geography is largely structured by Lake Malawi, a fresh water lake that spans almost the
entire length of the country. Like its neighboring countries, Malawi has a long history of colonialism. From 1891 to 1964, the British ruled Malawi as a protectorate state under the name Nyasaland. In the early 1960s, Malawi achieved political independence from Britain and became a one-party state with Dr. Hastings Banda as its first President. Banda’s regime came to an end in 1994 when the country entered a period of multi-party politics, which interacted with the influence of donor aid and ultimately resulted in the failure of the private market (Peters, 1997).

Today, Malawi has a population of 13.1 million (National Statistical Office & ORC Macro 2011) and a Gross Domestic Product (GDP) per capita of $893 USD (The World Bank 2011). Lilongwe and Blantyre are its two major cities and the majority of the population resides in rural areas. More than 68% of Malawians over the age of five are considered literate, with lower rates among women than among men (National Statistical Office & ORC Macro 2011). Girls are significantly less likely to complete primary school and go on to attend secondary or higher education as compared to boys, in part, due to early childbearing. At current fertility levels, a Malawian woman would bear an average of 5.7 children over the course of her lifetime (National Statistical Office & ORC Macro 2011). The economy of Malawi is primarily driven by agriculture, which accounts for 30% of the country’s GDP (National Statistical Office & ORC Macro 2011). Nonetheless, at the national level, the economy depends on substantial inflows of economic assistance from the International Monetary Fund, World Bank, and individual donor nations.
The country is divided into three regions (north, central, and south) and 27 districts. This dissertation was conducted in the Balaka district of southern Malawi (as indicated by Figure 2.3). Balaka has a hot, dry climate given its lower elevation and distance from Lake Malawi. Residents of the surrounding Balaka district villages travel to the Balaka boma (or district center) for commerce and health services. The Balaka boma consists of a thriving market, several grocery stores, banks, and bars, a soccer field, several regional non-governmental organization (NGO) offices, the main Balaka district hospital, a combination of public and private health clinics, and numerous churches and mosques—including a large Catholic church that attracts many pilgrims and visitors from across the country.

Figure 2.3: Balaka District of Southern Malawi
The three regions of Malawi differ greatly with regard to socio-economic status, ethnicity, religion, level of polygyny, lineage system, and pattern of residence. For both genders, education levels are higher in the southern region than in the central region, but lower in comparison to the north (National Statistical Office & ORC Macro 2011). The major ethnic groups in the northern region are the Tumbuka, Ngoni, and Tonga. The Chewa and Ngoni tribes predominantly populate the central region. The southern region is home to the Yao, Lomwe, Sena, and Mang’anja peoples (Zulu 1996). The north is predominantly Protestant, the central region is a combination of Protestants and Catholics, and the south is predominantly Muslim. At the national level, about 86% of women and 84% of men are Christians, while 13% of women and 12% of men are Muslims (National Statistical Office & ORC Macro 2011). Polygamous unions are more common in the Christian north than in the predominantly Muslim south (14% vs. 6%) (National Statistical Office & ORC Macro 2011).

In general, the southern region follows a matrilineal/matrilocal orientation where men physically move in with their wives’ families after marriage as compared to the predominantly patrilineal/patrilocla north (Chimbiri 2007; Peters 1997). In matrilineal areas, villages are typically organized into clusters of compounds made up of houses consisting of matrilineal relatives. For example, groups of sisters live together with their respective husbands and children. However, residence patterns are not always uniformly distributed by region for reasons related to migration, temporary employment, and scarcity of land (Peters 2010). In matrilineal families, women determine the lineage structure, however, inheritance is still passed through the maternal uncle who owns and controls the inherited property (Phiri
The southern region of Malawi has higher rates of divorce as compared to other regions with around 33% of all marriages ending before their 5th year anniversary (Reniers 2003), which may be partially attributed to its matrilineal marriage system.

**Gender Relations and HIV/AIDS in Malawi**

Matrilineal succession and inheritance provides women with considerable authority, particularly over land, however, this factor alone does not guarantee gender equality. Most of the major external influences on the region over the past 200 years have come from patrilineal and patriarchal groups (Peters 1997). These groups include, but are not limited to, British colonialism, Christian missionaries, and more recently, the international AIDS enterprise (refer to Peters 2010 for more detail on the former two groups of influence). During the colonialism period, Europeans obtained large plots of land from local chiefs at a very low cost and forcibly recruited local laborers—some of whom had previously resided on the land—to tend to their agricultural estates in return for rent (1997). With them, colonialists brought their conceptions of patriarchy and forced this gender hierarchy upon their newly designated constituents. Pauline Peters writes, “estate owners assumed and promoted men as the natural holders of land and heads of households, so they assigned authority to men” (1997). Yet, in southern Malawi, this conflicted with the existing matrilineal organization of the resident population and led to expansive population growth as daughters married and were joined by their new husbands and future children on the estates. Such rapid population growth could not be supported by the land’s agricultural production and resulted in famine in many parts of the Shire Highlands in southern Malawi.
Also in southern Malawi, Kaler (2001) discusses how patriarchal traditions were invented not necessarily through time-honored practices, but rather through the interactions between local chiefs and colonial administrators. Colonial administrators sought to define local customs in southern Africa as something that paralleled British law. Chiefs saw that it was advantageous for them to maintain the perception that tradition was responsible for women’s subservience to men and for male elders and chiefs to hold power over land and other resources. The colonialist roots of patriarchy are likely to affect modern gender relations in Malawi. Demographic data from 2010 show that approximately 72% of households are considered headed by men (National Statistical Office & ORC Macro 2011). The upper ranks of village chiefs are mostly male (Peters 2010). Similarly, higher-level positions within government, civil service, and private corporations are overwhelmingly male (with the exception of Malawi’s current President Joyce Banda, who served as Vice President at the time President Bingu wa Mutharika died in office in 2012 and therefore became his legitimate successor).

Across sub-Saharan Africa, adult HIV prevalence rates range from 0.1% in Comoros to 26% in Swaziland (UNAIDS 2010). Malawi has some of the highest rates of HIV infection in this region, with around 11% of all adults of reproductive age infected (National Statistical Office & ORC Macro 2011). Of the 42 sub-Saharan African countries with data, only eight have higher adult HIV prevalence rates than Malawi (UNAIDS 2010). All eight countries are located in southern Africa. In Malawi, HIV prevalence among adult women is higher than their male counterparts (13% of women vs. 8% of men) (National Statistical Office & ORC.
Young men and women aged 15-24 also have high rates of HIV infection. Approximately 3% and 5% of young people aged 15-19 and 20-24, respectively, tested positive for HIV in 2010 (National Statistical Office & ORC Macro 2011). The southern region of Malawi has the highest rates of HIV infection in the country, with an estimated 15% of its reproductive age population infected (National Statistical Office & ORC Macro 2011).

In Malawi, the connection between relationship power and HIV/AIDS is conflicted by two competing bodies of literature with varying degrees of support for the vulnerability paradigm. In one set of research, several qualitative studies on Malawian women’s risk for HIV argue that women do have the agency necessary to navigate the HIV epidemic and are not just helpless victims of gender inequality (Schatz 2005; Tawfik and Watkins 2007). Here, women invoke HIV prevention strategies that are considered locally, instead of globally, appropriate for their everyday realities. For example, spouses use subtle and gender-specific communication strategies to encourage fidelity in their marriages (Watkins, Rutenberg, and Wilkinson 1997; Zulu and Chepngenyo 2003). Other researchers argue that women draw upon their social resources to protect themselves from HIV/AIDS including bringing in marriage mediators, confronting male partners’ mistresses directly, and leaving a partner who refuses to reform (Schatz 2005; Watkins 2004). Some evidence from research on pre-marital partnerships illustrates how young women continuously evaluate a partner’s risk for HIV using their social networks and then formulate or terminate relationships to minimize their chance of infection (Poulin 2007).
In sharp contrast, a second set of research suggests that women’s decision-making power around HIV/AIDS is severely limited at the societal level. In rural areas, it has been documented that married women dominate domestic areas around cooking and childbearing while their husbands control domains like money and sex (Mbweza, Norr, and McElmurry 2008). While power is most likely expressed through multiple domains, it is important to point out that female-dominated domains such as cooking are less important for HIV transmission than male-dominated domains of sex. Women’s power in Malawi likely varies, but still some women report that they have little control over their relationships such as the ability to choose their husbands, to bear children, and to have sex or not (Rankin 2001; Lindgren, Rankin, and Rankin 2005). In fact, a recent demographic report featuring a nationally representative sample shows that 25% and 28% of Malawian women reported ever experiencing sexual and physical violence, respectively (National Statistical Office & ORC Macro 2011).

**HIV Testing and Treatment in Malawi**

HIV testing and counseling (HTC) first became available in Malawi during the 1990’s, although such services were widely inaccessible to the majority of rural Malawians. Starting in 2004, the Malawi Ministry of Health received external donor funding to support free HIV testing services in the main district hospitals and rural clinics (Ministry of Health [Malawi] 2005, 2006). Around the same time period, Malawi expanded its prevention-of-mother-to-child transmission (PMTCT) services by offering routine HIV testing of both mother and child. In 2003, the government mandated routine HIV testing of all pregnant women
through antenatal care clinics (Office of the President and Cabinet and National AIDS Commission [Malawi] 2003). Today, HTC is offered through integrated health services such as antenatal care and at standalone testing centers, clients’ homes, and workplace sites—among other venues. As of 2010, 73% of women and 53% of men of reproductive age had ever been tested for HIV, reflecting a significant increase in the number of people who know their status from previous years (National Statistical Office & ORC Macro 2005, 2011).

Many of Malawian women are now tested though opt-out, provider-initiated testing during antenatal care, which is generally perceived to be compulsory (Angotti, Dionne, and Gaydosh 2010). Some research suggests that rates of antenatal care testing among expectant mothers who receive antenatal care may be as high as 99% (Weir, Hoffman, and Muula 2008). Few data are available on the prevalence of reoccurring HIV testing in Malawi; however, I suspect that the young people in this study will likely have been tested multiple times over the course of 16 months as they negotiate the circumstances of their relationships and begin to have children.

Across the region, including Malawi, couples-based VCT (or CVCT) has gained little momentum. In their randomized controlled trial of CVCT in Tanzania, Becker and colleagues (2010) had to stop enrollment prematurely because rates of acceptance among the intervention arm (CVCT) were significantly lower than in the control arm (VCT), thus posing ethical issues. Low levels of couple involvement in VCT have been supported elsewhere, including in Nairobi and Lusaka (Farquhar et al. 2004; Semrau et al. 2005). For
women, factors associated with reluctance towards couples testing include male dominance over testing decision making and fears of the negative consequences of testing positive, such as divorce or violence (Maman, Hogan, and Kilonza 2001; Kranzer et al. 2009; Njau et al. 2011). Although notably, Becker and colleagues demonstrated that for couples who did test together, rates of marital dissolution and domestic violence were substantially lower than those who tested individually (2010). Men, on the other hand, may be reluctant to test with their partners because they feel embarrassed about being seen in the clinic or because of a heightened sense of risk related to extramarital relationships (Gipson et al. 2010; Njau et al. 2011).

Home-based CVCT provides an alternative solution by circumventing public testing venues or so-called “women’s places.” In Malawi, some research suggests that home-based testing is perceived to have many benefits: it is confidential, convenient, and credible (Angotti et al. 2009). Indeed, a study on Likoma Island in Malawi found that rates of home-based VCT were exceptionally high, especially among poorer households (Helleringer et al. 2009). Home-based couples testing may offer new opportunities for overcoming barriers related to clinic-based testing (Njau et al. 2011).

The key benefit of HIV testing, however, depends upon reliable access to ART. In Malawi, ART first became available on a fee basis (for pay) in public hospitals in 2000. Although at the time, only a small group of patients could afford them (Van Oosterhout et al. 2007). During early rollout, clinical shortcomings, drug supply interruptions, and difficulties determining eligibility imposed limitations on quality of care and access to ART.
With the assistance of donor funding, ART was scaled up between 2004 and 2006 at large hospitals and offered free of charge. Adults were eligible if they were HIV positive and WHO clinical stage 3 or 4, or had a CD4 count less than 200 cells/L (Ministry of Health [Malawi] 2003). Over this period, the number of patients on ART within the public sector increased from approximately 4,000 to 60,000 (Lowrance et al. 2007). In 2009, almost 200,000 people were taking ART through 377 health facilities (Ministry of Health [Malawi] 2009). The WHO recently estimated that around 48% of adults in immediate need of ART currently receive treatment in Malawi (WHO 2010). Estimates from Malawi using self-reported data from 2010 show that between 24% and 62% of women who tested positive for HIV are currently taking ART (National Statistical Office & ORC Macro 2011).

However, recently, a new policy was introduced in Malawi referred to as Option B+, which allows all pregnant women who test HIV positive to be placed on ART for life regardless of their CD4 counts or clinical stage (Schouten et al. 2011). This policy is expected to dramatically increase the number of women on ART. For men, coverage estimates range from 16% to 60% (MDHS, 2010). Overall, challenges still remain for ART programs in Malawi in order to overcome clinical problems with ART staging and eligibility, continuity of care after testing positive, and staff shortages (MacPherson, Laloo et al. 2012; Makwiza et al. 2009; McGrath et al. 2010). Nonetheless, the ART program is Malawi is widely heralded as a success in the region (Harries et al. 2011).
CHAPTER III

METHODOLOGY

In this chapter, I outline the research design and methods I used to accomplish the following goals: (1) to investigate appropriate quantitative measures of relationship power for the Malawi context (a) and to evaluate their cultural relevance with qualitative data (b); (2) to test whether relationship power influences the use of HIV testing services (a) and disclosure of test results to primary partners (b); and (3) to understand the meaning of HIV testing within the context of a sexual relationship.

Study Design Overview

The present research used a sequential mixed methods design with three complementary phases: a measure development phase (qualitative and quantitative) to develop a measure and conceptual model of relationship power, a hypothesis-testing phase (quantitative) to test whether the measure of relationship power predicts HIV testing behavior, and an interpretative phase (qualitative) to offer context for the quantitative findings. In the first phase, I developed a pilot measure of relationship power for the Malawi context and then re-formulated it using a larger set of couple data collected as part of the TLT study. Then, I applied grounded theory (Glaser and Strauss 1967) to a set of qualitative data in order to understand relationship power from rural Malawians’ perspectives. This process allowed me to confirm or challenge the quantitative measures of power and to uncover other areas of nuance. In the next phase, I tested for associations between the final model of relationship power and HIV testing behavior. Here, I utilized longitudinal couple data to test hypotheses related to relationship
power and two HIV testing behaviors: HIV testing uptake over time and disclosure of test results to a primary sexual partner. During the interpretive phase, I again applied a grounded theory approach to qualitative data to explain, cross-validate, or challenge the quantitative findings from the hypothesis-testing aim. During the fall of 2011, I spent two months in the Balaka district of southern Malawi conducting focus group discussions (FGDs) with men and women and gathering other contextual data. Previously collected couple interview data from 2009 supplemented the FGD data as necessary.

I used a mixed methods design for important reasons that added significant value to the study. As I have already discussed, relationship power is a complicated construct that carries multiple meanings at many different levels of influence, which vary not only according to geographical locality, but also over time. As such, understandings of power and its hypothesized associations with HIV testing are likely to benefit from multiple, complementary research methods including surveys, focus group discussions, couple interviews, detailed field notes from several trips to Malawi, and participant observation, including informal conversations with Malawians about issues related to power and HIV testing. Survey measures of power are limited in capturing the depth, complexity, and meanings behind relationship power. Not only could qualitative interviews provide insight into the culturally rooted meanings of relationship power, interviews may uncover other underlying constructs or variables that have not yet been identified through previous survey research. Informal data gathering allowed me to observe the more nuanced forms of power that may or may not arise during more formal interviews or FGDs. While the qualitative
results are helpful to identify new associations, they are not generalizable (at least in the statistical sense) to the larger population of young people at risk for HIV. In addition to playing off the strengths and weaknesses of multiple methods, I could also show if the results were congruent, that is, the findings were not simply due to a methodological artifact (Morgan 1998).

I characterized this study as a sequential mixed methods study where one method precedes another as opposed to simultaneous data collection. Throughout the study, I constantly compared and contrasted the various forms of information in order to formulate and revise my understandings of relationship power and HIV testing. The model of relationship power finalized in the measurement phase was used in the hypothesis-testing phase. Preliminary findings from the hypothesis-testing phase informed the line of questioning I used in the FGDs. Focus group discussions, field notes, and the previous qualitative couple interviews I collected were examined together and used to reflect back on what was learned through the survey data. Figure 3.1 provides a timeline for when the data were collected and analyzed.
The quantitative data for the measure development and hypothesis-testing aims came from *Tsologo La Thanzi* (TLT; “Healthy Futures” in Chichewa). The overall objective of the TLT study was to collect and analyze new data on the reproductive goals and behaviors of young adults in Malawi within the context of HIV testing and counseling. Longitudinal survey data were collected at quarterly intervals over a period of approximately three years (for a total of 8 waves). Trained interviewers, matched by gender to the respondents, administered questionnaires through face-to-face interviews conducted in private rooms at

**Figure 3.1: Timeline of Data Collection and Analysis, 2009-2013**

**The TLT Study**

<table>
<thead>
<tr>
<th>June 2009</th>
<th>May 2011</th>
<th>January 2012-April 2013</th>
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<tbody>
<tr>
<td>Conducted semi-structured interviews on power with 34 coupled individuals</td>
<td>Finalized the power measure</td>
<td>Used the semi-structured interviews and focus groups to reflect on the measure of power; completed hypothesis testing phase; used qualitative data to explain the quantitative findings</td>
</tr>
</tbody>
</table>

## The TLT Study

The quantitative data for the measure development and hypothesis-testing aims came from *Tsologo La Thanzi* (TLT; “Healthy Futures” in Chichewa). The overall objective of the TLT study was to collect and analyze new data on the reproductive goals and behaviors of young adults in Malawi within the context of HIV testing and counseling. Longitudinal survey data were collected at quarterly intervals over a period of approximately three years (for a total of 8 waves). Trained interviewers, matched by gender to the respondents, administered questionnaires through face-to-face interviews conducted in private rooms at
the TLT research center in Balaka. The survey data included information on reproductive goals and behaviors, fertility preferences, contraceptive use, and sexual behavior.

Previously administered TLT sampling procedures were as follows. A random sample of 1500 women aged 15-24 was selected from a household listing, which included people who lived within 7 kilometers of the Balaka town center (boma). Women were given enumerated incentive tokens for each partner that they named (husbands and boyfriends) and asked to give the tokens to their partners, redeemable for 500 Malawi Kwacha (around $3.25 USD) upon completion of the interview. Women could initially recruit up to three partners; however, since it was expected that some relationships would dissolve over the 3-year study period, new partners could be enrolled at each successive interview. In addition to the random sample of women, a smaller random sample of men aged 15-24 was also recruited and enrolled in order to be able to make generalizations about men. Combined, approximately 2500 individuals (500 couples) were enrolled in the study, although these figures vary slightly with each wave due to attrition and partnership dissolution or formation. However, the final couples sample (details to follow) only included these randomly selected men if they were partners of the random sample of women.

Women and their partners were randomly assigned to receive HIV testing in order to assess causal impacts of changes in the knowledge of HIV status on reproductive and prevention goals. Once baseline enrollment was completed, the women were assigned to three equal study groups consisting of 500 women and their male partners. Group 1 received regular HIV testing every four months. Group 2 received an HIV test at the end of the first
year and then again at the end of the study. Group 3 only received an HIV test at the end of the study. Figure 3.2 illustrates the timing and allocation of VCT over 8 waves of data collection.

<table>
<thead>
<tr>
<th>Wave</th>
<th>1</th>
<th>2</th>
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<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<tbody>
<tr>
<td>Group 1</td>
<td>VCT</td>
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<tr>
<td>Group 2</td>
<td></td>
<td>Power Module</td>
<td>VCT</td>
<td>Power Module</td>
<td></td>
<td>VCT</td>
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<tr>
<td>Group 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>VCT</td>
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</tr>
</tbody>
</table>

**Figure 3.2: Overview of the VCT Infrastructure for TLT**

**Creation of the Analysis Datasets**

In waves 3 and 5, a special module on relationship power was added to the TLT partnership survey (as shown in Figure 3.2). Respondents were asked the relationship power statements if they reported a current serious sexual partner including a spouse, live-in partner, steady boyfriend/girlfriend, or new boyfriend/girlfriend. If a respondent had more than one currently ongoing sexual relationship, the relationship power questions were asked with regard to the most serious relationship, ascertained with the question: “Of the sexual partners that you specified earlier, which one are you closest to?” However, if the respondent was married, their spouse automatically served as the reference partner even if other extramarital relationships had been ongoing for quite some time.

A couple dataset was created for respondents who answered the power questions about each other at wave 3 using a separate database linking women and their male partners. The following steps were taken:
1. Respondents completed a baseline questionnaire eliciting demographic and other information when they first enrolled in the study. At each wave, respondents completed a wave-specific questionnaire and partnership questionnaire. Respondents who entered the study at a subsequent wave only completed the baseline questionnaire at that wave and then at the next wave, completed the wave-specific and partnership questionnaires. Note that at wave 1, respondents completed all questionnaires. All respondents who entered the study at wave 2 and completed baseline questionnaires (N=199) were appended to respondents who participated at wave 1 (N=2,496). This created a sample with complete baseline data by wave 3 (N=2,695).

2. This dataset was merged with respondents who participated in wave 3 (N=2,462). Of these respondents, a total of 1,510 respondents were eligible (reported an ongoing sexual relationship) and completed the power statements. This dataset was called as the wave 3 individuals dataset. Each individual was represented only once in this dataset with a unique individual identifier. Example data are illustrated in Table 3.1.

<table>
<thead>
<tr>
<th>Respondent ID</th>
<th>Gender</th>
<th>Birth year</th>
<th>History of forced sex</th>
<th>History of physical abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>110266</td>
<td>2</td>
<td>1990</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>110307</td>
<td>2</td>
<td>1994</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>110311</td>
<td>2</td>
<td>1993</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>110420</td>
<td>2</td>
<td>1989</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>110467</td>
<td>2</td>
<td>1990</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3.1: Example data from the wave 3 individuals dataset
3. A second dataset called the **wave 3 couples dataset** was used to identify a set of ongoing couples at wave 3. The couples dataset contained the following information: a unique respondent ID for each individual, a unique couple ID, wave number (1 to 8), two variables corresponding to the status of the relationship reported by both partners at that wave, and a variable indicating when the relationship was first formed. The process below resulted in a list of couples who completed the power statements at wave 3.

   a. To create a baseline set of couples for wave 3, records for other waves were dropped (i.e., the wave number does not equal 3).

   b. Couples at wave 3 in which either member reported that the relationship was dissolved, unknown, or missing were dropped. A code of “3” indicated an ongoing relationship.

   c. Couples who were first matched at wave 3 were dropped since new partners would not have completed the wave 3 and partnership questionnaires (only baseline). This process resulted in 493 couples. Example data are illustrated in Table 3.2.

**Table 3.2: Example data from the wave 3 couples dataset**

<table>
<thead>
<tr>
<th>Partner 1</th>
<th>Partner 2</th>
<th>Couple ID</th>
<th>First matched (wave #)</th>
</tr>
</thead>
<tbody>
<tr>
<td>110116</td>
<td>6101161</td>
<td>1001</td>
<td>1</td>
</tr>
<tr>
<td>110167</td>
<td>6101671</td>
<td>1002</td>
<td>1</td>
</tr>
<tr>
<td>110311</td>
<td>6103111</td>
<td>1003</td>
<td>1</td>
</tr>
<tr>
<td>110420</td>
<td>6104201</td>
<td>1004</td>
<td>1</td>
</tr>
<tr>
<td>111883</td>
<td>6118831</td>
<td>1009</td>
<td>1</td>
</tr>
</tbody>
</table>
d. The list of couples was transformed from wide to long format so that each row represented an individual (no duplicates were present). The **wave 3 couples dataset** was then merged with the **wave 3 individuals dataset** using the respondent ID. Respondents who completed the power statements were dropped if they were not matched in the **wave 3 couples dataset** by using an internal Stata “merge” variable. Individuals could have completed the power statements in reference to a past partner or to a partner who never showed up at wave 3 to participate in the study. This process resulted in 466 couples or 932 individuals. This dataset was labeled as the **final wave 3 couples dataset**.

Example data are illustrated in Table 3.3.

**Table 3.3: Example data from the final wave 3 couples dataset**

<table>
<thead>
<tr>
<th>Respondent ID</th>
<th>Couple ID</th>
<th>Gender</th>
<th>Birth year</th>
<th>First wave</th>
<th>History of forced sex</th>
<th>History of physical abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>110311</td>
<td>1003</td>
<td>Female</td>
<td>1993</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6103111</td>
<td>1003</td>
<td>Male</td>
<td>1990</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

e. The data were transformed back into wide format in order to create additional couple level variables and then back-transformed again into long format to run the study analyses.
4. For the longitudinal couple dataset used to test the hypotheses related to testing uptake, the **final wave 3 couples dataset** (N=932 respondents) was merged with questionnaire data from waves 4, 5, 6, and 7. This dataset was called the **uptake dataset**. New respondents who enrolled at each subsequent wave were not included since they were not present in the **final wave 3 couples dataset**. Each of the 932 individuals (466 couples) could have up to 5 records (some respondents did not participate at every subsequent wave). The following steps were taken:

   a. The **final wave 3 couples dataset** was merged with the wave 4 questionnaire and partnership data. Variables that were collected at each wave, e.g., perceived likelihood of being infected with HIV, were renamed with a suffix corresponding to the wave so they were not replaced during the merge (e.g., risk_w3, risk_w4, etc.). This resulted in a new combined dataset linking the 466 couples from wave 3 with their corresponding data for wave 4. A similar process was completed using wave 5, 6, and 7 data.

   b. In order to get the data from a wide format (e.g., each row contains an individual) to a long format (e.g., each row contains a wave), the data were transformed using the variable suffix “w” for all longitudinal variables. Time invariant variables (e.g., birth year, gender, etc.) were also carried over into the **uptake dataset**. An internal “time” variable corresponding to each of the seven waves was also created in this transformation. Note that since the main predictor variables (perceived risk, power, etc.) from waves 1 and 2 were intentionally not
carried over during earlier data merges, the value of “time” at these waves is
displayed as “missing” (indicated by a “.” in Table 3.4) for all respondents.

Example data are illustrated in Table 3.4.

Table 3.4: Example data from the uptake dataset (long format)

<table>
<thead>
<tr>
<th>Resp ID</th>
<th>Couple ID</th>
<th>Gender</th>
<th>Birth Year</th>
<th>Time</th>
<th>Perceived HIV Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>1</td>
<td>.</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>2</td>
<td>.</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>110167</td>
<td>1002</td>
<td>Female</td>
<td>1992</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>1</td>
<td>.</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>2</td>
<td>.</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>6101671</td>
<td>1002</td>
<td>Male</td>
<td>1989</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

5. For the dataset used to test the disclosure hypotheses, the **final wave 3 couples dataset** (N=932 respondents) was merged with questionnaire data from waves 4 and 5. This dataset is called the **disclosure dataset** (long format). The following additional steps were taken.

a. At wave 5, respondents from the baseline set of respondents (N=932) were dropped if they did not participate in the study at wave 5 (N=65) and had never tested for HIV—as reported at wave 5 (N=64). This process resulted in 803
respondents. Given that the analysis was stratified by gender, respondents were retained even if their partner did not meet the above criteria (as shown in Table 3.5).

b. Given that there was a time lapse between wave 3 and 5, it was important to verify that respondents at wave 5 were reporting disclosure information in relation to their partner from wave 3. For some respondents, their marital status changed over the period from wave 3 to 5. Of the 803 eligible respondents at wave 5, 21 respondents had divorced, 6 respondents had separated, 2 respondents had lost their spouses, and 20 respondents became married. Two additional respondents whose spouses had died were dropped since they could not possibly report on disclosure to their partner at wave 5.

c. For those who reported being divorced or separated at wave 5, many still reported that they had disclosed their results to their spouse. I assumed that those who reported being divorced at wave 5 reported disclosure to a spouse whom they were married to in wave 3. The chances of divorcing a spouse from wave 3 and remarrying another by wave 5—over a short eight-month period—would be rare. But for those who were newly married by wave 5, it was necessary to ensure that they had married the same partner from wave 3. Otherwise, a respondent could have reported on two different partners at wave 3 and 5. For those 20 respondents, I manually checked the couple database from wave 5 to verify that the relationship was indeed ongoing. All of these relationships were
ongoing at wave 5, indicating that respondents had married their partner from wave 3—with one exception. The couple database indicated that one of the relationships had “dissolved” at wave 5, however, the female respondent was not paired with another partner whom she had supposedly married. This woman and her partner from wave 3 were dropped from the analysis given the uncertainty that they may not have been reporting on each other at wave 5. This process reduced the sample size to 799 (432 women, 367 men). Example data are illustrated in Table 3.5.

Table 3.5: Example data from the disclosure dataset (long format)

<table>
<thead>
<tr>
<th>Respid</th>
<th>Couple ID</th>
<th>Gender</th>
<th>HIV status at wave 4</th>
<th>Disclosure to partner at wave 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>6103111</td>
<td>1003</td>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>110420</td>
<td>1004</td>
<td>Female</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6104201</td>
<td>1004</td>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>111956</td>
<td>1010</td>
<td>Female</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6119561</td>
<td>1010</td>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Measure Development Phase**

**Design and Rationale**

For specific aim 1a, I re-formulated a measure of relationship power that was previously developed for the Malawi context during a pilot study in 2009. The pilot data demonstrated the feasibility of a Malawian relationship power scale, however, more research was needed to confirm the psychometric properties of the scale using a larger sample with a
more diverse set of power experiences (Conroy 2010). I had expected that such a sample would minimize the impact of random error on reliability estimates (Singleton and Straits 2005) and improve the scale's reliability. First, I describe the process used to create the power measure, starting from the qualitative interviews conducted in 2009.

**Power Measure Development**

In 2009, I conducted semi-structured qualitative interviews with 34 coupled men and women simultaneously, but separately, using trained Malawian research assistants. The interviews elicited multiple dimensions of relationship power based on Connell's (1987) Theory of Gender and Power (e.g., relationship control, economic dependence, decision-making dominance, and social norms). The qualitative data were analyzed to create a preliminary pool of statements on power. Additional details of the semi-structured interviews can be found later in this chapter.

Face validity was addressed by consulting with academic scholars, Malawian key informants, and TLT interviewer staff and then the power statements were added, deleted, or reworded accordingly. The power statements were translated from English to Chichewa and reverse translated by two separate individuals unfamiliar with the study in order to ensure sentence meaning was preserved. Items were both positively worded (e.g., “My partner shows that they care about me.”) and negatively worded (e.g., “My partner punishes me when he/she is really angry with me.”). Cognitive interviews (Tanur 1992) asking respondents to “think aloud” as they responded to the power statements were administered to a separate convenience sample of young adults (n=8) in order to detect comprehension
and translation problems. This process resulted in 31 power statements. Response choices were based on a 4-point Likert scale (4=strongly disagree, 3=disagree, 2=agree, or 1=strongly agree).

The power statements were administered through face-to-face interviews using a small pilot sample of 254 individuals. The sample was drawn from the same six target villages used in the qualitative phase. Study participants were between the ages of 18 and 45 years and had a primary sexual partner. Research assistants started at the village chief’s home, usually centrally located within the village, and approached every third compound to recruit respondents. Interviews took place in a quiet, private location usually near the respondent’s primary residence.

An initial exploratory factor analysis with oblique rotation was performed to reduce the set of items down and identify the underlying constructs. Exploratory factor analysis is appropriate when you have obtained measures on a number of variables and want to identify the number and nature of the underlying factors that are responsible for the covariation in the data (Hatcher 1994). A scree plot suggested four meaningful factors so only these factors were retained. All items receiving a factor loading of less than 0.30 were dropped. The results showed that four items loaded on the first factor, which was subsequently labeled “autonomy.” Four items loaded on a second factor, which was labeled “communication.” Four items loaded on the third factor, which was labeled “love and trust.” Finally, four items loaded on a fourth factor, which was labeled “relationship dominance.” Table 3.6 contains
the final factor pattern for the preliminary relationship power scale. Refer to Appendix A for the full wording of the 16 items.

**Table 3.6: Final rotated factor pattern for preliminary relationship power scale**

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1: Autonomy</th>
<th>Factor 2: Communication</th>
<th>Factor 3: Love and Trust</th>
<th>Factor 4: Relationship Dominance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would never leave</td>
<td>0.48</td>
<td>-0.19</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>In trouble if partner left</td>
<td>0.41</td>
<td>0.02</td>
<td>-0.01</td>
<td>0.23</td>
</tr>
<tr>
<td>Would leave if really bad</td>
<td>0.53</td>
<td>0.06</td>
<td>-0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Could find another partner</td>
<td>0.54</td>
<td>0.08</td>
<td>0.17</td>
<td>-0.07</td>
</tr>
<tr>
<td>Discuss matters together</td>
<td>0.02</td>
<td>0.39</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Partner cares about me</td>
<td>-0.19</td>
<td>0.35</td>
<td>0.25</td>
<td>0.31</td>
</tr>
<tr>
<td>Talk to partner about affair</td>
<td>0.04</td>
<td>0.65</td>
<td>0.00</td>
<td>-0.06</td>
</tr>
<tr>
<td>Consult advisors if problems</td>
<td>0.04</td>
<td>0.61</td>
<td>-0.20</td>
<td>-0.06</td>
</tr>
<tr>
<td>Helps me with needs</td>
<td>-0.17</td>
<td>-0.09</td>
<td>0.43</td>
<td>0.06</td>
</tr>
<tr>
<td>Able to initiate sex</td>
<td>0.15</td>
<td>0.06</td>
<td>0.49</td>
<td>0.03</td>
</tr>
<tr>
<td>Able to buy expensive items</td>
<td>0.15</td>
<td>-0.07</td>
<td>0.53</td>
<td>-0.06</td>
</tr>
<tr>
<td>Have own money</td>
<td>0.11</td>
<td>-0.10</td>
<td>0.44</td>
<td>-0.18</td>
</tr>
<tr>
<td>Partner punishes me</td>
<td>0.08</td>
<td>-0.04</td>
<td>-0.12</td>
<td>0.58</td>
</tr>
<tr>
<td>Partner chooses relatives side</td>
<td>-0.06</td>
<td>0.02</td>
<td>-0.06</td>
<td>0.41</td>
</tr>
<tr>
<td>Partner having an affair</td>
<td>-0.17</td>
<td>0.02</td>
<td>0.07</td>
<td>0.36</td>
</tr>
<tr>
<td>Partner might beat me</td>
<td>0.14</td>
<td>-0.12</td>
<td>-0.01</td>
<td>0.53</td>
</tr>
<tr>
<td>Proportion of variance</td>
<td>0.40</td>
<td>0.39</td>
<td>0.32</td>
<td>0.32</td>
</tr>
</tbody>
</table>

*Scale items have been summarized into shorter descriptions for readability. Refer to Appendix A for actual scale items.

Factor loadings greater than 0.30 are in bold print.

The 16-item power scale accounted for the majority of variation in responses. The proportion of variance was determined to be 40%, 39%, 32%, and 32% for the autonomy, communication, love and trust, and relationship dominance factors, respectively (see Table 3.6). The reliability of the scale was determined by computing Cronbach’s alpha for the entire power scale and for each of the four factors separately (Cronbach and Meehl 1955). The overall power scale demonstrated moderate reliability of 0.58, which falls within the
recommended range of 0.50 to 0.60 for early stages of research (Nunnally 1967). Scale reliability was also addressed by gender since future researchers may desire to study men and women’s responses to the scale items separately (see Table 3.7). Reliability of the overall scale was similar for men and women with coefficient alphas of 0.55 and 0.57, respectively. Reliability estimates were 0.59, 0.59, 0.57, and 0.54 for the autonomy, communication, love and trust, and relationship dominance subscales, respectively.

Table 3.7 also presents the mean factor scores computed from a range of 1 (strongly agree) to 4 (strongly disagree) for each of the subscales. Mean factors scores were computed for the entire sample and by gender. Higher mean factor scores (i.e., more likely to strongly disagree with scale items) are indicative of higher relationship power. Mean factor scores were higher for men on all the subscales with the exception of communication, suggesting that women had higher relationship power in this domain as compared to men.

### Table 3.7: Means, standard deviations, and reliability coefficients for the preliminary relationship power measure

<table>
<thead>
<tr>
<th>Factor</th>
<th>Overall (n=254)</th>
<th>Men (n=127)</th>
<th>Women (n=127)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean 95% CI</td>
<td>Alpha</td>
<td>Mean 95% CI</td>
</tr>
<tr>
<td>Dependence/Autonomy</td>
<td>2.22 2.13-2.32</td>
<td>0.59</td>
<td>2.55 2.43-2.68</td>
</tr>
<tr>
<td>Communication</td>
<td>3.57 3.51-3.63</td>
<td>0.59</td>
<td>3.46 3.39-3.54</td>
</tr>
<tr>
<td>Love and Trust</td>
<td>2.77 2.68-2.86</td>
<td>0.57</td>
<td>3.16 3.07-3.25</td>
</tr>
<tr>
<td>Relationship Dominance</td>
<td>2.82 2.73-2.91</td>
<td>0.54</td>
<td>3.03 2.92-3.14</td>
</tr>
</tbody>
</table>

*Mean refers to the mean value of the factor score. The factor score was computed by taking the sum of the row (where 1=Strongly Agree, 2=Agree, 3=Disagree, and 4=Strongly Disagree for each scale item) divided by the number of scale items answered for the row. Positively worded items were reverse coded prior to calculating the row value.
The preliminary relationship power scale items were then placed on TLT’s wave 3 and wave 5 partnership surveys. In order to confirm the underlying constructs using a larger, more representative sample, I conducted a second exploratory factor analysis with oblique rotation using the **final wave 3 couple dataset** (N=932 individuals). I applied rotation to force variables to load more strongly on a given factor, thus making it easier to interpret the data. Oblique rotation was used since factors are most likely to be correlated with each other, thus yielding a more accurate representation of the data (Adock 2006; Hatcher 1994). However, both oblique and orthogonal rotations yielded the same factor structure. Factors were retained if eigenvalues were greater than one and as suggested by the scree plot. Scale items were retained if factor loadings were greater than 0.40. I then performed two separate factor analyses by gender to see if similar factor patterns were present for men and women.

Next, I tested for differences in the final factors and item scores between men and women using two-group mean comparison $t$ tests. I computed Cronbach’s alpha for each subscale by gender (Cronbach and Meehl 1955). Refer to Figure 3.3 for a visual representation of the steps taken to develop the relationship power measure.
Table 3.8 presents the distribution and descriptive statistics for the relationship power subscales and corresponding items (total sample). Missing data were negligible. All seven scale items ranged in value from 1 to 4. For the three unity items, the majority of
respondents either agreed or strongly agreed with the statements (upwards of 92%).

Responses were more equally distributed between agreement and disagreement for the discordance items, particularly for “punishes me” and “might beat me”, and “sides with relatives.” For the “having an affair” item, the majority of respondents disagreed or strongly disagreed with the statement (85.7%).

The final scores for the subscales were calculated using the mean of the items. Higher scores meant more agreement with the statements. For the unity subscale, a mean of approximately 3.77 indicates that on average, people either agreed or strongly agreed with the items. For the discordance subscale, a mean of approximately 1.98 indicates that on average, people disagreed with the items (meaning less discordance).

Table 3.8 also provides data on normality by subscale and by individual items. Severe non-normality was defined as >|3| for skew or >|8| for kurtosis (Kline 2005). Using these criteria, the mean scores for the unity factor were considered approaching a non-normal distribution (skewness=-2.28; kurtosis=9.59). The mean scores for discordance were considered normally distributed (skewness=0.43; kurtosis=2.50).

Table 3.8: Descriptive statistics for the relationship power subscales, TLT wave 3 couples sample (N=932)

<table>
<thead>
<tr>
<th>Scale item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Missing data</th>
<th>Mean (SD)</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unity factor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.77 (0.41)</td>
<td>-2.28</td>
<td>9.59</td>
</tr>
<tr>
<td>Cares about me</td>
<td>0.3</td>
<td>1.2</td>
<td>10.1</td>
<td>88.4</td>
<td>0</td>
<td>3.87 (0.40)</td>
<td>-3.4</td>
<td>16.49</td>
</tr>
<tr>
<td>Helps me</td>
<td>1.9</td>
<td>6.1</td>
<td>19.3</td>
<td>72.6</td>
<td>0</td>
<td>3.63 (0.69)</td>
<td>-1.91</td>
<td>6.24</td>
</tr>
<tr>
<td>Discuss together</td>
<td>0.4</td>
<td>2.0</td>
<td>14.4</td>
<td>83.2</td>
<td>0</td>
<td>3.80 (0.47)</td>
<td>-2.64</td>
<td>10.69</td>
</tr>
<tr>
<td><strong>Discordance factor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.98 (0.71)</td>
<td>0.43</td>
<td>2.51</td>
</tr>
<tr>
<td>Punishes me</td>
<td>33.8</td>
<td>24.1</td>
<td>22.1</td>
<td>20.0</td>
<td>0</td>
<td>2.28 (1.13)</td>
<td>0.26</td>
<td>1.66</td>
</tr>
<tr>
<td>Might beat me</td>
<td>50.6</td>
<td>19.6</td>
<td>14.8</td>
<td>15.0</td>
<td>1</td>
<td>1.94 (1.12)</td>
<td>0.76</td>
<td>2.09</td>
</tr>
<tr>
<td>Sides with relatives</td>
<td>37.6</td>
<td>31.7</td>
<td>16.0</td>
<td>14.4</td>
<td>3</td>
<td>2.08 (1.05)</td>
<td>0.59</td>
<td>2.1</td>
</tr>
<tr>
<td>Having an affair</td>
<td>58.9</td>
<td>26.8</td>
<td>8.6</td>
<td>5.7</td>
<td>0</td>
<td>1.61 (0.87)</td>
<td>1.37</td>
<td>4.01</td>
</tr>
</tbody>
</table>

*1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree. Refer to Appendix A for full wording of the items.*
Table 3.9 presents the standardized factor loadings and reliability coefficients for the subscales and items. For the total sample, factor loadings for unity items ranged from 0.60 to 0.62, with women loading higher on the subscale than men. The discordance item factor loadings were generally lower than those for unity and ranged from 0.52 to 0.56—with the exception of the “having an affair” item that had a loading of approximately 0.37. For all four discordance items, men’s loadings were slightly higher than women’s loadings.

These differences in loadings were also reflected in the reliability coefficients of the subscales for men and women. The Cronbach’s alpha for unity was 0.65 (women: 0.74; men: 0.53) and for discordance was 0.60 (women: 0.56; men: 0.64). While the latter three reliability coefficients fell below the recommended cutoff of 0.70 (Nunnally and Bernstein 1994), they still exhibited normal reliability values for early stage research (Nunnally 1967). Table 3.9 contains the factor loadings and reliability coefficients for each subscale.

**Table 3.9: Standardized factor loadings and coefficient alphas for the power scale items**

<table>
<thead>
<tr>
<th>Scale item</th>
<th>Total</th>
<th>Unity</th>
<th>Men</th>
<th>Discordance</th>
<th>Total</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cares about me</td>
<td>0.62</td>
<td>0.70</td>
<td>0.51</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps me</td>
<td>0.61</td>
<td>0.71</td>
<td>0.49</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss together</td>
<td>0.60</td>
<td>0.63</td>
<td>0.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punishes me</td>
<td></td>
<td>0.56</td>
<td>0.52</td>
<td>0.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Might beat me</td>
<td></td>
<td>0.53</td>
<td>0.52</td>
<td>0.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sides with relatives</td>
<td></td>
<td>0.52</td>
<td>0.51</td>
<td>0.55</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having an affair</td>
<td></td>
<td>0.37</td>
<td>0.32</td>
<td>0.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coefficient alpha</td>
<td>0.65</td>
<td>0.74</td>
<td>0.53</td>
<td>0.60</td>
<td>0.56</td>
<td>0.56</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Refer to Appendix A for full wording of scale items.
Gender differences were examined for the final two factors and scale items (range: 1-4). Table 3.10 presents the mean scores, standard deviations, and statistical differences in the measures by gender. The mean score for unity was almost exactly the same for men and women (3.77). Two-group t tests revealed that men and women’s responses were not statistically different from each other for the unity subscale or for the individual unity items. For the discordance subscale, higher scores meant more discordance (less power). Mean scores for the discordance factor were higher for women (2.12) than men (1.83) suggesting that women were more likely to experience discordance in their relationships. Two-group t tests revealed that men and women’s responses were statistically different from each other for the discordance subscale or for two of the discordance statements: “If my partner were angry with me, he/she might beat me” and “My partner is probably having an affair.” Figure 3.4 illustrates the iterative process used to develop the final model of relationship power that was used in the hypothesis-testing phase.

Table 3.10: Gender differences in relationship power factors

<table>
<thead>
<tr>
<th>Scale item</th>
<th>Total</th>
<th>Women</th>
<th>Men</th>
<th>t test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cares about me</td>
<td>3.77 (0.41)</td>
<td>3.77 (0.45)</td>
<td>3.77 (0.37)</td>
<td>0.937</td>
</tr>
<tr>
<td>Helps me</td>
<td>3.87 (0.40)</td>
<td>3.86 (0.44)</td>
<td>3.88 (0.35)</td>
<td>0.460</td>
</tr>
<tr>
<td>Discuss together</td>
<td>3.63 (0.69)</td>
<td>3.65 (0.67)</td>
<td>3.60 (0.70)</td>
<td>0.253</td>
</tr>
<tr>
<td>Discordance factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punishes me</td>
<td>1.98 (0.71)</td>
<td>2.12 (0.72)</td>
<td>1.83 (0.66)</td>
<td>0.000</td>
</tr>
<tr>
<td>Might beat me</td>
<td>2.28 (1.13)</td>
<td>2.35 (1.15)</td>
<td>2.22 (1.11)</td>
<td>0.088</td>
</tr>
<tr>
<td>Sides with relatives</td>
<td>1.94 (1.12)</td>
<td>2.32 (1.19)</td>
<td>1.56 (0.89)</td>
<td>0.000</td>
</tr>
<tr>
<td>Having affair</td>
<td>2.08 (1.05)</td>
<td>2.07 (1.10)</td>
<td>2.08 (1.00)</td>
<td>0.924</td>
</tr>
</tbody>
</table>

*1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree. Refer to Appendix A for full wording of the items.*
In the hypothesis-testing phase that follows, I ultimately decided to drop the discordance factor in the statistical analyses. This was for several reasons. First, there appears to be two or more underlying constructs being measured in the discordance scale, including couple disagreement or conflict (or the punitive aspects of power such as being able to beat or punish a partner) and perceptions of a partner’s infidelity. The item related to perceptions of a partner’s infidelity had significantly lower factor loadings than the other three items and was conceptually distinct from the other three items. Hatcher (1994) argues that in order for a factor to be retained, one of the criteria is that all the variables share a conceptual meaning. Second, in my experience trying to publish the results of the scale, I learned that acceptable minimum levels of scale reliability for high quality journals range from 0.65-0.70. While the discordance subscale reliability was not terrible, it was not ideal either. Rather than pursing a path that I will eventually deviate from when trying to publish selections from this dissertation, I chose to examine several of the underlying constructs as single-item measures, particularly, physical violence and perceived partner infidelity (as will be discussed). The findings above related to the discordance subscale were intentionally documented herein to demonstrate the process of creating a new scale—and the decisions that needed to be made along the way—in order to provide other researchers with a possible starting point for a measure of discordance for the Malawi context.
Figure 3.4: Iterative Stages of Development for the Relationship Power Model
The Hypothesis-Testing Phase

Design and Rationale

For specific aim 2, the objective was to test whether relationship power influences the use of HIV testing services and disclosure of test results to primary partners—in accordance with the study hypotheses documented in Chapter 2. My initial intention was to conduct a dyadic analysis for the hypothesis-testing phase of this dissertation. As I started to analyze the quantitative TLT data, preliminary findings changed my original analysis approach. I first computed the Intraclass Correlation (ICC) for the unity and discordance measures, which is the first step in a dyadic analysis to evaluate non-independence or the degree of similarity between two members of a dyad on the same variable (Kenny, Kashy, and Cook 2006). The ICC was computed through a large one-way ANOVA using a unique couple identifier as the grouping variable. The ICC for unity showed that only 9% of the variance in unity was explained by the dyad, $F(465, 466)=1.20, p=0.025$. The ICC for discordance showed that only 6% of the variance in discordance was explained by the dyad, $F(465, 466)=1.12, p=0.12$.

What do ICCs tell us? The idea behind evaluating a measure’s ICC is to assess how similar two dyad members’ responses are to the same measure—a measure that is hypothesized to involve an interaction between the two people. With unity, for example, I would expect that if a wife reports higher levels of communication, her husband would also be more likely to report this, though certainly it would not be extraordinary for couple members to report divergent responses. For discordance, which includes perceptions of a partner’s infidelity and physical violence, I would expect that if couples had high levels of
reciprocal violence and mutual mistrust, they would provide similar responses to each other. However, the ICC for discordance showed that couple member’s responses were even more independent than for unity. Reciprocal violence only occurred in 1% of couples (or in 5.4% of all physically violent couples). Similarly, only 3% of all couples both reported that they believed their partners were having an affair. Thus, the majority of the time if one partner was suspected of cheating, the other partner was not suspected of the same behavior.

The ICC values can be used to inform a particular analytic approach. Data with high levels of non-independence would be best suited for a dyadic-level analysis. According to Kenny and colleagues (2006), a dyadic level analysis controls for the non-independent nature of two individuals providing more similar information on one measure than two individuals who are not part of the same couple. Individual-level data that are actually hierarchical such as data from dyads may bias estimates when non-independence is present (Kenny, Kashy, and Cook 2006).

Another way to conceptualize the ICC is as a proportion of the total variance in a measure that is explained by the dyad. For unity, only 9% of the total variance (within couples and between couples) is explained by the dyad—the ICC for discordance is even less (and also non-significant). There is generally a lack of agreement about “how much” non-independence is enough to warrant a dyadic level analysis. Cohen (1998) defines 0.50 as a large ICC, 0.30 as a medium ICC, and 0.10 as a small ICC. Dagne et al. (2002) argues that if there is little variance between couples and the ICCs are close to zero, then it is possible to examine the data at the individual level.
For the hypothesis-testing phase of this dissertation, I chose to analyze the data at the individual level rather than at the dyadic level given that the couple data—at least the main predictor variables for this study—were largely independent. Multiple possible reasons may explain why the ICCs were found to be so low. One reason may relate to statistics. Given that the majority of the sample agreed or strongly agreed with the unity statements, there may not have been enough variation overall to show differences between couples. In other words, if most people in the entire sample reported that they “agree” with a given statement on a 4-point Likert scale, then the ICC could be low because the two dyad members’ responses were not more similar than any other two people in the entire sample.

Now that I have outlined the rationale for analyzing the data at the individual level, I will justify the general approach I used to testing the hypotheses related to testing uptake and disclosure. For the HIV testing uptake models, I used longitudinal testing history data collected over a 16-month period (wave 4, 5, 6, and 7). This allowed me to follow respondents over time to see if relationship power, measured at wave 3, had an effect on testing over each 4-month interval. Longitudinal analyses are generally thought to be superior to cross-sectional analyses. Cross-sectional studies are inherently limited at demonstrating causal linkages since directionality of cause and effect cannot be evaluated (Singleton and Straits 2005). If the data were captured at the same time, it would be difficult to determine whether having an HIV test changed power or whether power changed after getting tested. The background literature presented in Chapter 2 suggests that both directions are possible.
For the disclosure models, I used the power measures captured at wave 3 to predict disclosure at wave 5 in order to help establish temporality and widen the time gap between when power and disclosure was ascertained. For both analyses (HIV testing uptake and disclosure), I stratified the analysis by gender because I perceived that the pathways would differ between men and women. Though the data are largely independent, gender stratification provided an additional level of protection against any bias from non-independent data.

### Sample Selection

Two separate datasets were used to test the hypotheses related to: 1) HIV testing uptake; and 2) disclosure to primary partners. For the HIV testing uptake models, I used the baseline sample of couples from wave 3 who completed the power module questions (N=932). Here, I refer back to the uptake dataset discussed earlier. For several reasons, I chose to use the couple dataset instead of a cross-sectional dataset of all respondents who completed the power module. First, use of the couple dataset ensured that only legitimate and serious couples answered the power questions about their partner, potentially increasing the validity of the data (e.g., respondents were not reporting on a phantom partner). Second, because I used data from both couple members as predictors, it was necessary to link the couple members to determine their partner’s information.

The baseline sample was followed from wave 3 to 7 in order to obtain HIV testing histories over a 16 month time period. Limiting the analysis to only TLT’s group 3 (refer to Figure 3.2)—who had no testing until the end of the study—would have minimized the
effects of TLT testing on regular testing behavior; however, this would have dramatically reduced the sample size, which was already halved through use of gender stratification. Therefore, I used all three TLT study groups in order to make use of a larger sample. Even though group 1 received an HIV test through TLT at each wave and group 2 received an HIV test at wave 4, I still expected that respondents could have obtained an HIV test outside of the TLT study. Respondents were not told when they would be tested and thus if they desired to learn their status, knowledge of the TLT testing schedule may have had little impact on the decision to wait to be tested at TLT. I also controlled for cumulative number of previous TLT tests at each wave in order to account for any differences between the regular TLT testers (group 1), the occasional testers (group 2), and the non-testers (group 3).

For HIV test disclosure, I started with the baseline set of couples identified at wave 3 (N=932). Here, I refer back to the disclosure dataset discussed earlier. Respondents were not eligible for the analysis if they were never tested for HIV or if they did not participate in wave 5. When attempting to understand factors that influence disclosure of HIV test results, it was important to consider HIV status in the analysis since it had been noted as a key predictor of disclosure in the literature. At wave 4, approximately two-thirds of the entire TLT sample received an HIV test as part of TLT, allowing me to know the HIV status of many respondents. At wave 5, the TLT questionnaires asked respondents about whether they shared the results of their last HIV test with spouses or sexual partners. Thus, it was possible to determine whether those tested through TLT at wave 4 disclosed their test results by wave 5. Since group 3 tested outside of TLT (if they tested at all), I could compare
the rates and predictors of disclosure between groups 1 and 2 to determine if the same associations held true.

**Measures**

Table 3.11 outlines the format and interpretation for each of the main predictor variables (minus control variables). Table 3.12 contains a summary of the all independent and dependent variables used in the two statistical models for HIV testing uptake and disclosure.

**Socio-Demographic Characteristics**

Several individual-level variables were included in all multivariate models as statistical controls: age, years of education, household economic status, and marital status. Age and years of education were modeled as continuous variables. Up to and including 8 years of education was considered primary school, 9 to 12 years was considered secondary school, and greater than 12 years was considered tertiary school. An index of 9 common household goods (bicycle, television, bed with mattress, radio, land line/mobile phone, motorcycle, animal-drawn cart, car/truck, or Bible/Koran) was used to approximate household economic status.

At wave 3, respondents had to have an ongoing sexual relationship to be included in the couple dataset. However, over the 16-month period, it was expected that for some, their marital status would change. For the HIV testing uptake models, marital status was considered a 4-level categorical variable consisting of the following states: married/cohabitating, separated/divorced, widowed, or unmarried. Marital status was considered a time-varying predictor and included at each wave.
For the disclosure models, a binary variable was used to capture marital status (married/cohabitating or unmarried). I expected that married couples would be more likely to share test results due to emotional closeness and difficulties associated with hiding test results from their spouses. I created a hybrid measure of marital status (married or unmarried) using the marital status measures from waves 3 and 5. Respondents were still considered married even if they had reported separating or divorcing at wave 5 since most reported that they had disclosed to their spouse in the disclosure question—thus, reflecting a ongoing connection with their ex-spouse. Respondents whose marital status had changed from unmarried at wave 3 to married at wave 5 were considered married in the analysis.

**Relationship Characteristics**

Relationship duration and shared children were included for descriptive purposes, but not in the analytical models. Relationship duration was computed by subtracting the date of the survey from the date the respondent first started spending time with their partner. For shared children, respondents were asked how many living children they have with their partner at wave 1. Given that the sample was young and the mean number of shared children was around 1, a binary variable was created to indicate whether a couple had at least one child together. Discrepancies were sometimes noted between couple members’ account of relationship duration and whether or not the couple had children together. For relationship duration, the average between female and male partner’s reports was calculated and replaced individual reports. For shared children, the female couple member’s report was used, with the assumption that the mother’s report might be more accurate.
Relationship Power

As shown in Figure 3.4, five variables or constructs were conceptualized as relationship power: 1) socio-economic inequalities, 2) relationship dominance, 3) relationship violence, 4) unity, and 5) discordance. As previously discussed, the discordance construct was reformulated as single item measures of relationship violence and mistrust/suspected partner infidelity.

Socio-economic inequality. Three variables were created to measure socio-economic inequality between partners: age inequality, education inequality, and employment inequality. Given that men normally marry when they are on average of 3 years older than women (MDHS, 2011), I considered an age gap of 5 to be a meaningful measure of age inequality (National Statistical Office & ORC Macro 2011). Thus, age inequality was captured as a binary variable where 0 referred to less than or equal to 5 years age difference and 1 referred to greater than 5 years difference. Education inequality was captured as a three-level categorical variable where 0 referred to equivalency in education for partners, 1 referred to higher male education, and 2 referred to higher female education. Respondents were asked to specify their occupation and then asked if the work was piecework, temporary employment, or a steady job. Women who specified that their occupation was ‘housewife’ were not asked the second question on employment type. Using the responses for women and their partners, I created a four-level categorical variable for employment inequality where 0 referred to both unemployed, 1 referred to man employed, woman unemployed, and 2 referred to woman employed, man unemployed, and 3 referred to both employed.
**Relationship dominance.** Relationship dominance was measured by asking respondents: “In your relationship, who would you say is generally in charge?” with answer choices respondent, equal control, or partner. Since less than 2% of women and less than 1% of men responded that their relationship was female-dominated, a binary variable was created where 0 referred to egalitarian or female-dominated and 1 referred to male-dominated.

**Relationship unity.** As previously discussed, the factor analysis resulted in two subscales named unity and discordance. The three-item unity subscale was included in all statistical models (“My partner shows they care about me”; “When I need my partners assistance, he/she is there to help me”; and “My partner and I discuss important matters together”). TLT interviewers asked respondents whether they strongly agreed (1), agreed (2), disagreed (3), or strongly disagreed (4) with these statements. Responses were reverse scored so that higher mean scores meant more unity in the relationship. The discordance subscale was dropped for lower reliability and other reasons, but re-formulated using three single-item measures: relationship violence (physical and sexual) and mistrust/perceived partner infidelity.

**Relationship violence (sexual and physical).** Respondents were asked if they were victims of sexual and physical violence (but not if they were perpetrators) in relation to the reference partner noted in TLT’s power module. The format and wording of these two measures came from the study conducted by Pulerwitz and colleagues (2000), who used these measures to assess construct validity for the original Sexual Relationship Power Scale (SRPS). Sexual
violence was captured as a binary variable that asked respondents if their partner has ever forced them to have sex when they did not want to. I asked my research assistants to clarify the translation of the term “forced.” I found that the measure of sexual IPV does not refer to rape (i.e., being physically forced against one’s will to have sex), but rather to verbal pressure to have sex when one does not want to. The term “sexual coercion” may more accurately reflect the measure of sexual violence. Physical violence was captured with a binary variable that asked respondents if their partner ever hurt them by beating them. While multiple forms of physical abuse are possible such as hitting, kicking, or punching, the question on physical abuse in this study was restricted to “beating” in order to reflect the predominant local term used to describe physical abuse in Malawi.

*Mistrust (perceived partner infidelity).* Perceived infidelity of a partner was measured with the statement: “My partner is probably having sex with someone else.” TLT interviewers asked respondents whether they strongly agreed (1), agreed (2), disagreed (3), or strongly disagreed (4) with this statement. I next created a binary variable for perceived partner infidelity by collapsing the strongly agreed/agreed (set to 1) and strongly disagreed/disagreed (set to 0) response categories.

**Perceived Risk**

Perceived risk for HIV—of self and of partner—were included as predictors of HIV testing uptake and modeled as categorical variables. *Perceived risk of self* was first captured with the statement: “Pick the number of beans that reflect how likely it is that you are infected with HIV now.” The respondent could select up to 10 beans. I created a 5-level categorical
variable where 0 equaled no likelihood, 1 equaled low likelihood (1-4 beans), 2 equaled a medium likelihood (5 beans), 3 equaled high likelihood (6-9 beans), and 4 equaled certain likelihood. Rather than collapse the initial response options into low, medium, and high, I specifically wanted to include “no likelihood of infection” and “certain likelihood of infection” as separate categories to account for actual knowledge of HIV status (i.e., respondents who presumably knew their HIV status would theoretically be less likely to test).

Perceived risk of partner was captured with the statement: “What is the likelihood that your partner is currently infected with HIV?” Response options included no likelihood, low, medium, high, and “I know she/he is” (infected with HIV). I created a 3-level categorical variable for perceived risk of partner, where 0 referred to no or low likelihood of infection, 1 referred to medium likelihood of infection, and 2 referred to high or certain likelihood of infection. For the statistical models, I later collapsed the medium likelihood with the high/certain category given the low number of “medium” responses.

HIV Status (self and couple)

By wave 5, approximately two-thirds of the sample was tested for HIV via TLT. The TLT survey also included a question about the respondent’s likelihood of being HIV positive—collected at each wave (i.e., perceived risk of self). I considered respondents to be HIV positive if they tested positive through TLT (up to and including at wave 4) or if they indicated that they were certain they were HIV positive at wave 5 (i.e., reported a 10 on a
scale of 0 to 10 for perceived likelihood of HIV infection). Thus, HIV status was a categorical variable where 0 referred to HIV negative and 1 referred to HIV positive.

It was expected that respondents would make decisions to disclose based on whether they perceived their partner’s HIV status to be the same or different from their own HIV status. Therefore, in the disclosure models, I included a measure of concordance between the perceived status of a partner and their own HIV status. I used the HIV status variable and the perceived risk of partner variable (ascertained at wave 4) above to create a new 4-level categorical variable called perceived HIV status concordance, where 0 referred to ‘HIV negative respondent, partner perceived to be HIV negative/low risk’, 1 referred to ‘HIV positive respondent, partner perceived to be HIV positive/high risk’, 2 referred to ‘HIV positive respondent, partner perceived to be HIV negative/low risk’, and 3 referred to ‘HIV negative respondent, partner perceived to be HIV positive/high risk’.
Table 3.11: Format and interpretation of the main predictor variables

<table>
<thead>
<tr>
<th>Variable name</th>
<th>Categories /Range</th>
<th>Interpretation</th>
</tr>
</thead>
</table>
| Age inequality              | 0, 1              | 0=Partners within 5 years age difference  
1=Male partner at least 5 years older                                                                                                       |
| Education inequality        | 0, 1, 2           | 0=Equal education  
1=Male higher education  
2=Female higher education                                                                                                                  |
| Employment inequality       | 0, 1, 2           | 0=Both unemployed  
1=Male employed, female unemployed  
2=Female employed, male unemployed  
3=Both employed                                                                                                                           |
| Relationship dominance      | 0, 1              | 0=Female dominated/egalitarian  
1=Male dominated                                                                                                                              |
| Unity                       | 1-4               | Higher scores mean more unity power                                                                                                         |
| Physical violence           | 0, 1              | 0=No history of physical violence in the relationship  
1=History of physical violence in the relationship                                                                                           |
| Sexual violence             | 0, 1              | 0=No history of sexual violence in the relationship  
1=History of sexual violence in the relationship                                                                                             |
| Mistrust                    | 0, 1              | 0=Disagreed/strongly disagreed partner is having affair  
1=Agreed/strongly agreed partner is having affair                                                                                             |
| Perceived risk (self)       | 0, 1, 2, 3, 4     | 0=No likelihood of HIV infection  
1=Low likelihood of HIV infection  
2=Medium likelihood of HIV infection  
3=High likelihood of HIV infection  
4=Certain likelihood of HIV infection                                                                                                           |
| Perceived risk (partner)    | 0, 1              | 0=No/low likelihood partner is infected with HIV  
1=Medium/high/certain likelihood partner is infected with HIV                                                                                         |
| HIV status                  | 0, 1              | 0=HIV negative  
1=HIV positive                                                                                                                               |
| Partner HIV status concordance | 0, 1, 2, 3       | 0=HIV negative respondent, partner perceived to be HIV negative/low risk  
1=HIV positive respondent, partner perceived to be HIV positive/high risk  
2=HIV positive respondent, partner perceived to be HIV negative/low risk  
3=HIV negative respondent, partner perceived to be HIV positive/high risk                                                                 |
Control Variables

Three additional control variables were included in the multivariate models for HIV testing uptake: new antenatal care HIV test, previous TLT testing, and previous external testing (all modeled as time-varying predictors). Since this study focused on relationship factors that influenced use of client-initiated HIV testing, a control variable was included in the multivariate models for women in order to adjust for those who tested as part of antenatal care and thus would be less likely to seek HIV testing elsewhere. At each wave, pregnant women completed a separate pregnancy questionnaire that asked if they had started antenatal care and if yes, whether or not they had been tested for HIV through their antenatal care. Women were not asked the date of the antenatal care HIV test. Pregnant women who started antenatal care very early could have reported they had received an antenatal care HIV test at two sequential waves over an 8-month study period. Thus, I considered it a new antenatal care test for that particular wave if they did not report in the previous wave that they had tested for HIV via antenatal care. Take, for example, a pregnant woman who reported that she had been tested for HIV via antenatal care at wave 5. I did not consider her test a new antenatal care test for wave 5 if she also reported that she received an antenatal care test at wave 4. This logic also assumes that women were only tested once through antenatal care and that a miscarriage did not occur between waves (e.g., reported antenatal care testing at wave 4, then miscarried and got pregnant again, and reported antenatal care testing at wave 7).
The multivariate models also included a control variable for previous TLT testing. Since I used all respondents’ HIV testing histories collected at waves 4 through wave 7, approximately two-thirds of people were tested through the TLT study at wave 4 and another one-third were tested at waves 4 through 7. All respondents were included in this study because even if they were tested as part of TLT, they may have also tested outside of the study. Given that this study used a subsample of the entire wave 3 population to begin with (i.e., those who were in serious sexual relationships), statistical power would have been significantly reduced if respondents who tested via TLT were excluded from the analysis. Therefore, a continuous variable was included in the models to control for the number of previous TLT tests (cumulative) at each wave. Respondents were considered to have tested via TLT if they were allocated to group 1 or group 2 (for wave 4 only) and had an HIV test result on file for that wave.

I also expected previous external HIV testing would influence future uptake of HIV testing outside of TLT. Therefore, I included a continuous variable called previous external testing in the models to control for the number of previous external tests (cumulative) at each wave.

In the multivariate disclosure models, it was expected that disclosure rates would vary based on whether respondents tested through TLT at wave 4 or not. Therefore, an additional variable was included as a statistical control in the disclosure models: TLT test at wave 4. This binary variable indicated whether a respondent’s last HIV test was conducted at
TLT’s wave 4 (yes/no). Respondents were considered to have tested at wave 4 if they were allocated to TLT group 1 and 2 and if they had an HIV test result on file.

Dependent Variables: New HIV Test and Status Disclosure

At each wave, respondents were asked: “When were you last tested for HIV?” If they had previously tested, respondents specified the date of their last HIV test (month and year) and whether it was conducted through TLT or at a local health care center. A binary variable was created to track whether respondents received a new HIV test (outside of the TLT study) at waves 4 through 7 using the survey date of previous wave and last test date of current wave. If the “last test date” was greater than “previous survey date” and the test was reportedly conducted outside of TLT, then it was considered a new HIV test for that wave. If a respondent was missing for a particular wave, they were not included in the analysis at that wave only.

Respondents were specifically asked, “The last time you tested, to whom if anyone did you tell your results?” Response options included spouse/long-term partner, other sexual partner, a relative, etc. A binary variable was created to measure whether a respondent disclosed the results of their last HIV test to either their spouse (if married) or to a primary sexual partner (if unmarried). For unmarried respondents who disclosed to their sexual

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4 Initially, I considered respondents to have tested at wave 4 if they reported at wave 5 that their last test was at TLT, however, this appears to have missed a number of respondents who actually did test at TLT’s wave 4. Of the 932 individuals in the couples dataset, 489 of them tested at wave 4 through TLT yet only 410 reported that their last test was at TLT. Some of these respondents may have simply misreported where the last HIV test occurred while others may have tested again after TLT.
partner, it was not possible to confirm whether this individual was the same sexual partner in the couple dataset (though this was likely to be the case).
Table 3.12: Independent and dependent variables for the two statistical models of uptake and disclosure

<table>
<thead>
<tr>
<th>Variable</th>
<th>HIV testing uptake models</th>
<th>HIV test disclosure models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Included in model?</td>
<td>Type</td>
</tr>
<tr>
<td>Marital status</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Years of education</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Household goods</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Age inequality</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Education inequality</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Income inequality</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Unity</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Relationship dominance</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Physical violence</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Perceived risk (self)</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Perceived risk (partner)</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>HIV status concordance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived partner infidelity</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>New antenatal care HIV test</td>
<td>X</td>
<td>Binary</td>
</tr>
</tbody>
</table>
## Table 3.12, continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>HIV testing uptake models</th>
<th>HIV testing disclosure models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Included in models?</td>
<td>Type</td>
</tr>
<tr>
<td><strong>Independent variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous number of TLT tests</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Previous number of external tests</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Tested at TLT’s wave 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dependent variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New HIV test (since previous wave)</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Disclosure to sexual partner</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Statistical Analysis

For repeated events data such as the binary variable of ‘new HIV test’ collected at each wave in this study, Allison (2004) suggests the use of fixed and random effects models—each of which has their own set of advantages and disadvantages. Peterson (2004) adds that the choice of model depends more on the underlying study objectives. Fixed effects models are used to address how individual change on a given predictor (e.g., marital status) affects a change in the dependent variable over time. On the other hand, random effects models are tilted more towards differences between individuals, such as those who perceive themselves to be at high risk for HIV and those who do not.

Fixed effects models are advantageous in the sense that each individual serves as their own control and it is possible to control for both observed and unobserved variables that remain constant over time (Petersen 2004). However, the main drawback to fixed effects models is the inability to estimate the effects of any variables that do not vary over time (Allison 2004). Individuals with no across-time variation in any of the predictor variables would not contribute at all in the estimation and may reduce the sample size considerably (Petersen 2004). In the present investigation, some of the predictor variables did not change over time. For example, data pertaining to the unity variable was also collected at wave 5 when the power module was included in the partnership survey. A two-sample t-test for the mean differences showed that unity was not significantly different in wave 3 and 5 (see Table 3.13 below). I also calculated the percentage of respondents who provided the same response to each of the three unity items at both wave 3 and 5 (N=840). Approximately
80.3%, 74.9%, and 60.8% of respondents provided identical responses for the “cares for me”, “discuss together”, and “helps me” items at both waves. Since unity is one of the most important variables used to predict HIV testing uptake in this study, fixed effects models would not have been able to produce reliable estimates for this variable.

Table 3.13: Mean value of unity at TLT’s wave 3 and 5

<table>
<thead>
<tr>
<th>Wave</th>
<th>Mean of unity</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3.773</td>
<td>0.398</td>
</tr>
<tr>
<td>5</td>
<td>3.767</td>
<td>0.426</td>
</tr>
</tbody>
</table>

A two-sample t test showed that the mean difference between the two measures of unity was not significantly different from zero ($p=0.70$).

Therefore, random effects models were used to test for associations between the predictor variables and HIV testing uptake using the `xtlogit` function in Stata 11.2. All variables, with the exception of marital status, perceived risk, antenatal care testing for HIV, previous TLT testing, and previous external testing, were modeled as time-invariant predictor or control variables (as illustrated in Table 3.12 by the “wave” column).

For the disclosure models, multivariate logistic regression was used to test for associations between relationship power and status disclosure using the `logistic` function in Stata 11.2. Even though multiple waves of data were used (e.g., predictor variables were from wave 3, HIV status was from wave 4, and disclosure was from wave 5), only a single time point was examined for the disclosure dependent variable—thus making conventional regression an appropriate analytic approach. The disclosure models were also stratified by gender.
The Interpretative Phase

Design and Rationale

I used two main sets of qualitative data, namely semi-structured interviews and focus group discussions (FGDs), to carry out specific aim 1b (to evaluate the cultural relevance of the measure of power) and specific aim 3 (to understand the meaning of HIV testing within the context of a sexual relationship). As part of these objectives, the qualitative data also allowed me to verify, challenge, and explain the quantitative results from the factor analysis and from the hypothesis-testing phase on HIV testing behavior.

I used grounded theory as a method to accomplish these qualitative objectives (Strauss and Corbin 1998; Glaser and Strauss 1967). Starks and Trinidad (2007) outline three qualitative approaches to data that can be used in health research: phenomenology, discourse analysis, and grounded theory. Discourse analysis focuses specifically on the use of language through a careful analysis of speech—which was not my intention, although, categories of codes that emerged did resemble narratives or discourses. I chose grounded theory over phenomenology for the following reasons. In contrast to phenomenology, which seeks to understand a particular phenomenon of interest by sampling subjects who have directly experienced this phenomenon, grounded theory serves to develop an explanatory theory of basic social processes using a range of different experiences (this will become evident through the discussion of my sampling approach). Grounded theory originates from the field of sociology, specifically from symbolic interactionism (Starks and Trinidad 2007). Briefly, symbolic interactionism posits that meaning is negotiated and understood through actions...
with others in social processes (Jeon 2004; Blumer 1969). Because I was interested in the relationship context and how men and women’s interactions created new meanings and responses to HIV testing programs, symbolic interactionism was an appropriate approach.

For specific aim 1b, I used the TGP to frame constructions of power in the Malawi context, but also invoked grounded theory as a method to uncover areas of nuance. In this respect, my approach to specific aim 1b was primarily deductive since I used the TGP. However, the approach was complemented by an inductive perspective that allowed Malawians’ voices to emerge organically from the data. The need for this complementary inductive approach is especially important given the limitations of the TGP (as pointed out in Chapter 2) and its primary application in western settings; by relying solely on the TGP, I could miss important dimensions of power relevant to the Malawi context.

A second limitation of the TGP is its rather stagnant prescription of gender relations—as if they are stagnant and not shaped by geography. As sociologists have long argued, “gender” is a fluid concept that is socially constructed across time and space (Butler 2003; deBeauvoir 1989; Benedict 1959; Mead 1935). As such, people do not take on one particular gender identity for life but rather reconstruct their gender in response to the changing world around them. Gender norms are constantly evolving as people interact with larger social structures and with each other, and then respond accordingly. By listening to the voice of Malawians themselves, I hoped to capture the evolution and dynamic nature of gender and power that could not be revealed by relying on the TGP alone.

For specific aim 3, I took a more purist inductive approach using grounded theory and
particularly, symbolic interactionism as a method for understanding HIV testing behavior. With this type of analysis, I could then question whether my deductive hypothesis-testing results were rooted in the actual experiences and perceptions of Malawians. I used the semi-structured interviews to document individuals’ experiences getting tested for HIV within the context of their relationships and used the focus group discussions to capture broader social norms and perceptions of HIV testing.

For both of the specific aims above, I also drew upon other informal sources of qualitative data such as field notes from participant observation, interviews with VCT counselors and village chiefs, debriefing sessions with my Malawian informants, and casual conversations with other young Malawians. Rather than go back and conduct another set of semi-structured interviews to follow up on interesting ideas or areas that were incomplete in the interviews, I used the FGDs as a way to fill these gaps in knowledge. Group discussions are also a useful method for observing how people interact and converse with one another on issues (Schensul 1999), albeit in a semi-structured research setting. As such, I use the focus group discussions as a way to explore interactions between participants on perceptions of power and HIV testing. I found the FGDs to be much richer and more colorful than the one-on-one individual interviews and therefore, I focused my analysis on the FGDs and used the semi-structured interviews to provide backup support.
The Couple Interviews

Sampling and Recruitment

Purposive sampling was used to select three distinct geographical areas in order to obtain a diverse set of relationship experiences among participants: 1) Balaka boma or the villages surrounding Balaka town; 2) a trading center village; and 3) an isolated rural village. After selecting six villages as the final catchment area, a random sample of dating and married women (n=90) aged 18 to 25 were selected from each village using age, sex, and marital status data from a recently collected demographic household listing of the Balaka district. After obtaining permission from the local village authorities, we approached women at their homes. Sexual partners were recruited through the sample of women. Since we did not have addresses for respondents, we relied heavily on the village chiefs to help us track down respondents in their villages. If the target sample member could not be found or the sample member was ineligible during the time of recruitment, the interviewer moved onto an alternate sample member listed for that particular individual.

Training

Prior to data collection, hired Malawian research assistants attended a two-day training session conducted by myself on topics related to qualitative research, interviewing techniques such as probing and listening, the interview guide, consent for participation, ethical issues, and transcription and translation. Research assistants were trained to conduct flexible and unobtrusive interviews, so that fuller responses were elicited and new themes could emerge spontaneously. Research assistants were also re-trained on qualitative interviewing
throughout the data collection process using completed transcripts from previous interviews. During training, research assistants were asked to provide feedback on confusing, unclear, and culturally irrelevant interview questions and their feedback was incorporated into the interview guide.

Semi-Structured Interview Guide

A semi-structured interview guide was developed using constructs from the Theory of Gender and Power (Connell 1987; Wingood and DiClemente 2000) and background literature on gender and relationship power (Perez et al. 2006; Pulerwitz, Gortmaker, and DeJong 2000; Pulerwitz et al. 2002; Dunkle et al. 2004; Pettifor et al. 2004; Mbweza, Norr, and McElmurry 2008). Respondents were asked to share their perceptions of ideal relationships, but also asked about their relationship histories and experiences with regard to their current spouse or primary sexual partner if not married. The first half of the interview covered topics such as relationship characteristics, gender roles and ideals, dependence/autonomy, control, decision-making, spousal communication, love, and trust. For example, the following question was asked on decision-making: How do you and your partner decide on important things in your relationship? Probes were used to extract more detailed information from respondents about their relationship dynamics. Examples of probes included: What types of decisions do you have more say in, what types of things does your partner have more say in? Do you need to consult with your partner on certain types of decisions? The second half of the interview focused specifically on experiences with HIV testing. For example, respondents were asked if they had ever been tested for HIV (but not
about the test results), if their relationship changed after testing, and if yes, how so. Refer to Appendix B for the semi-structured interview guide.

Semi-Structured Interviews

In order to minimize social desirability bias and help respondents feel more comfortable providing sensitive information about themselves, two research assistants were matched by sex with the respondents. Another PhD student conducting fieldwork in Malawi had recommended several research assistants after interviewing them for her own work, but found that they did not speak the local language of her study population—and thus she could not hire them. After interviewing several possible candidates for the job, I selected two candidates who had some college-level training, demonstrated strong English, and whom I thought were personable enough to establish a good rapport with the respondents. The research assistants fell within the age range of the sample population (female interviewer, age 21; male interviewer, age 25).

While the couple interviews were conducted at the same time, partners were interviewed separately in a private location chosen by the respondent—such as under a tree, on a straw mat near the back of the house, or on the veranda. The interviews lasted approximately 45-80 minutes. The interviews were audio taped with digital recorders. Each respondent received four hotel-sized washing soaps as a gift for participating in the study.

Semi-structured interviews were conducted with 34 women and their male partners (17 couples). Of the 34 respondents, 12 respondents were in dating relationships and the remaining were married. The average age of the men was 23 years, whereas the women were
slightly younger with an average age of 21 years. Of the 17 couples, 8 resided in Balaka town villages, 5 resided in a rural village, and 4 resided in a trading center village.

Translation and Transcription

After each interview, research assistants wrote a summary of the interview and debriefed me on the highlights of the interview. In the summaries, the research assistants noted their overall impression of the respondent and discrepancies in the conversation that may indicate respondent bias. Research assistants simultaneously translated and transcribed their respective interviews from Chichewa to English immediately following the interview. Interviews were translated word for word. I reviewed the transcripts for clarity as they were completed and asked the research assistants to explain language that was unclear. During the transcription reviews, I noted areas where additional clarification was needed from the research assistants on language, events, and cultural practices or beliefs. As I reviewed each successive interview, I noted in my own summaries any new information that is learned and how the information compared or differed from previously conducted interviews.

The Focus Group Discussions

Sampling and Recruitment

Participants were eligible to participate if they fell within the age range of 16 to 24 years and were considered maturated\(^5\). Unmarried minors could be placed at considerable

\(^5\) While participants were advised to talk in general terms and share their opinions but not personal experiences, we anticipated that sensitive information could inadvertently be disclosed to the group and create confidentiality risks. Therefore, we limited participants to maturated adults, i.e., if they were under 18, they had to be married. To the contrary, I found
risks if they disclosed details on their secret relationships to the group and this information later became public. Individuals were considered maturated adults if: 1) they were married and/or; 2) over the age of 18 years.

After obtaining permission from the local village authorities, we recruited focus group respondents from the same three geographical areas in the Balaka district as we did for the semi-structured interviews. Respondents were approached by a project staff member at their homes, explained the details of the study and their responsibilities, and asked to participate. If they agreed, respondents were given appointment cards indicating the time and location of the focus group discussion. In order to minimize confidentiality breaches and social desirability bias due to knowing a fellow focus group member, respondents in each focus group were selected from different geographical areas to the extent possible.

During recruitment, I had expected that some respondents would forget about their appointments or change their minds about participating and thus, we over-sampled in order to allow for this (in order for a scheduled FGD to take place, we needed at least five but no more than eight respondents). However to my surprise, most respondents showed up to participate—sometimes very late, which I learned was typical on “African time”, and most likely motivated by the expectation that they would be compensated for their time. We selected three sites to conduct the interviews, each with varying degrees of formality and levels of comfort.

that most of the time people shared experiences about others from their home villages and family/friends as opposed to themselves.
1) A teacher development center (referred to locally as a “TDC”) located in the Balaka town. This building was centrally located near a secondary school and was equipped with chairs and tables, and had intermittent electricity.

2) An under-five immunization clinic that doubled as a village preschool. This small concrete structure had a large open space with two small private rooms and was located in a rural trading center village. Respondents huddled along a cement wall ledge on the building’s perimeter while the facilitator sat in the middle of the group on an empty bottle cart.

3) An agricultural field under a large baobab tree. This site was located in an isolated, rural farming village. We had hopes of conducting the interviews outside of the chief’s house on large straw mats, however, local men were brewing beer and talking loudly so we were forced to move to the field for more privacy.

**Sample Size**

Regarding the number of FGDs to be conducted in this study, a number of researchers recommend conducting two group discussions for each variable of concern in order to ensure that the discussions adequately capture most aspects of the topic (Schensul 1999). This study used two stratifying variables (e.g., gender and marital status), which indicated a minimum of two FGDs for men and two FGDs for women. The following calculations were based on Schensul’s (1999) recommendations for the number of FGDs:
Gender = 2 x (male, female)

Marital Status = 2 x (married, single)

Total number of FGDs: 2 x 2 = 4

However, I decided to double the number of recommended FGDs to eight in order to ensure that saturation points would be met and to account for the fact that the quality of some interviews would be better than others depending upon group dynamics. I also expected that as the facilitators gained more experience with each subsequent interview, the data quality would improve.

The FGD Guide

Individuals were asked to share their perceptions, attitudes, and opinions on relationships among people like themselves. They did not need to be personally involved in a sexual relationship to be able to talk generally about relationship power. The focus group guide was divided into two sections. The first section asked questions on general power dynamics within married and dating couples such as what does it mean to be head of the household? What makes a man (and a woman) feel powerful in their relationships? How does power change after marriage? What happens when married couples disagree or even cheat? The second half of the guide presented a series of vignettes on HIV testing that involved a hypothetical couple named “Lucy” and “Promise.” For example, in one scenario, Lucy was worried about getting HIV from her husband and respondents were asked if she should go for testing on her own or get her partner’s permission first, and why. Refer to Appendix C for more details on the FGD guide.
Training

I hired two English-speaking Malawian research assistants to facilitate the FGDs in Chichewa, who were matched by gender to the respondents. The two research assistants were trained to conduct flexible and unobtrusive group interviews so that fuller responses could be elicited and new themes were allowed to emerge spontaneously. Before starting, we pilot tested the FGD guide on groups of TLT staff members in order to finalize the instrument and train the facilitators at the same time.

The male interviewer was 30 years old and came highly recommended to me by the TLT staff. He had a college degree in economics from a Malawian university, was very bright, and possessed strong leadership skills. The female interviewer was hired through word-of-mouth. I initially had heard about her from another PhD student who thought she was very articulate and had impeccable English. She was 19 years old, came from a relatively wealthy family in Balaka, and had college-level training and certificates. Although the female interviewer was very capable and confident in her abilities, she had the difficult and challenging job of trying to get shy, village women to talk openly in a group setting. Certainly some women were boisterous and eager to participate, but many remained quiet and unsure about their responses (as if there was a right or wrong answer), and had to be continuously probed for their thoughts. The men, on the other hand, were very loquacious and verbose in their responses.
Focus Group Discussions

One research assistant facilitated the interview, while the other person acted as the “observer” by assisting the facilitator with paperwork and refreshments, taking notes, and creating interview summaries to be used in a debriefing session on the most salient discussion points, problematic questions, and how new information differed from the previous focus groups. As the interviews took place, I recorded notes on body language, interactions between FGD members, and respondent characteristics.

We conducted eight focus group discussions consisting of 7-8 participants each for a total of 62 respondents. Focus groups were stratified by gender and marital status in order to make participants feel more comfortable sharing their opinions, perceptions, and understandings of power and HIV testing with their peers: two groups were married women, two groups were married men, two groups were single women, and two groups were single men. The focus group discussions lasted between 75 and 120 minutes. The set of transcripts consisted of 283 single-spaced pages.

Table 3.14 shows the demographic characteristics of the FGD sample. Half of the sample was married. The average age of the men and women was approximately 21 and 20 years, respectively. The sample was split almost evenly between having a primary school and secondary school education. Approximately half of the respondents resided in the Balaka town villages, 26% resided in a large trading center village, and 24% resided in the rural villages.
Table 3.14: Characteristics of the focus group respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Men (n=32) N(%)</th>
<th>Women (n=30) N(%)</th>
<th>Total (n=62) N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>21.25</td>
<td>19.8</td>
<td>20.5</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>16(50)</td>
<td>15(50)</td>
<td>31(50)</td>
</tr>
<tr>
<td>Single</td>
<td>16(50)</td>
<td>15(50)</td>
<td>31(50)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school or less</td>
<td>16(50)</td>
<td>13(43)</td>
<td>29(47)</td>
</tr>
<tr>
<td>Some secondary school</td>
<td>15(47)</td>
<td>17(57)</td>
<td>32(52)</td>
</tr>
<tr>
<td>Higher education</td>
<td>1(0)</td>
<td>0(0)</td>
<td>1(0)</td>
</tr>
<tr>
<td>Resident village</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balaka town villages</td>
<td>16(50)</td>
<td>15(50)</td>
<td>31(50)</td>
</tr>
<tr>
<td>Trading center village</td>
<td>8(25)</td>
<td>8(27)</td>
<td>16(26)</td>
</tr>
<tr>
<td>Rural villages</td>
<td>8(25)</td>
<td>7(23)</td>
<td>15(24)</td>
</tr>
</tbody>
</table>

Translation and Transcription

Audio-recorded focus group discussions were immediately translated from Chichewa into English and typed into electronic format for review. The focus group recordings were translated word for word. Short and long pauses, laughter, and other non-verbal gestures were included in parentheses in the transcripts. These non-verbal gestures were important to include because they indicated instances where respondents were struggling with a question (i.e., a long pause). I interpreted laughter as a positive sign that respondents felt comfortable with each other and were enjoying themselves enough to bring a little bit of humor into the discussions. During transcription, focus group respondents were assigned a number based on the first time they spoke in the interview. Respondents who could not be identified by the transcriptionist were labeled with a question mark (i.e., “Man ?” instead of “Man #2”). If respondents were speaking at the same time (overlapping speech) and it was not possible to distinguish what each person was saying, the transcriptionist placed the phrase “cross talk”
in square brackets immediately after the last identifiable speaker’s text and then picked up with the next audible speaker. There were also times when it was not possible to decipher what was said on the audiotapes, for example, when it was raining outside or there was too much echo in the room. In these cases, the transcriptionist identified segments of the tape that were unintelligible and indicated this in square brackets in the transcripts. As each transcript was completed and I reviewed it, we all sat down to discuss translation issues, where better probes could have been used, and the larger themes found in the focus group discussion.

**Qualitative Data Analysis**

With the semi-structured interviews, I imported the data into the *Atlas.ti* software for analysis. After significant coding of the interviews, I realized that the software inhibited my ability to intuitively analyze the data; I felt too distracted by the laborious process of coding instead of focusing on what was going on in the data. Therefore with the focus groups, I decided to develop my own data analysis method by coding the data in *Microsoft Word*, organizing the coded data in binders that I could easily flip through to compare codes across and within the FGDs, and used colored sticky notes to identify key passages and themes. Yet the same overall process was used for both analysis strategies; I utilized a series of steps outlined by the grounded theory approach (Strauss and Corbin 1998) to analyze the qualitative data.
Open Coding

Descriptive codes and categories of themes, concepts, experiences, and processes were created prior to data analysis using the preliminary reviews of the data as described above, the interview guides, and relevant background literature. Codes refer to labels for assigning units of meaning to the information collected as part of the study (Miles and Huberman 1994). An initial set of codes included labels such as “qualities of an ideal partner”, “meanings of love”, “sources of power”, and “HIV testing decision-making.” Coding began as an open coding process, in which a priori codes were assigned to text in a systematic manner by examining the transcripts line-by-line or by set of lines. As I read each passage, I asked myself the questions “what is this about?” and “what is being referenced here?” As the coding continued, existing codes were modified or deleted, and new codes (such as in vivo codes) were continuously added until all the transcripts were coded.

Axial Coding

After open coding, axial coding was used to specify the relationship between codes and to group codes into categories and sub-categories. Categories are “concepts that stand for a phenomenon” and subcategories are “concepts that pertain to a category, giving it further clarification and specification” (Strauss and Corbin 1998).

Selective Coding

The final coding step was selective coding, defined as “the process of integrating and refining categories” (Strauss and Corbin 1998). In this stage, I organized the codes around a central, unifying core category that reflected the main actions and events described in the
semi-structured interviews and FGDs. Through selective coding, the categories were integrated and developed into theory around what relationship power means in Malawi and its connection to HIV testing.

**Memo Writing**

I used the codes to develop theoretical memos that compared and contrasted, and summarized phenomena, groups, and individuals. A memo is “the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding…it can be a sentence, a paragraph, or a few pages…it exhausts the analyst’s momentary ideation based on data with perhaps a little conceptual elaboration” (Glaser 1978).

**Data Matrices**

I used the methods outlined by Miles and Huberman (1994) to develop data reduction matrices that summarized and displayed key concepts/themes by demographic characteristics such as gender and marital status. A matrix allows the researcher to conceptually piece together fragmented text in one place in order to reduce a complicated data set to a manageable size (Ulin et al. 2002).

**Data Presentation**

Modest changes were made to the transcripts to improve readability. For confusing words or phrases—that made sense to me, but would be considered foreign to others not familiar with Malawian English—I inserted brackets with short explanations for clarification. Given the difficulties in assigning names or pseudonyms to 62 different focus group respondents, I choose to leave the respondents’ identification as numbers; I realize that this
may be awkward to read and decontextualize peoples’ stories. With the semi-structured interviews, I could more easily label respondents by providing each of the 34 respondents with a pseudonym (e.g., “Ruth” and “James”) in order to give life and context to their stories.

**Ethical Considerations**

This study received approval from the Colorado Multiple Institutional Review Board or COMIRB (protocol numbers 10-758 and 10-861). The TLT study received approval from Penn State University (protocol number 31397) and the National Health Sciences Research Committee (NHSRC) in Malawi (protocol number 558). All TLT data were de-identified prior to my analysis and thus I had no access to respondent names or personal identifiers. For the qualitative data, many of the same ethical considerations were taken into account during data collection for both the semi-structured interviews and focus group discussions. In what follows, I briefly summarize some of the key ethical considerations for the focus group discussions.

During recruitment of the focus groups, respondents were informed that the FGDs would involve questions about gender and power in sexual relationships and were asked if they felt comfortable talking about these issues in a group. Respondents were told that they did not need to provide intimate details of their own sexual relationships, but rather to talk more generally about relationships based on their perceptions of others. Efforts were made to ensure that FGD participants in each group were recruited from different geographical areas and did not know each other personally.
FGDs took place at comfortable, centrally located community sites. As part of the formal consent process, respondents were explained the purpose of the study, why it was important and what would be learned from the research, the risks and benefits of participating, the right to not answer any questions or stop the interview at any time, and who would see their responses. They were provided with contact information for the principal investigator should any additional questions arise. Participants were also asked for their permission to audio record the interviews so that they could be translated from Chichewa into English. Verbal consent was obtained since signatures of the respondents would be the only piece of information linking the respondent to the study. A copy of the consent form (explaining all of the above) was translated into Chichewa and back-translated into English to ensure that the form was interpreted as I expected. The final Chichewa version was left with respondents to read over at their leisure. Two witnesses (a Malawian research assistant and myself) were always present during the consent process.

Following the completion of the FGD, each participant was given a modest cash gift of 500 Malawi Kwacha (MK) or the equivalent of $3.25 USD. The amount of the gift was not be specified in the recruitment materials. Consent forms disclosed more details regarding the gift. This amount of money given to respondents had been approved for the larger TLT project by Penn State University and the National Health Sciences Research Committee (NHSRC) in Malawi and the research team had not encountered any problems with this incentive over the first year of the project. The gift also addressed potential transportation and food costs participants might face by participating in the study.
I anticipated that this study would pose minimal risks to research subjects. One possible risk of the FGDs was the breach of confidentiality in which private information could have been shared with others outside the group. To protect against this risk, I ensured that the audio equipment containing project files and hardcopies of transcripts were locked up and stored on a password protected computer that only I had access to. Although I collected demographic information such as age, education level, resident village/town, marital status, etc. on study participants, I did not collect any identifying information such as names or identification numbers. Any names mentioned in the transcripts were anonymized (i.e., names were changed to a name other than the one mentioned) after translation/transcription.
CHAPTER IV

CONSTRUCTIONS OF GENDER AND POWER:
TRADITION, UNITY, AND RIGHTS

In Chapter 3, I presented a new measure of relationship power for the Malawi context. The statistics revealed that two constructs were important domains of power in young couples: unity and discordance. While I used qualitative interviews to develop the initial set of power scale items, this formative work was carried out in a rapid fashion during a short field trip to Malawi in 2009. Formative qualitative work—conducted using a deductive framework and a priori theory—may not fully capture the breadth or depth of the construct of interest in the same way that more inductive qualitative methods allow for. This chapter presents the results for specific aim 1b: to evaluate the cultural relevance of the measure of power using qualitative data. To accomplish this aim, I used the Theory of Gender and Power (TGP) to frame how rural Malawians construct meaning around gender and power, while at the same time allowing any additional theoretical constructs to emerge inductively from the data.

To briefly recap from Chapter 3, Connell’s TGP (1987) proposes that three social structures characterize the gendered relationships between men and women: 1) the sexual division of labor, or the economic inequalities that favor males; 2) the sexual division of power, or abuses of authority and control in relationships; and 3) cathexis, or social norms and affective attachments around femininity and masculinity. The three social structures are overlapping, but distinct, and explain the gender roles that men and women act out in their relationships and society (Connell, 1987). In addition, these three social structures are thought to operate
at two different levels: the societal (the higher level) and the institutional (which includes the family and relationship level) levels. I focus mostly on how power is manifested at the relationship level. At the end of this chapter, I describe how structural-level interventions aimed to empower women filter down to influence relationship power dynamics.

I focused the analysis on the focus group discussion data—rather than the original set of semi-structured couple interviews used to develop the power measure—because I found them to be much richer and to offer a fresh perspective on gender and power relations. One explanation for this may relate to the willingness of respondents to disclose private information. In the focus group discussions, respondents were not asked to talk about their own personal experiences, but rather their perceptions of people they know in their villages and therefore, they may have been more forthcoming than the semi-structured interview respondents. In the future, it may be worth spending more time with individual respondents to build rapport—perhaps by conducting several consecutive interviews—and help respondents feel more comfortable sharing their private experiences.

**Tradition, Unity, and Rights**

Using the grounded theory approach outlined in Chapter 3, I found that respondents voiced their perceptions of gender and relationships using three interrelated narratives (or discourses), which I named *tradition, unity, and rights*. The thematic code of *tradition* was assigned to passages that referenced patriarchal gender roles, norms, and ideals (including those reflected in conservative religious teachings), such as statements like “husbands are heads of households” and “wives must obey their husbands.” The *unity* code was assigned to
passages around shared power, egalitarianism, communication, mutual respect, and collaboration. Finally, the rights code was assigned to passages that showed support for individual freedoms and privileges—especially with regard to women’s rights. In some cases, the narratives were not easily distinguishable as respondents invoked multiple codes in a single train of thought—suggesting that the narratives are not always mutually exclusive but rather intertwined.

How do these three narratives tie to Connell’s three social structures of labor, power, and social norms? I believe that each of these three narratives offers a higher order framework for categorizing the division of labor, the division of power, and social norms around gender in Malawian sexual relationships. The TGP inherently assumes that relationships operate under a tradition orientation, characterized by male dominance and female submissiveness. However, rural Malawians’ challenged this notion; while tradition was certainly a prevalent narrative used to describe gender relations, it was not the only one. The other narratives of unity and rights offered alternative explanations for power relations beyond notions of tradition. While rights narratives tended to emphasize female autonomy and freedoms, unity narratives suggested the presence of egalitarian relationship dynamics. I believe that these additions of unity and rights serve as extensions to the three TGP social structures of labor, power, and cathexis. Figure 4.1 illustrates how the TGP could be re-conceptualized to include all three narratives related to tradition, unity, and rights. The short descriptions under each box are examples of what follows in this chapter.
Figure 4.1: Re-Conceptualizing the Connell’s (1987) Theory of Gender and Power
Cathexis: Gender and Relationship Ideals

According to the TGP, cathexis refers to the attachment of women’s sexuality to other social concerns around impurity, immorality, and the primary goal of bearing children (Wingood and DiClemente 2002). The same conventional notions of gender apply to men and constructions of masculinity. But how do rural Malawians define the structure of cathexis, that is, the social norms and ideals around gender? I start by cataloging the short phrases used to describe ideal relationships as they related to each of the three narratives of tradition, unity, and rights (as illustrated in Table 4.1).

When asked to describe the characteristics of a perfect relationship, a large majority of focus group respondents used a unity discourse to describe their relationship ideals. Slightly nuanced patterns emerged by gender and marital status. Both married and single men mentioned similar characteristics of ideal relationships including love, cooperation, mutual respect, trust, sex, and getting tested together (refer to Chapter 6 for more detail on testing). Married men also mentioned the importance of “understanding each other”, referring to the need for good communication, peace in the household, and respect for relatives. Married and single women described ideal relationships using similar constructs as men (with the exception of sex) including peace, love, cooperation, understanding, good communication, trust, and getting tested together.

When asked to characterize an ideal spouse, respondents often drew upon multiple discourses (unity, rights, and tradition). In reference to tradition, the men noted that they wanted a wife who was virtuous and faithful to their husbands, beautiful in terms of her physical
appearance, and respectful in terms of clothing and behavior towards husbands, in-laws, and neighbors. Married men, in particular, mentioned their desires for a wife who was god-fearing, humble, religious, loving, and did not gossip or share family secrets with others. When men were asked about what makes a good husband, all focus groups drew upon notions of tradition and stated that he must be a good provider for the family. Men also mentioned how he should be faithful and loving towards his wife.

Women were also questioned about what makes an ideal husband. Common traits mentioned by both married and single women included being a good provider, trustworthy, loving, and an open communicator. Single women noted that he should be healthy and free of HIV, able to bear children, good looking, and refrained from alcohol and smoking—which reflected their status as unmarried in search of a man who demonstrated strong marriage potential. In addition, they often used a tradition narrative to describe how an ideal wife should be obedient to their husband, faithful, virtuous, respectful, loving, and avoided gossiping about others.

Mutual respect was noted as a relationship ideal in virtually all of the focus group discussions. Intuitively, mutual respect would be coded as part of a unity discourse. However, sometimes respondents really meant rights. In one quote, a single man referred to respect as “they get along and agree on what to do without taking someone’s human rights.” (FGD #3, single men). He went on to explain that men and women could violate each other’s rights when they did not agree on an issue and when one person dominated all the decisions. He added, “People will not admire this type of couple.” His extrapolation to larger community
perceptions of a good marriage suggests that mutual respect is an important relationship ideal that many couples desire in their marriages.

**Love, Materiality, and Power**

In about half of the focus groups, love was noted to be the most important relationship ideal. I characterized love as an aspect of *unity* under the social structure of cathexis, although respondents’ descriptions suggested that it intersected with the divisions of labor and power. In nearby South Africa, Mark Hunter (2010) describes two types of love: the first type is called “provider love” and is intimately tied to the division of labor through cooperation and mutual assistance. The second, a more modern type, is called “romantic love” and could be explained by couple interactions such as the exchange of love letters. Hunter describes this type as more of an individualistic love reflecting a greater choice in marriage partners whereby men and women can leave relationships at any time.

We asked respondents to explain what love meant to them. Unsurprisingly, love carried different meanings to men and women. The meaning of love also diverged based on marital status. Female focus group respondents associated love with materiality and exchange. For married women in particular, love was strongly tied to *tradition* and the sexual division of labor, that is, whether their husbands lived up to the provider role. In one example, a married woman replied, “it shows he has love when he leaves food in the house” (FGD #1, married women). Another group of married women talked about love as a collaborative act of *unity*, i.e., “working together” (FGD #7, married women). While single women also talked about materiality, their descriptions of love included the exchange of luxury items—beyond
subsistence items like food and other necessities required for a family. Other women described love as a means to control a partner, as enacted through the sexual division of power. They argued that when you love your partner, you do what they want, whether it be dressing a certain way, providing sex, or giving a girl what she asks for. One single woman said, “The love I am talking about here is when you tell your partner that you want something, he does it immediately. When you tell your parents [to do something for you], they take a long time to give it to you. But your boyfriend does it fast and gives you want you are looking for.” (FGD #4, single women). A few respondents conceptualized love as faithfulness and dedication to the relationship. According to these women, people who love each other do not search for love elsewhere and cheat on their partners.

For the men, love was also understood as a product of the sexual division of labor, specifically with regard to cooperation, working together, caring and loving each other, and helping each other out when it came to sex and decision-making. In the following passage, a married man from one of the focus groups discussed the collaborative aspects of love using a *unity* narrative and pointed out how love makes a man put his wife first:

Love is very difficult to understand. Love means that you and your wife are doing things together and doing everything in time [quickly/immediately], like work for the house. Maybe there is a time when she wants you to be with her, but you go somewhere else instead. Maybe you say I am going to watch the video [there are places in the villages where a person can pay to watch a video in a group setting]. It means the woman has a feeling that when her husband goes somewhere, there is someone he loves more than me [suspects he could be cheating]. Love means that you should consider your wife before considering other people [women]. But if you love your wife and you don’t do what she wants, the woman takes herself as not good enough [she thinks she’s not a priority]. (FGD #6, married men)

Similar to the women’s accounts, men also mentioned how love leads to obedience or power: when you love her, you do what she wants. According to this narrative, love provides a pathway to power such that the partner who receives more love has more control over the
circumstances of the relationship. Much of the literature on relationship power focuses on
decision-making (refer to Blanc 2001 for a summary), with the assumption that men have
the final say on many financial, sexual, and household decisions. But here, women whose
material needs and wants were successfully met by a loving partner, indirectly controlled how
family finances were spent through the enactment of love.

Men (both single and married) emphasized the distinction between *true love* and *false love.*
For example, one single man lamented, “Some women are attracted to different things. It
can be that she is in a relationship with you but she is attracted to a drummer [musician who
plays African drums in ceremonies and other events] or what not. She is not satisfied [with
you]. A girl with real love cannot be found these days.” (FGD #3, single men) In this
example, these men alluded to a second type of love reflected in Hunter’s definition of
romantic love—something that is fleeting and rooted in an individual’s ability to selectively
choose a partner. In the next passage, a group of married men discussed how real love is not
superficially based on a woman’s physical appearance or driven by sexual desires:

Man #1: But I can also say that it can happen that one doesn’t move about [cheat] and the other
doesn’t move about and you say there is love. But also when you say love, you don’t
regard the appearance of your partner or what she has. Because there are some who
have love when the person is rich or well to do and say, “I love her.” But also there is
another love where you say this one is good looking that is why I love her. So without
looking good, there is no love. So when we say love, it doesn’t regard the appearance
[crosstalk]; it’s like real love that has no doubts (group laughs) [crosstalk]

Man #3: It can make us have another woman because we don’t trust the woman. We don’t love
her. The main thing is that if there is love, you shouldn’t have another relationship and
the woman shouldn’t have another relationship.

Man #4: Because some say that I proposed that woman, I love her. While others say that I don’t
love that woman, I just use her with the aim of just sleeping with her. So there is no
love since he just wants to sleep with her. (FGD #8, married men)
Though briefly mentioned in the above passage, married men elaborated in other conversations that *real love* was not based on riches. The level of detail in their stories suggests that these are not just perceptions but rather reflections of personal experiences with women who claimed to love them but later only wanted them for their money. According to these men, true love meant that you accepted a person as they were during the good times and bad times. As one married man put it, “Love is not tied to money. In some families, they love each other because one of them is working, simply because of the money. And when one loses their job, love decreases because that person is no longer able to provide.” (FGD #4, married men)

Tremendous social pressures are placed upon young men to provide women with what they want—and not just during marriage. This idea resonated in a follow-up conversation that I had with James, a 23 year old, English-speaking man from one of the focus groups of single men. When I asked James why he does not have a girlfriend and is living at home with his parents, he replied that he couldn’t afford a girlfriend right now since he was unemployed. The following is an excerpt from my field notes:

I asked him to tell me about any current girlfriends or memorable relationships of the past. He does not currently have a girlfriend. His last girlfriend was from 2 months ago but they broke up because he wanted to focus on his education. He claims that they broke up because she was demanding too much and since he had no job, he couldn’t afford to give her what the wanted. He says that Balaka girls want money. When I asked him what he was giving her, he said money for clothes, units, biscuits (not school fees, as I had presumed). He says she wasn’t materialistic, but came from a poor family and needed the money for these things. When I asked him if he wants a girlfriend, he says no, but qualifies his answer with having no money and she will need money (so its not a matter of not wanting one, its just not an option for him right now). He said that he wants to have a good job before getting married.

(Field notes dated October 18, 2011)
Materiality and the exchange of resources from men to women are important factors that bind relationships in rural Malawi; this exchange may empower both genders. Women feel powerful when they receive, while men feel powerful when they give. As noted by Wamoyi and colleagues (2011) in Tanzania, young women felt powerful when they used their sexuality to exploit men for money and gifts. These women considered themselves as “lucky”, not disadvantaged, to have female bodies that could be cashed in to meet their material desires.

In their seminal qualitative study in Malawi, Swidler and Watkins (2007) argue that transactional sex may be best understood as one of the many ties of unequal exchange between patrons and clients. The authors write, “just as women need patrons to provide them with material benefits, men need clients who provide them with an outward display of power, prestige, and social dominance and an inward sense of behaving morally.” The consequences of being a poor man and lacking the very thing women desire limits men’s ability to carry out their life aspirations around marriage and childbearing: social states that bring tremendous status to men. In such systems of dependence, women rely on men for material gain just as much as men depend on women to perform their masculinity and for upward social mobility.
### Table 4.1: Focus group respondents’ perceptions of ideal relationships

<table>
<thead>
<tr>
<th>Gender</th>
<th>Married</th>
<th>Single</th>
</tr>
</thead>
</table>
| **Male** | **Perfect relationship:**  
- Love  
- Cooperation  
- Understanding each other  
- Mutual respect  
- Trust  
- Sex  
- Peace  
- Relatives are treated right  
- HIV testing together | **Perfect relationship:**  
- Love  
- Cooperation  
- Mutual respect  
- HIV testing together  
- Trust  
- Sex  
**Perfect wife:**  
- Understanding  
- Loving  
- Virtuous  
- Respectful  
- Trustworthy  
- God-fearing/religious  
- Beautiful  
- Does not gossip/share secrets | **Perfect relationship:**  
- Love  
- Cooperation  
- Mutual respect  
- HIV testing together  
- Trust  
- Sex  
**Perfect wife:**  
- Beautiful  
- Respectful  
- Virtuous  
- Hard worker  
- Trustworthy (does what she says)  
**Perfect husband:**  
- Understanding  
- Loving  
- Calm  
- Trustworthy  
- Loves his wife  
- Good provider  
- Cooperates with wife  
- Uses his power wisely |
| **Female** | **Perfect relationship:**  
- Peace  
- Love  
- Cooperation  
- Understanding each other  
- HIV testing together  
- Trust  
**Perfect husband:**  
- Good provider  
- Understanding man  
- Trustworthy  
- Loves your relatives  
- Open (communication)/discusses HIV with wife  
- Loves his wife  
- Obedient (gives wife what she wants)  
**Perfect wife (not asked)**  
- Obedient  
- Faithful  
- Virtuous  
- Respectful  
- Does not gossip  
- Loving | **Perfect relationship:**  
- Respect  
- Love  
- Cooperation  
- Good communication  
- HIV testing together  
- Trust  
**Perfect husband:**  
- Loves his wife  
- Should be able to bear children  
- Good provider  
- Trustworthy (faithful)  
- Open communication  
- Respectful  
- Religious/spiritual  
- Does not drink or smoke  
- Physical appearance  
- Healthy (no HIV)  
**Perfect wife:**  
- Obedient  
- Faithful  
- Virtuous  
- Respectful  
- Does not gossip  
- Loving |
The Sexual Division of Labor

According to the TGP’s sexual division of labor, men and women are allocated to certain professions and occupations. It assumes that women are assigned to more unequal positions as compared to men, which creates economic imbalances that force women to rely on men financially—a premise that centers on what I call *tradition*. In order to determine the extent to which this theory held in the Malawian context, respondents were asked to debate the meaning of the phrase “head of the household” and to verbalize whether men, women, or both genders are allowed to take on this role. After reading the transcripts, I was struck by how critically respondents contemplated their answers to this question in such a pensive and rational manner. Both men and women used *tradition*, *unity*, and *rights* narratives to describe the division of labor. Given the interconnectedness of the TGP social structures, respondents also invoked the social structure of cathexis to justify the appropriate division of labor between men and women. In what follows, I separated out examples of the different narratives used and then presented how respondents contested multiple discourses together during a single conversation or debate.

**Tradition Narratives**

The *tradition* discourse was by far the most widely used narrative to explain the role of head of the household. Women described the head of the household as the leader and provider for the family, the one who works, the breadwinner, the one who takes care of the household needs and his wife and children, the one who sets the rules and gives instructions, the owner of the house, the problem solver, the decision-maker, and the one who plans for
the family’s future. With regard to tradition, the men’s narratives echoed many of the women’s responses. In one of the groups of married men, a respondent used a tradition narrative to describe how husbands make the important decisions and wives obey their husbands’ orders.

Most women depend on their husbands for everything, saying “if my husband tells me that we won’t go to the garden, then we won’t.” Three quarters of women in the village—I can’t say for women in the town because I haven’t lived there before—just wait for the man. Even if the house is leaking and if there is no plastic paper and the woman tells the husband you should buy me a paper. If the man refuses, the woman can’t get the money. Even if she sees the money, she can’t buy the plastic papers. She just waits for the rule of the man to happen. When it happens, she is just obedient and she just waits for that rule from the man. (FGD #6, married men)

Male respondents provided additional justifications for who is the household head: some cited Christian teachings from the Bible, while others defined the head of the household by the one who proposes marriage—which was largely perceived to be the man. Respondents also noted how the head of the household was supposed to be the older partner (presumably the man) given cultural rules that dictate more respect for elders. In general, many respondents believed that the man was always considered the head of the household as dictated by customs and long-lasting ideals around male respect—regardless of what the circumstances may be.

Why might male respect surpass the respect deserved by women? In South Africa, Mark Hunter (2010) talks about male respect in relation to the head of the household role as something that came out of men’s migration to urban areas in search of jobs that later brought status, wealth, and respect. Respect and its historical ties to labor is just one explanation. Yet women who are employed may not be privy to the same social benefits. When focus group respondents were presented with the scenario of a wife works or who
was the sole breadwinner, some respondents argued that she could never be the household head. A wife can rule a husband, “but not like the way that women are ruled” by their husbands (FGD #5, single women). In the following conversation, the facilitator presented a hypothetical scenario of a husband who did nothing to contribute to the household, but the wife worked. He then questioned the group about who was the head in this scenario, which elicited conflicting responses among them:

Man ? She looks after children, buys food in the house, and does everything else that needs to be done? In such a case, the woman is the head of the household.

Man #1: A train does not turn as a car does, when it wants to return, it just moves backwards. But though it moves backwards, we are still able to tell which side is the front and which one side is the back. This is the same in the family. In a relationship whereby the man does not work but the woman does, more people will say the head of the household is still the man. (group laughs)

Man #3: What you are saying is not true because in this case, the woman is doing everything. (FGD #4, married men)

According to the second man’s perspective, larger societal definitions of gender trump any local derivatives. Although this may indeed be the majority’s opinion, the presence of differing opinions among the focus group men suggests that gender roles related to the division of labor are not straightforward or easily definable. As further exemplified in the next section, not everyone believed that tradition justifies men’s unquestioned authority over household members.

Unity Narratives

Though unity was less frequently invoked as compared to the tradition narrative when explaining the division of labor, some respondents believed that if both spouses contributed to the household, they were each entitled to the role of “head of the household”—and not just symbolically. For example, a group of married women reported that men and women
could lead the household together since both partners were required to make important family decisions. In one group of married women, a respondent stated:

They need to sit and make decisions together as one. Looking at the fact that these two are working together, the man nor the woman cannot be called head of the household without the next person who in this case is the woman or the man. They both need each other’s help to be called the head of the household. (FGD #1, married women)

In a different focus group, single women also shared the perspective that women could be household heads with their husbands through their contribution to the domestic sphere (i.e., washing clothes, cooking, and raising children). These beliefs resonated amongst the men as well. For example, one focus group of single men contended that a marriage is about two people and both husbands and wives should respect each other; thus, both of them could be considered household heads. In contrast to the tradition narratives and the emphasis on male respect, unity narratives encompassed ideas of collaboration and mutual respect for one another.

Rights Narratives

I coded passages as rights narratives when respondents talked about the circumstances in which women could lead the household alone. I also cited the rights code when people spoke of women receiving an education and gaining jobs. I suspect that respondents were most likely reciting language they learned from their exposure to government and community gender empowerment programs—notably founded upon a human rights framework. Respondents, including men, identified several situations in which women could independently take on the role of head of the household. For some respondents, the title of
head of the household was perceived as fluid, subject to change with a family’s economic circumstances, and a position that was up for grabs.

First, a woman could declare herself as the household head if she had a husband who was quiet and submissive. However, these women who took control over the household were perceived as usurping their husband’s legitimate power; something that was not rightfully theirs. One married woman said, “Sometimes it is because their husbands treat them very well and they take advantage and take up the role of being the head of the household. Because of this, some women challenge their husbands.” (FGD #1, married women). Second, women could be considered the head of the household when their husbands did not work and the women were forced to provide for the family. In the following group of single men, respondents carried on a conversation about how a woman could take over as the household head if her husband was lazy and failed to find work.

Woman #2: A woman can be the head of the household because of what the man is doing. Because if you, the man, are docile [lazy], a woman can have more say in the household even though you are there.

Interviewer: Can you explain that you cannot be docile, in what way?

Woman #4: Meaning a docile person who just stays (cross talk), just waiting [not working, staying at home]. A woman is running a business but he just stays from morning to dusk.

Woman #2: Just waiting for what the wife will bring [to eat].

Woman #4: When she brings things (cross talk), he eats (cross talk) and then he just goes and plays games with friends.

Woman #1: Even if the woman says “we will eat not today”, he will still stay [fail to find work to buy food]. (FGD #3, single men)

While these extenuating circumstances certainly increased women’s responsibility and decision-making power in the household, it was probably a situation that many women would have preferred to defer to their husbands. This is unlike in the West, where young
people perceive notions of egalitarianism to be the ideal relationship arrangement (Gerson 2010).

**Contested Narratives**

While the *unity*, *tradition*, and *rights* narratives above appear well defined and neatly bounded, men and women often used all three narratives—sometimes in a single conversation thread or individual response—as they made sense of the division of labor in Malawian relationships. In the first debate below, four single men debated back and forth about whether women can be household heads. The first man (man #5) argued with a *unity* narrative that women could help to provide for the household. A second man (man #4) chimed in with a *tradition* narrative, contending that social norms dictated that it was the man who provided for the family. He questioned where a woman would get her money from, suggesting that she may be receiving money from her extramarital partner. The first man replied to this man’s remarks using a *rights* narrative, saying that these days women received higher education and could therefore contribute to the household through employment.

They said,

| Man #5: | If the man is failing to find money [through work], the woman can also help since the marriage is two people. She can help, by saying “here is the money, let’s buy relish [food, usually vegetables or meat] so that we can eat in the household.” (UNITY) |
| Man #4: | But man will still question the woman’s money, saying “where has it come from?” Because at the household, it is I who provide everything. So you have to ask. You cannot just be receiving because in the end you will eat things from a fellow man [boyfriend of wife] (group laughs). (TRADITION) |
| Man #5: | On the point about how the household head is the man, I for one disagree because nowadays the world is changing. Women are getting educated and finding good jobs. Let’s say I am working and the woman also working. We will be doing things together. There is no relish, maybe the man has no money and the woman will give the money. So we can’t say the household head is the man. There we should accept that the household is supposed to be run by two people. That’s a household. (FGD #3, single men) (RIGHTS/UNITY) |
As the conversation continued, the interviewer questioned the group about whether there were other characteristics of the “household head” beyond those related to economics. He asked specifically about decision-making dynamics in the family.

Interviewer: Ok, as you have all said, you are taking the head of the household as the one who provides the household needs, if I got you correctly. Does it mean that the household head [role] ends at providing? Because there are other households where the man is not working but the woman is the one working. But for something to be done, the man is needed [for example, to make an important decision]. So can we say in households like those, the man is not the household head?

Man #4: He’s the head, as he is needed [to make decisions].

Man #2: Because it is the man who makes the big decisions. (TRADITION)

Man #4: But also what we need to say is that a woman can’t help provide the whole budget for the month in the household without the man doing something, even if you don’t work. You can try doing other things with the aim that you should solve other problems. You should lighten the burden. You can’t just say that because I am not working then I will be eating what the woman provides, no. (TRADITION) (FGD #3, single men)

In this scenario, two other men argued that even if the wife was the family breadwinner, the husband still had the final authority on important family matters. In this case, the social structure of cathexis, specifically men’s legitimate right to power, had a stronger influence on power relations than the actual division of labor in the household.

In a subsequent conversation about the special circumstances of when a woman could be considered the family leader, the same group of single men debated about changing gender roles and how people are taught about freedom and rights in school, but nevertheless, a woman cannot have more freedom than a man—pointing to the structure of cathexis.

Interviewer: Ok, is there any other ways that a woman can be the head of the household? Because it seems we have shifted. At first we were saying that a woman can’t be the household head, but it seems there are some times where a woman can be the head of the household. What other times are there?

Man #8: There are times where you as a man, you know about freedoms. Maybe you went to school and you know that personal freedoms are supposed to like this and that when in marriage. But the woman can have greater freedom such that she can direct the household. And you do not even know that she is directing you. (RIGHTS)
Man #4: But her freedom can’t be greater than you, the man, when you are present. It’s not true, the woman giving you money to go and buy relish [vegetables and meat] and you rush out going to buy the relish (group laughs) Are you man enough or not? Or you have become a woman? (TRADITION)

Man #2: A woman is just a helper. (TRADITION)

Man #4: A woman is like a worker. You marry her and leave her at your house. Everything you buy, like relish, clothes, food at the home. So if you are buying those things, a woman cannot tell you to go and buy this, or do that no. Or even on dressing [clothing], you can tell her that what she is wearing is not proper dressing but someone else can’t tell her. (TRADITION)

(FGD #3, single men)

In this group, the men worried about losing their masculinity to an overpowering woman who ordered them around. Women’s rights to power conflicted with what they perceived as a man’s legitimate right to authority in the family.

In a different group of single men, respondents participated in a very lengthy, 7 single-spaced page debate on the appropriate division of labor. Eight men shared their opinions during the debate with many of them supporting a tradition justification for male entitlement to the head of the household role. Tradition narratives were contrasted with a unity viewpoint that both husbands and the wives could rule the house together. What follows is a condensed version of their conversation. The first man started off the debate by explaining how it was true that in some households women were the main providers, but the Bible ultimately designated the man as the authority figure. He said,

Man #8: I can explain that it all starts from the Bible, which says that [crosstalk] women should respect their husbands and that the man is a very important person in the house. But even though the man is the household head, we should not say that in all families they depend on the man. Some households depend on the woman [crosstalk]. She can plan such that the household is run by the woman. But we just say that the household head is the man because of the Bible. (TRADITION)

Interviewer: There, you have said it perfectly that some households, it is the woman who plans. And can we say that in that situation the household head is the woman? (Pause)

Similar to the other group of single men presented earlier, what emerged from this question was a debate about the extent to which tradition dictates male authority. The men continued,
Man #2: In that household, the household head can be the woman [crosstalk].
Man #4: But she can’t be a household head.
Man #7: But let us not say that because the woman does that [provides] then the household head is the woman. The head will still be the man. [crosstalk] (TRADITION)
Man #4: She just works hard.
Man #3: She does all that but she still has to respect the man as the husband. The household head is the man. (TRADITION)
Man #6: We are saying that the household head is the man, but I disagree. The household head is both of them because when they say marriage it is both of them. Marriage can’t be one person only. Everything concerns both of them, like sex. Two people have sex. In the Bible, you said that the woman should respect their husbands but how I heard it is that the woman should respect their husbands but also husbands should respect their wives. (UNITY)
Man #8: Yes they said that, but brother, let us take the Bible, Jesus Christ, when he fed people with fish and bread, between men and women, who were counted? [meaning only men were counted] (TRADITION) (FGD #8, single men)

In recognition of the strong passions people have for their religions and the possibility of it of derailing the conversation, the facilitator politely redirected the group’s attention to the question at hand. This time, the group used a second metaphor around the military to make the argument that both spouses could not lead a household together.

Interviewer: Ok, let us leave the Bible there, but in this area, the household head means what?
Man ?: It is the man.
Man #6: When they say a marriage, it is how many people? (UNITY)
Man #3: A marriage is two people but there is a leader [crosstalk]. (TRADITION)
Man #8: For example, let’s take soldiers. We say there are soldiers but there is also a leader, a commander. Even though they are all soldiers, there is a need to find one who will lead the group. Any group has a leader even here as a committee [referring to the focus group], there will be someone. It can’t work on its own [the committee] but there will be a need for a leader who will run the committee. That one is the head. Similarly in a family, whether five children or seven but the one who is there, the man, that is the one you all look up to. Maybe there is hunger and you have no food, you go there [to the leader, i.e., man]. (TRADITION) (FGD #8, single men)

The men then transitioned to a discussion of household decision-making and who had the final authority in that particular domain. In the next passage, several respondents discussed how a double standard existed around how men could make decisions on their own, but women needed to consult with their partners beforehand.
Man #7: It may be that the woman is well to do, is rich. Perhaps a child says he doesn’t have a pen, you’ll hear that child tell the father first. The father should buy it for the child but the woman has the money. She still says ‘tell [ask?] your father’. (TRADITION)

In response to his statement, the next man argued that it was both spouses who share the household power. However, this man’s opinion was counterpointed by other men who believed that husbands should have the ultimate authority.

Man #4: Let me explain. We are saying that the household head is the man, which means that we [the men] should all be household heads. Because now with money, the woman doesn’t always depend on the man and the man doesn’t always depend on the woman that she’ll give me money, no. But together you’ll find that the woman works and the man also works. Both of you receive the money you have made. Meaning that both of you are household heads and that you depend on each other. (UNITY)

Man #8: When they go and work in someone’s farm, they get money. Or the woman will farm in someone’s field and the man in another field. It can’t happen that the woman takes the money and makes plans on how to spend the money. What will happen is that the woman will get the money and give the husband. The man will get his and put it here. The man will do his plans and he will tell his wife that what is here is for the children’s notebooks. Get the money and buy them, meaning that the man is the household head. (TRADITION)

Man #3: Even the woman, when she finds a contract to farm she can’t just go and farm without telling the man. It can’t happen. She will tell the man that I have found this, I want to work in the farm. If the man has found another contract, he will tell her that don’t go there, let’s go and farm here. (TRADITION)

Man #6: The man can just go on his own without telling the woman. (TRADITION)

Man #3: Meaning she can’t complain. (FGD #8, single men)

As they ended the conversation, two men arrived at the conclusion that the man had all the power in the marriage but his power was passed down to him through unspoken traditional rules and norms around gender relations (cathexis).

Man #2: I can say the man has all the power. The man has 100% power. (TRADITION)

Man #1: Not having it by force, but by how the rules are here. (TRADITION)
(FGD #8, single men)

To summarize this debate, respondents’ narratives allude to the interconnectedness of the three social structures of labor, power, and social norms on gender. The division of labor could be based on husbands and wives respective economic contributions to the family, but perhaps more from deeply embedded social norms related to cathexis. The division of power
was perceived to result, in part, from the sexual division of labor—who had more economic power—as well as from social norms around male respect and legitimate authority.

Even though the majority of respondents appeared to hold conservative gender ideals around tradition, this did not necessarily mean that the balance of power always favored men. In the next section, I show how respondents talked more about unity when asked about sources of power. It is plausible that tradition narratives around social norms such as a man’s legitimate and cultural right to power masks the actual distribution of power in relationships.

The Sexual Division of Power

In this section, I present what relationship power means to young Malawians. The most common narrative used by all focus groups to describe power was unity, which included references to love, sex, respect, helping each other, and open communication—as indicated in Table 4.2. While love as a source of power was mentioned by almost all of the groups, the ways that men and women talked about love differed between the two groups. Women talked of feeling loved when their partners gave them gifts or things they asked for, which in turn made them feel powerful. Men associated love with obedience—i.e., women did what they wanted and when they wanted it, such as cooking for them, drawing water from the well so that they could bathe, and having sex. In one conversation, the interviewer asked a group of single men to explain exactly how love was associated with power. One man summarized the main point of the discussion with his response. He argued that when a woman loved her man, she obeyed his orders—which in turn brought him power.

The major point is that we propose to the woman. So when you propose you say to her, “I see you with another man, you should not move with him again.” The woman will listen if she loves you with all her heart and her trustworthiness. You give her rules and she follows the rules. So the power also
comes from when she following rules. That means the power is working [cross talk]. For example, if the government declares that the people should not steal and they are not stealing, that means they are following the orders from government. That’s where the powers are. (FGD #8, single men)

There was some common ground among men and women in the way that love—as it related to power—was tied to open communication. Both married and single groups of women mentioned how they felt powerful when their partners listened to their advice when they disagreed with his approach to important family decisions. Some people stated that when you loved each other, you could talk freely about things. In the following passage, a single man provided a vivid example of how love was inextricably linked to aspects of unity: understanding, mutual respect, and the ability to speak openly with a partner, which yielded power:

A person knows that he has power in the relationship when there is love. When he speaks to his partner, he speaks respectfully and the other partner responds respectfully as well. And when he brings up a story and the story is discussed properly amongst them, he knows that he has power and he is free and open to bring in different issues to be talked about with his wife. He knows there will not be a problem with coming up with better solutions. In such a way, one knows that he has power to speak. (FGD #4, married men)

Similarly, in another example, a single woman believed that she had power when her partner listened to her thoughts and opinions:

When you tell your friend something and they listen to you, you know you have power because when you tell a person and they don’t listen, you know you don’t have power. He belittles me. So when you tell him something and he listens, you know that you have power. (FGD #2, single women)

Sex and sexual satisfaction were also noted as important sources of power among male and female respondents. Some men provided details about how “being on top” during sexual intercourse made them feel powerful while women spoke about sexual satisfaction as a source of power. The following group of married women suggested that feeling sexually desired and having one’s own sexual desires met made them feel powerful:
Woman #4: All that matters in a relationship is sex and that is what makes a woman feel powerful.

Interviewer: In short, we can say for a woman to feel powerful it is all about sex?

All: Yes.

Woman #2: When the two satisfy each other’s needs. For example, if the woman has strong sexual desires and the man doesn’t have them, can we say that anything will work out there?

All: No (group answers).

Woman #2: For sure it cannot work because women are like fishing hooks whereby men get stuck on them and women always want their hook to have something hooked to it. So if both parties have strong sexual desires and have sex, that’s something that makes us feel powerful. (FGD #1, married women)

In this narrative, the example of sex was used to typify how broader relationship characteristics such as reciprocity and consideration for the other partner’s needs, thoughts, and circumstances brought individuals power in their relationships.

In addition to unity, male respondents also brought in tradition narratives to describe additional sources of power for themselves—specifically, regarding the division of labor. First, men spoke about their social roles as heads of the household, family providers, leaders (and the respect that came with leadership), and decision-makers as sources of power.

Second, men noted that they felt powerful through proposing women (a man can propose a woman to “date” him as well as to be his wife). Finally, one group of married men mentioned how their fertility and ability to produce children—through the social structure of cathexis—made them feel powerful. Surprisingly, none of the women mentioned children as a source of power.
Table 4.2: What makes people feel powerful in their relationships?

<table>
<thead>
<tr>
<th></th>
<th>Married</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Proposing a woman; being the head of the family/main provider/leadership; the respect that comes with leadership; love and speaking freely with your wife (open communication); bearing children; farming</td>
<td>When women do what he wants (cooks for him, calls her and she comes); making decisions; sex; being the head of the household; proposing a woman; giving the wife rules; when the wife obeys your rules and listens to you; being on top during sex; love</td>
</tr>
<tr>
<td>Female</td>
<td>Sex and sexual satisfaction; when your husband loves you; when he does what you ask; when he listens to your advice; being able to say ‘no’ to a husband; ruling the family with your husband</td>
<td>Love; when a boyfriend gives a girl what she asks for; when he takes your ideas into consideration</td>
</tr>
</tbody>
</table>

The Balance of Power in Relationships

We asked respondents to tell us how much power (in the descriptive sense) men and women should have in their relationships. The social structure of cathectic was used to describe how gender norms determine the balance of power in relationship. Both men and women provided similar narratives centering on the idea that women should be treated with respect and given “a say” in the relationship. Most focus group respondents arrived at the conclusion that men should have more power in the relationship overall (with a minority of people leaning towards equal power) and virtually no one concluded that women should have more power than men. In 2010, when the wave 3 TLT couple sample was asked, “who is generally in charge of the relationship”, approximately 88% of men stated that they were the ones in control of the relationship. Approximately 80% of women confirmed their male partner’s reports. Less than 1.5% of men and women reported that the women have more
control than men in their relationships. Approximately 18% of women and 10% of men said that they shared power equally with their partners. Chapter 5 will present more details on these statistics. Regardless, statistics such as these do not capture the nuances of power and the fact that respondents may be more likely to justify their responses to an absolute measure of power given the social norm that men are supposed to rule the household.

Several male focus groups had respondents that said power in relationships should be more balanced—yet not equal—and used a unity narrative to describe the ideal distribution of power. According to respondents, a man shouldn’t abuse his power by beating up his wife or by treating them like “slaves.” Instead, the couple should collaborate on family issues and decision-making. In the following passage, a group of married men shared their opinions on when men’s power had exceeded its limits and how this could affect the relationship quality.

They explained that when a man was using his power wisely, he was respectful of his wife and her different opinions. The first man said,

Man #4: There are some that have power in their relationships and they take their wives as slaves because they have power over everything. They say what should happen, whether the woman wants it to happen or not, she still does it because he husband has commanded and that he has power. Because she has less power, she fails to meet what the husband wants. The husband then beats her up, shouts at her, and sometimes disagreements occur. He becomes violent to her, and later people say he is abusing her. Mostly abuse comes with someone that has power because someone that does not have power cannot abuse the next person. In this case, it is good that the man should have enough power but he should use it accordingly. When we say accordingly, he should be able to respect others for example, his wife, children, and everybody else that lives there with him.

A second man emphasized that a husband should take his wife’s opinions into consideration not just out of respect, but because it could ultimately benefit him to do so:

Man #3: There are some men that say that they have more power in the relationship and do not want their wife to oppose what they have said. When the wife dares to oppose the man tends to beat her up and even chasing her to go back to her parent’s house. In this case, the man should have power to also welcome other people’s ideas and suggestions.
Because to the point whereby he abuses his wife, that means his power has exceeded its limits. But even though he has too much power, he should not use these powers by bringing in disagreements or by being violent to his wife. When the woman is opposing what her husband is saying it means that there is something that is wrong because there are some women that can help you make better decisions that can even make you rich. We now see different women in towns getting involved in different businesses. When you ask them, they tend to tell you that they got their ideas from their husbands. We cannot know who in the first place came up with the idea of starting a business; sometimes it is possible that the woman is the one that brought up such an idea. For example, she may say “To avoid overspending, you should open for me a shop that when you are away, me and the children should not have any problems and the business will provide everything for us.” Looking at the idea that the woman has brought, the man will take his money and give it to the woman to start the business but when the man is not using his powers accordingly, he will not agree with his wife and this also may cause disagreements. (FGD #4, married men)

According to these two men, overly controlling male behavior that included disrespect and abuse of a wife were not acceptable uses of power—even when a wife intentionally opposed her husband’s authority. As a result, abuses of power and the failure to consider a wife’s opinion could end up backfiring on men and limiting their opportunities to build a better life for themselves.

Another group of married men used a rights narrative to explain how men’s power shouldn’t exceed that of the wife. For example, if the wife is sick, he shouldn’t make her complete her farming work, because such an act would violate her rights. In the next passage, one man summarized a previous point made in the group by stating that, “power and rights need to go together.” Another man added that the husband should also respect the number of children she wanted and give her a pause in between pregnancies.

Man #4: Powers of a man should not exceed the point that it disappoints the wife. The powers should have limits not exceeding the ability of the wife. Because there can be the use of power such that the woman does not have peace in the marriage. For example, maybe she is sick, but because of your power, you tell her “you’ll not sleep until you water the nursery of tobacco seedlings.” Or maybe it is a garden and you are not ploughing, but because the woman is the one who goes to the garden and you go to town, you won’t listen that she is sick and you tell her to still go and farm. For those powers, the man
should look at the limits. His powers should end there so that the woman has a role in terms of her rights. Power and rights need to go together.

Man #3: On the same issue he has explained, you need to see how the woman is, especially how you are staying. Especially on the part of childbearing, you need to know that I should give my wife a break although I have the power to have a number of children. I should have a small number considering how things are. (FGD #6, married men)

According to the focus group respondents, a woman’s rights could also be violated when a man did not consider her opinions in important family matters that could potentially improve the household well being. The following group of single men engaged in a debate about women’s level of decision-making power by contrasting rights with tradition. At the end, they all agreed that women did not have to listen to everything their husbands said, especially when they felt his decisions were not wise for the family.

Interviewer: You said you know you have power when you tell a woman to do something. So should the woman listen to anything because you have more say?

Man #1: It’s not that, it all depends on what things. When she is not happy about it she can’t accept [agree to] everything. When you force her, its like you are infringing on her right. (RIGHTS)

Man #4: Because it’s different, when she is coming from her mother’s house and you are dating, she can refuse something. You can say “let’s go somewhere” and she can say “I don’t want to.” She stays with her parents then but with your wife, you can just tell her “let’s go.” (TRADITION)

Man #2: You have taken beer and you tell her to drink it. So she should just accept because she is a woman (cross talk) and you are a man? (TRADITION)

Interviewer: But here, let us say how we see things in our villages, are women expected to accept everything that their husbands say?

Man #1: No, they are not expected to accept everything that the husband says. It depends on what he says.

Man #2: If the things will be beneficial for the household, she will accept but if not [beneficial for the household], then she can’t accept.

Interviewer: Ok, as we have said that as people, you have powers. I believe women also have some power at the household. Since you have said that she cannot just accept everything, it shows that she does have some power right?

All: Yes. (FGD #3, single men)

Some male respondents attempted to quantify exactly how much power men and women should be allocated using percentages. A group of single men argued back and forth about the figures and the transcripts revealed that there was a lot of cross-talk going on during the
discussion, suggesting that respondents were actively engaged and interested in coming to a group consensus on the ideal balance of power. Their conversation continued:

Man #3: The man should not have a lot of power but should have a little more than the woman.
Man #4: I can say that the man should have more power but the woman should have a little less power, but it should not be a lot [less]. Because if it is a lot [less], the woman will be low.
Man #5: Maybe the woman should have 50 per cent and the man should have 100 per cent?
Interviewer: You have said 50 per cent and 100. That can be a problem. [alluding to the incorrect math]
Man #3: Yes, that is too much power.
Interviewer: My point is that you are saying 100%, you mean the man should have all the power in the household?
All: Yes.
Man #3: Even to move the house into a tree, it can be done?
Man #4: The woman can’t have a say.
Man #5: Maybe there we can say I am wrong.
Man #6: The man should have 60% while the woman 40%. [crosstalk]
Interviewer: So mainly we are agreeing that the man should have powers more than the woman?
Man #5: The difference [between them] should be 10%. [crosstalk] (FGD #8, single men)

Regardless of the exact number, the group generally seemed to conclude that men should have more power overall than women.

It was not just the male respondents who believed men should have more power than women. When asked about how much power women should have in their relationships, women often drew upon social norms related to the tradition narrative to support men’s higher power. One group of women discussed how women should not be more “intelligent” than men, meaning that it was unacceptable for a wife to rule her husband by demanding things from him or withholding sex until he met her requests. In another group of married women, one respondent stated that, “A woman should have power in marriage, but she should not have powers that will exceed the man’s powers. Sometimes when you have more powers than your husband you can also ruin your marriage.” (FGD #7, married women). This woman suspected that a wife with more power could become rude and disrespectful
towards her husband thus causing marital conflict. Her account suggests that for some
women, relationship aspirations and goals are a higher priority than the quest for more
power in the relationship. In the next section, respondents expanded upon this idea that
“too much female power can lead to problems” as they described the consequences of
gender role transgressions related to female empowerment.

The Influence of Gender Policy on Relationship Power

In 2000, the Government of Malawi passed its National Gender Policy in order to
“enhance the participation of women, men, boys and girls for sustainable and equitable
development for poverty eradication” (White 2007). Following the development of the
National Gender Policy, a National Gender Program was launched in 2004 to bring about
gender equality and the empowerment of women. Eight priority areas were identified and
include—but are not limited to—education, health, HIV/AIDS, economic
empowerment, and human rights.

Human rights are often at the forefront of gender empowerment policies and programs
worldwide—as referenced in the United Nations 2010 Millennium Development Goals
(United Nations 2010). Gender empowerment programs attempt to shift power imbalances
by directly addressing the sexual division of labor as well as social norms around gender (i.e.,
cathexis). In sub-Saharan Africa, structural level interventions aimed at changing the sexual
division of labor have ranged from microfinance solutions, to land rights, food security, and
education for women. Social norms around gender have been addressed through the
diffusion of messages on gender equality, for example, as incorporated into secondary
education curriculums. These structural-level factors operate at a different level of the Social Ecological Model than the interpersonal level studied in this dissertation. However, changing gender roles at the societal level have real consequences at the relationship level by challenging the ways in which men and women relate to each other. In Brazil, for example, Hautzinger (2007) suggests that women’s gains in the labor market could, in part, be interpreted as men’s respective losses. She argues that the shifting gender organization of labor, household authority, and perceptions of entitlement creates new patterns of conflict within relationships, particularly, the rise of gender-based violence as men attempt to defend themselves against more powerful women (Hautzinger, 2007). In South Africa, Mark Hunter (2010) notes similar increases in gender conflict that came as a consequence of modernity, women’s rights, and men’s decreasing control over work and housing. These examples, among many others around the world, highlight the need to consider how gender empowerment programs and policies at the structural level change the way gender is talked about and ultimately understood at the ground level.

Focus group respondents were asked to share their opinions and perceptions of government-sponsored policies and programs on gender. Overall, men and women shared mixed opinions on the benefits and the drawbacks of gender empowerment, but appeared to place stronger emphasis on their negative consequences. Despite the widespread accolades of gender empowerment in the West, rural Malawians carried very different perceptions.
Gender Equality Fosters Unity in Marriage

When respondents spoke of the benefits of gender empowerment, they used a *unity* narrative. From men’s perspectives, the advantages included women’s ability to help with family decision-making and the opportunity to contribute to family income via their labor outside the household—thus taking some of the pressure off men to provide everything for the family. In addition, men viewed additional income gained through women’s employment as a chance to improve their family’s economic situation and plan for the future. Men also perceived women’s employment as a form of insurance to prevent the family from starving should the husband die, become ill, or fail to find employment. Some men even said that when both spouses are working, it builds *unity*—love and openness—because both parties feel like they can contribute to family discussions.

Respondents generally agreed that recent gender empowerment policies have increased women’s power in society through the sexual division of labor. At the relationship level, increased earning potential was thought to buy women a level of decision-making power on how to spend their contribution of the family income. But not everyone agreed with this perception. For example, in one group of married men, a respondent disagreed saying that gender empowerment has given women rights, but not more power. This man juxtaposed *rights* with *tradition* to explain how women have the right to make decisions, but they still need to gain approval from their husbands. In this account, new social norms around *rights* were secondary to norms around *tradition* that required women to seek their partner’s permission.
Well, according to me, when a woman agrees or disagrees does not mean that she has power but I can say that she has human rights than allow her to choose what she wants. But when she makes her choice, if she is married, there’s a need for someone to analyze if it is good or not. Because even when a woman wants to be a builder, she has to let her husband know first before she takes a step in doing so. Her husband should agree and see if she can manage or not. This does not mean that the woman has power because if she did, she would just go ahead without letting her husband know. (FGD #4, married men)

As the above conversation continued, men talked about how it was not only women who needed to review their decisions with their spouses—in contradiction to the above man’s perception of a double standard. In the following passage, the facilitator asked the question about whether a man could sell a bicycle (an expensive possession by rural Malawian standards) without informing his wife. Several respondents pointed out that a man could get himself into serious trouble with his wife by doing this.

Interviewer:  There were human rights before not power. Thirty years ago a man would just sell one of his cows without informing his wife. The wife would just get to know about it in the end when the cow was already sold. So tell me, can you do the same today?

Man ?  No, that is impossible.
Man #1:  You cannot do that. Your wife will probably divorce you.
Man #3:  Even just a bicycle, you cannot sell it without your wife knowing about it.
(FGD #4, married men)

In another exchange among a different group of single men, the facilitator brought up the same scenario around a man’s ability to sell a bicycle without the wife’s approval. One respondent replied that a man could not sell the bicycle without telling his wife. Another person in the group added that the couple would argue if he did this, unless he bought the bicycle on his own—perhaps before the marriage started. A third person stated that even if he got it on his own, he needed to tell his wife about his decision to sell it. A fourth person said that nowadays, it is important to consult with each other—emphasizing the importance of unity. From this example, the group concurred that women’s decision-making power has
increased as compared to days of the past. The following excerpt documents the remainder of the conversation:

Man #8: Culture before and now are different. Things are changing with culture. If culture changes, everyone changes his behavior. Because before when you get married, they were saying a lot of things, like you should listen to your husband, that he is the household head, that’s your husband you should respect him, whatever he says you should listen [crosstalk]. So even if someone gets a bicycle and sells it, and the husband says, “I have sold the bike and used the money on beer”, the woman will listen since it’s what she was told [crosstalk], because it’s how culture was. But now with how things are changing, everyone’s actions are changing. Because you can’t take an ox-cart and sell it without telling the wife. It can’t happen now, so she will sue you even at the police.

Interviewer: So in that example, it is like the difference in power between a man and a woman is less.

Man #2: It’s like the powers of a woman are increasing.

Interviewer: It’s increasing?

All: Yes. (FGD #8, single men)

The first man above seems to argue that not informing a wife would violate her rights, rather than the unity in the relationship. This appears to be unrelated to the division of labor and more about changing social norms around women’s property rights. As suggested above, some men attributed gains in female power to the enforcement of gender policies. Whether or not this is true is debatable; yet still, the perception that there are legal ramifications to violating women’s rights may be enough to curb overly dominant behavior among men.

Most people seemed to agree that unlike the past, household decisions are now shared through women’s increasing participation in family matters. However in almost every focus group discussion, a common theme emerged around the belief that changing gender norms were overall a bad thing for men. Competing discourses of rights and tradition were used to explain how as women gain rights, men lose their traditional authority in society and in the household. Both women and men talked about how men felt threatened and emasculated by gender empowerment in several important ways. In their narratives, men expressed deep
fears about the negative consequences of changing gender roles for the family and the institution of marriage in Malawi.

**Loss of Respect in Society**

Respondents believed that if a wife was working, it usually meant that the man was a failure in society—or at least this was what other people would think of him⁶. This perception would imply that as women’s education and participation in the workforce shifts the division of labor, social concerns around masculinity (cathexis) threaten men’s power at the societal level. It appeared that many of the rural men were unfamiliar with the western idea of dual income-earner families, especially ones where the wife was the primary breadwinner; men assumed that the only reason the wife was working was to keep the family from starving as a result of her husband’s so-called laziness or failure to find employment. According to the men in this study, they found it embarrassing to have an income-earning wife because it sent the signal of their failure to live up to the quintessential responsibility of family provider. The women’s narratives provided parallel accounts. Respondents believed that people would gossip if they saw a man doing a woman’s job and might even say that he was given a “love potion.” This finding parallels some of the earlier findings around the use of love to shift the division of power.

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⁶ Though notably, in the sample of 466 mostly married women from TLT’s wave 3, approximately 40% had earned some level of personal income in the past month—either through piece work, temporary employment, or a steady job. The focus group men were likely referring to female breadwinners who take away men’s status rather than women who earn a small amount of income alongside their husbands, e.g., selling produce in the markets. Future research may follow up on this finding in more depth, for example, by investigating how much income a woman needs to earn relative to her partner to decrease his social status.
I initially presumed that the “love potion” analogy was just a symbolic use of language to depict extraordinary cases of female power and male submissiveness—as opposed to real experiences. To the contrary, in her article entitled, “Of love potions and witch baskets”, Wilson (2012) documents how Malawian women use these love potions to curtail undesirable male behavior, particularly, men’s mobility and infidelity. As she writes, “some of these medicines increase the measure of love the recipient has for the giver and simultaneously decrease the recipient’s interest in having other sexual partners” (Wilson 2012). However, as Wilson discovered, love potions could sometimes backfire causing men to become economically unproductive and bound to the domestic sphere due “loving a woman too much.” These men no longer “move around”—as men are expected to do—and paradoxically cause women to lose out on resources gained through their husband’s employment.

In the focus groups, performing female jobs what thought to make men appear submissive in the eyes of others as if they had been given a love potion. As one married woman stated, “with the way that I see it here in the village with gender [meaning gender empowerment policies], for one to see somebody’s man is working [washing dishes] stories are going to be everywhere in the village that the man has been given love potion. That will make the man appear stupid [submissive] when each time you ask him to do something, he does exactly that.” This love potion analogy came up again during a male focus group (FGD #6, married men). In this case, men discussed how they don’t want to be seen by their peers doing women’s jobs like fetching water at the borehole. People believed that men were
embarrassed by performing women's work and so they refused to do these jobs—and resisted these changing gender structures. One of the men said,

Some do it [female jobs] while others are shy. Maybe she says “you should wash a cloth [chitenje] for me at the water tap.” He tells her, “my friends could see me washing a cloth for you.” So, on the issue of gender, some men don’t do it. (FGD #6, married men)

It appears that love has limits and there are instances when too much love—or perhaps socially inappropriate expressions of love—are problematic. Respondents deemed material transfers, caring for each other, and listening to each other as normal signs of love—presented in a positive light. Yet when men loved their partners so much that they performed female-related tasks and deviated from traditional male gender roles, love was perceived as abnormal and could even carry a mystical property that only “love potions” could explain.

In a group of single men, one man pointed out that while it was acceptable for women to help men out at home with male-dominated tasks like building a house, it was socially frowned upon for a man to do a woman’s job. He said,

They [men] are happy if the woman is doing work. (group laughs) A man is on the roof and is maybe roofing the house. For him to get down to get a stack of grass, it is difficult. The woman gets the stack and gives it to him and he opens his teeth [smiles] (group laughs) Maybe the woman is busy. Maybe she is washing dishes and doing everything but is able to leave that job. She thinks that my husband should not get down, let me pass him the stack. Sometimes the man even tells her to give him the stack. She leaves her job and she helps him. But for the man to do a woman’s job at the time the woman is busy, that can’t happen. That’s when you go to sleep, and only be woken up when food is ready. (group laughs) [meaning he won’t help with cooking, he’ll just eat it] After you eat, you say “Where is the water, I should bathe, I am tired.” So gender is there [things are changing with regard to gender], but its only with a few people. When it is known that you do those things, then you are [seen as] stupid [submissive] in the whole village. (group laughs). (FGD #3, single men)

But even if men hide these embarrassing jobs from public scrutiny, they cannot prevent their wives from telling their friends. Some men noted that when women gained too much power they become boastful and might brag to others about how they could coax their husbands to
do whatever they wanted. Thus, a husband could still be subjected to shame through the route of gossip. To summarize, shifts in the division of labor were believed to create a source of power for women while at the same time reducing men’s value at the societal level. This appeared to operate through the pathway of cathexis, that is, women’s increased economic power caused men to lose power when they were perceived as failing to live up to quintessential ideals around masculinity and the provider role. Men’s power deficit at the societal level filtered down to the relationship level as they lost their authority in the household. Similar findings have been noted elsewhere, such as in Bahia, Brazil (Hautzinger 2007).

**Men’s Loss of Authority in the House**

Women believed that, in general, men were not happy with gender policies that emphasized an equitable division of household labor. In one focus group, a single woman affirmed, “It cannot be something that will make them happy because men cannot wash dishes. Because they feel that they are male and they cannot wash dishes. Ladies are there to wash dishes.” Likewise, some men lamented that they do not want women to help them with jobs reserved for men. Similar to losing face in the community if a man was seen doing women’s work, there was also the risk of a tainted image in the eyes of a spouse. In one focus group, the facilitator summarized the general sentiment of the group by stating, “Men do not like it [gender empowerment] because women are doing the same things that the men are doing. Then it is like the man is losing power because the woman is doing the work that
was supposed to be done by men. This will make them feel like they are small.” (FGD #5, single women) Everyone in the group agreed with her assessment.

Power changes may also be related to men’s diminished sense of importance in the relationship. A group of married men argued that men’s power was decreasing because women could now do men’s jobs such as plowing the fields; when she put on her overalls to help, the man appeared weak in her eyes since she was doing the same work. One man stated, “Mainly, it can be that a man is working and the woman is working [in the fields]. She is using a spanner [tool for farming] and I am also using a spanner, then at home you still remain light [weak] in the face of the woman.” Another respondent chimed in to the conversation and said, “She regards you as a woman.” (FGD #6, married men). Here, it was not the shift in the division of labor itself that caused men to lose their power but rather the emergence of new social norms tied to the act of female labor (cathexis).

According to a group of single men, gender policies were thought to cause men to lose some of their authority with women out of fear of the legal ramifications. These new legal structures existed at the societal level, but created new social norms around women’s rights in the relationship—specifically, the right to a marriage free of violence. This created fear among the men because they believed that they could go to jail if they exerted their power in the household in previously tolerated ways. In the following passage, single men discussed how gender relations were changing due to new laws on domestic violence that punished men for abusive behavior:

Man #8: So it can be that I have disagreed on a very small thing with my wife in the house. Discussing or bringing in the marriage counselors might end it [the disagreement]. But when she just goes to the police. (group laughs)
Man #4: You'll be locked up there.
Man #3: They will say you are being violent. (group laughs)
Man #6: Their powers have started to get low [decrease] with how women are able to express their ideas.
Interviewer: It is like powers of men are decreasing?
All: Yes.
Man #4: Men are also bothered by how in the beginning [of the relationship], when the man says this or that, the woman was listening but now when the man says the same thing, she is not respecting the man. She knows that if he beats me I will go to the organizations (laughs) so now it’s like the man is afraid of the woman.
Man #3: If I beat her, I will be locked up [crosstalk]. So the power of men is declining because if I do this and we don’t agree, then for sure I am going to be arrested. (FGD #8, single men)

Men are Losing Out on Jobs

Based on what they saw in their communities, respondents perceived that men were having trouble obtaining jobs because women were replacing them in the workforce. In one focus group, a female respondent said, “This hurts most men. For example, at the hospital where the construction is taking place, there are a lot of female builders and because of this men are failing to get jobs because the women have taken over what was supposed to be for men.” (FGD #7, married women) A group of single men pointed out that a woman would be selected for a job or university spot when a man and woman were equally qualified because of gender empowerment policies.

Man #4: Nowadays, we can say that a woman can have 6 points at MSCE [Malawi school certificate of education, equivalent to O-level Cambridge]. And the man also has 6 points but what happens is that between the man and a woman, they pick the woman. [either for college or a job].
Man #3: They say the man has nothing in his head. (group laughs)
Man #7: While he has passed [his exams].
Man #3: No, because he has the same [qualifications] as a woman. (group laughs) [crosstalk]
Man #4: He is intelligent and the woman is intelligent but they want the woman to rise up so that is how they are being empowered. (FGD #8, single men)

Men’s ability to provide for their families through the division of labor was previously noted as a source of power, respect, and characterized as an ideal spousal trait. As a result, men felt
that gender policies were violating their right and entitlement to steady employment as the main family providers. Therefore, these changes to the division of labor could directly depower men through the loss of employment opportunities.

**The Destruction of Marriages**

Both men and women frequently mentioned the belief that gender empowerment destroys otherwise healthy marriages. Respondents noted that divorce happens through several pathways, one of which was when a husband did not feel respected in the household—that is, respected above what a woman should receive. In following passage, a married man presented an example of a farmer who was married to a wife with an upper class job. While such dramatic class differences within a married couple are probably highly unusual in this population, his account nevertheless painted the scenario of a situation where a husband felt dishonored and less important by his wife’s social status. This man believed that the husband would leave the marriage because his wife had a better job and he would not feel respected as the main family provider. He said,

> Maybe the job of the woman is of higher class, but the man’s is the same on of farming. It is usually that the man leaves the marriage because his wife has a better job. He says he is not respected. (FGD #6, married men)

As previously mentioned, respondents believed that a woman could become “rude” towards her husband when she had too much power and her husband might leave her for her disrespectful attitudes. According to this man, it was not the division of labor and women’s employment that caused a man to lose his power but rather her misuse of this power and how it violated social norms around *tradition.*
Respondents also believed that marriages dissolved when external gender equality messages—that attempted to change social norms—became a source of dispute between spouses. Overall, respondents believed that it was very difficult for a man to do the job of a woman and if she tried to persuade him to adhere to new ideals on gender, this could cause conflict in the marriage. In the following powerful quote using a *tradition* narrative, a married man believed that western ideals about gender shouldn’t come to the rural villages because it created problems.

It is becoming very difficult for the man to accept that the job of a woman can be done by a man. For example, even washing, even cooking *nima* [the staple food of Malawi], all that a woman does, it is difficult for many men here to follow considering that they take old cultures. There are many questions about why, up until now, these customs were not around. Town life should not come to the villages. These are villages, those things are done in town. So in the villages, women do their chores even if they are sick. A woman is sick but she drags herself, saying “I should cook for my husband.” It’s only a few men who are able to get water and heat it, maybe even heating it for your wife to bathe. So in the villages, it is very few who are following gender [gender equality ideals] and the man doesn’t want to hear a woman saying the word gender. For example, saying “I thought there is gender, prepare relish.” This is a problem for that marriage. It will be difficult to stay together, maybe the matter will even go to the counselors [marriage advisors]. The counselors are the ones who start to talk about things like this and that, and gender. When you follow gender, you will dissolve your marriage. To satisfy a man, satisfy the stomach. But also you should take care of him. You should do everything even if you are sick. Even our parents encourage us that a man should not do a woman’s job. This is for white people. We should leave these to white people. They will mislead us. That’s how it is in the villages. (FGD #6, married men)

While this quote was not inclusive of everyone’s opinion, it suggested the presence of conspiracy beliefs around how “white people” might intentionally destroy families and relationships by promoting western ideas that did not fit with traditional village life. And he may be right. To conclude, rural Malawians emphasized more of the negative consequences of rights-based gender policies than the perceived benefits. They struggled with how make sense of how *rights*-based gender policies fit with notions of *tradition* and *unity* in their everyday lives. Gender policies that center on individual human rights and freedoms socially
celebrated in the West may conflict with local values that many people desire in their relationships—perhaps causing more harm than good.

**Discussion**

**Theoretical Significance**

What can be learned about gender and power from the narratives of rural Malawians? A vast body of literature has almost exclusively centered on what I call *tradition*—patriarchal gender norms and roles that favor men—and has shaped much of what is known about the gender and power. While beliefs about *tradition* still played a role in the way gender and power were conceptualized and understood, rural Malawians invoked two additional discourses that have received significantly less attention in the literature, namely, *unity* and *rights*. At times there was contention between the three narratives of *tradition*, *unity*, and *rights*. In other instances, respondents used multiple discourses simultaneously to express their views on gender—indicating that there are points of overlap and congruency between the narratives. Overall, respondents expressed difficulties defining gender roles and coming to a consensus on the ideal balance of power between husbands and wives. There were signs of resistance to the predominant gender hierarchy as rural Malawians actively challenged the *tradition* paradigm with alternative *unity* and *rights* perspectives. This suggests that gender constructions may be more elusive than well-defined and likely undergoing serious change in Malawi as people interact with larger social structures—that tend to promote a western ideology centered on human rights and equality—and with each other as they try to make sense of gender and redefine gender relations for themselves.
I am drawn to believe that rights narratives may be rooted in western-backed structural changes and foreign influences during the AIDS epidemic in Malawi. The concept of individual rights and freedoms is an inherently western perspective, one that has been widely and deeply diffused throughout global AIDS interventions and policies—notably crafted in Western corridors of power and often with little engagement of local communities. Unity narratives, on the other hand, may arise more organically through the difficult times that Malawians live in and their need for collectivism that ensures family functioning and survival. By using “the past” as a reference point, male respondents saw tremendous value in their wives’ contribution to the household and believed that their opinions on family matters could ultimately improve the family’s circumstances. At the same time, men expressed fears about the legal consequences of rights violations and the failure of men to include their partners in important family dilemmas. There were also concerns among both men and women that western ideals that seek to elevate women’s power at men’s expense may ultimately backfire and destroy Malawian relationships. Perhaps unity ideals and practices may be best understood as a by-product of both structural changes that emphasize respect and rights for women and “bottom-up” adaptations to everyday experiences with poverty and AIDS. During this time of gender evolution, unity may provide a sort of “win-win” or more balanced solution for everyone—it promotes male respect but also facilitates women’s increased say in their relationships.

How do these findings fit with the TGP? In support for the TGP, the data illustrate the interconnectedness of the three social structures of labor, power, and social norms. This
framework accurately captures the complexity of gender relations and reaffirms the idea that one social structure cannot exist independent of the others. However, the TGP is historically rooted in a tradition orientation and this narrow focus misses the wider range and complexity of gender relations. For example, important aspects of unity such as love, communication, reciprocity, and respect are not accounted for in the current TGP. Likewise, the TGP does not consider rights-based approaches that strive to increase women’s participation in the labor force and generate new social norms related to women’s freedoms and choices.

Factors related to unity and rights have been largely ignored despite their relevance and importance in the Malawi context. I argue that the TGP should be extended to include additional aspects of unity and rights within the three social structures of labor, power, and cathexis.

But beyond this recommendation, I would also like to point out a few areas of mismatch between the current TGP and rural Malawians’ accounts. Through the sexual division of labor, the family member with the greatest command of resources to meet the other’s needs and goals has the greater power (Blood and Wolfe 1960). Rural Malawians indicated that most men are indeed the head of the household and carry the main responsibility for economic provisions. According to the TGP, this would imply that the distribution of resources favors men and therefore places women in a disadvantaged state. But to the contrary, the focus group data suggested that the receipt of more economic support from a partner may mean the very opposite—that women who receive support actually have more power in their relationships through their use love to command economic support. For
women, materiality symbolized that a male partner listened to her requests. Here, women may indirectly influence financial decisions (i.e., how their partners spent money) if their partners loved them, and, by default, showered them with signs of affection such as money, food, and gifts. These findings suggest that innovative measures are needed to take into consideration both women’s economic dependence on men and economic transfers that result from love and therefore signify a woman’s power—not disadvantage.

Other nuances of the sexual division of labor are noteworthy. Even though men generally have more access to wealth than women in rural Malawi, male focus group respondents point out that unemployed men or those who cannot live up to the provider role risk losing their wives who may desert them in search of better opportunities. In Malawi, men are placed under tremendous pressure to provide for the family and know very well what the consequences of failing to do so might be. Family power structures (meaning men have more power and women have less) may fall apart if women find support from other sexual partners when their husbands fail to meet their needs. As such, the stories in this chapter illustrate that both couple members are mutually dependent upon each other and affected by resource exchange—just in different ways depending on whether they are on the giving or receiving side of the transaction.

In addition, a discussion is warranted around the social structure of cathexis. Legitimate power, also referred to as “authority”, is based on an individual’s legitimate, normally prescribed right to change another person’s behavior (Cromwell and Olson 1975). Though not always, focus group respondents used tradition narratives to justify the husband’s title as
the head of the household regardless of any special circumstances, i.e., the wife may be the sole provider. They admittedly blamed cultural norms for allocating more power to men. Similarly, the quantitative TLT data reflect that most individuals (both men and women) considered men to be overall in charge—which is notably, also the most socially desirable response. However, as the narratives in this chapter unfolded, the social norm of legitimacy did not always determine the balance of power; women were often consulted for their options on family decisions and some men even reported that they could not even sell a bicycle without their wife’s approval. Therefore, while men were reported to possess more power than women, detailed examples suggest that power may actually be more balanced and democratic—at least for some couples. Cromwell and Olson (1975) also point out the difference between “potential power” (or perceived power) and “actual power” (the ability to change the behavior of others). Norms around male authority may serve as potential sources of power but whether or not this power is exerted over a partner is another question.

Rural Malawians expressed deep worries about how an imported division of power from the West—one that privileges women—could destroy their own relationships, i.e., “the women become rude and disrespectful towards their husbands.” Men, in particular, worried about their loss of authority and respect in the household for “doing ladies’ jobs” and appearing weak in the eyes of their partner or others in the community. Women also pointed out that resisting male dominance may bring larger troubles to the relationship, particularly divorce—a risk that many did not appear to be willing to take. In studies on power, there
appears to be an underlying, western-oriented assumption that disadvantaged women desire more power in the first place—but they are unable to rise to the occasion due to structural limitations around gender. The narratives in this chapter suggest that this underlying premise may not hold true.

Gwendolyn Mikell (1997) in her book on African feminism states that western feminist debates about essentialism, the female body, and radical feminism are not characteristic of African feminism. Rather, emerging African feminism is “distinctly heterosexual, pro-natal, and concerned with many bread, butter, culture, and power issues” (Mikell 1997). According to Mikell, African women view their responsibilities as dual: the bearing of children is a primary responsibility and their status as women depends on this, but their responsibility for maintaining the family, village, and community is also critical. No self-respecting African woman fails to bear children or to be an autonomous economic contributor as compared to their western counterpart who actively chooses these circumstances for herself. Thus, women’s choice to ostensibly maintain the “status quo” may be mistaken for female submissiveness or economic dependence when it is really a sign of agency—a deliberate act rather than the inability to act. Important aspirations around marriage and childbearing may trump the desire to resist male authority. In this respect, women act strategically in order to maintain the very thing that is so important to their livelihoods. The TGP’s emphasis on women’s economic dependence on men fails to consider how social benefits and status associated with marriage and childbearing may reinforce seemingly traditional power dynamics.
Implications for Power Measures

The complexity in which rural Malawians conceptualized gender and power relations suggests that quantitative measures may oversimplify the meaning of power and its relevance to the AIDS epidemic in Africa. Limitations aside, I address the extent to which the power measures are reflected in the focus group data. To briefly recap on the power subscales, three items loaded on a first factor and 4 items loaded on a second factor, which were named unity (“My partner shows they care about me”; “When I need my partner’s assistance, he/she is there to help me”; and “My partner and I discuss important matters together”) and discordance (“If my partner was really angry with me, he/she might beat me”; “My partner punishes me when he/she is angry with me”; “When I disagree with my partner’s relatives, my partner chooses their side over mine”; “My partner is probably having sex with someone else”). The construct of discordance was later deconstructed into three single-item measures of physical violence, sexual violence, and mistrust.

Given the above discussion, I conclude that the two dimensions of power captured in the scale—named unity and discordance—do reflect what Malawians say power means to them in their relationships. The unity subscale specifically captures some—but not all—aspects of unity under the social structure of cathexis (as shown in Figure 4.1). For instance, respondents felt powerful when their partners were understanding, listened to them, and took their opinions into account. The measure of unity went beyond couple communication and included aspects of love and care giving that respondents believed were so important to their relationships. Feeling loved by a partner was thought to be a source of power. Even
though social norms around unity were also noted by men as sources of power, masculine
gender roles rooted in tradition were not included in the power measure developed in Chapter 3. For men, attachment to traditional gender roles such as providing for the family was also closely tied to feelings of power in their relationships. This could be an important missing dimension of male power.

The discordance subscale closely maps to aspects of tradition and appears to center on factors at the TGP’s the sexual division of power. Wingood and DiClemente (2002) point out that the sexual division of power is maintained by social mechanisms such as the abuse of authority and control in relationships. They argue that physical violence, sexual violence, and having a unfaithful sexual partner are manifestations of this power imbalance. One particular scale item that emerged in the discordance subscale was the belief that one’s partner was having an affair. As the TGP argues, women who have a cheating husband may have less power in the relationship. For men, an unfaithful wife may also reflect lower power. Although women engage in transactional sex with men for reasons unrelated to economic necessity, the men in this study were very concerned that their wives might cheat on them if they failed to provide for the family. For the theoretical justifications provided earlier, having a wife who is perceived to be cheating shows that husbands may have less power in the relationship—especially if the infidelity is a result of their failure to provide.

Two other items of the discordance subscale get at punitive aspects of power, particularly, physical violence and punishment. In the focus group data, women and men reported that wife beating occurs when a man had too much power and abused his wife for opposing his
views. Some respondents from the 2009 semi-structured couple interviews discussed how their partners had beaten them in the past for transgressing from traditional gender roles—i.e., acting “rude” and “disrespectful” towards a husband or for coming home late. In these examples, the act of physical violence against women may be related to women challenging male authority or transgressing from ideals around female submissiveness. Certainly, physical violence against women may be less related to gender transgressions and more to adherence to patriarchal gender roles that celebrate male dominance and female submissiveness. Given these scenarios, it is difficult to ascertain using a single item measure whether the experience of violence is a sign of intolerance and power, or lack thereof.

Focus group respondents provided very few cases of women who abused men (when male IPV victimization was discussed, it was usually as mutual violence—i.e., “they beat each other up”). The TLT data reflects this as well. TLT respondents were asked a separate question on their experiences of physical abuse and approximately 2% of men reported that their female partners had beaten them, indicating it could be a relatively rare occurrence among men. Yet interestingly, these two discordance items loaded more strongly for men than for women. More investigation is needed to explain how violence and punishment—against men—may be linked to power in this population of rural Malawians. One possibility is that women punish men in non-physical ways, such as by withholding sex or refusing to cook food for them. Focus group participants attributed this to women having more power than their husbands to the point where they become disrespectful towards them. Future research
should seek to uncover if and how women discipline husbands whom they perceive to
demonstrate unacceptable behavior.
CHAPTER V
THE ASSOCIATION BETWEEN RELATIONSHIP POWER AND HIV TESTING BEHAVIOR

Chapters one, two, and three provided the rationale for why and how the relationship context—specifically power—shapes HIV testing behavior. Chapter 4 examined how rural Malawians themselves conceptualized gender and power relations and whether the measure of power developed in Chapter 3 is justified—which I believe it is. This process also produced a modified conceptual framework for relationship power. In this chapter, I present the results of the specific aim 2: to test whether relationship power influences two types of HIV testing behavior: uptake of HIV testing services (a) and disclosure of test results to primary partners (b). Specifically, I utilized variables related to power in Chapter 3 and the revised conceptual model on relationship power from Chapter 4 to test hypotheses related to HIV testing uptake and disclosure.

Conceptual Framework and Hypotheses

I begin with the modified version of the TGP from Chapter 4 to hypothesize that an association will exist between relationship power and two forms of HIV testing behavior: uptake and disclosure. Under each construct in Figure 5.1, I list the variables used to operationalize the TGP constructs related to the sexual division of labor, sexual division of power, and cathexis. The red boxes refer to constructs that I will test to determine if associations exist with HIV testing behavior. Many of these variables are categorical, allowing me to simultaneously test the constructs of tradition and unity using a single variable.
For example, the relationship dominance variable under the division of power has a category for a male-dominated relationship (tradition) and an egalitarian relationship (unity). In Figure 5.2, I show a condensed version of Figure 5.1—showing only the main predictor variables and their associations with HIV testing uptake and disclosure. My revised hypotheses from Chapter 3 relating each variable to the two testing behaviors are as follows.

**Hypothesis #1**

I hypothesize that each power variable will be associated with uptake of future HIV testing over a 16-month period. In addition, I hypothesize that the perceived risk construct from the HBM will be associated with HIV testing uptake.

A. *Socio-economic inequalities (division of labor):* Individuals in a lower socio-economic position relative to their partners will be less likely to get tested since they will have stronger fears around divorce or abandonment—and loss of financial support—that may come with HIV testing. With less economic power, these individuals may also be in a disadvantaged position to negotiate testing with their partners. Conversely, individuals were greater socio-economic power relative to their partners will be more likely to test for HIV.

B. *Relationship dominance (division of power):* Being in a male-dominated relationship as compared to an egalitarian relationship will be negatively associated with HIV testing among men due to male control over testing decision-making. For men, male-dominance will also be negatively associated with testing since these men may be more likely to adhere to traditional beliefs about masculinity and therefore be disinclined to test.
Figure 5.1: Conceptual Model of Relationship Power based on the Modified TGP
Figure 5.2: Conceptual Framework for Main Predictor Variables and HIV Testing Behavior
C. **Relationship violence (division of power):** Having a history of relationship violence (physical and sexual) is a proxy for fear of abuse, which has been shown to be a barrier to testing. Individuals in violent relationships will therefore be less likely to test for HIV. Having a history of violence (sexual or physical) could also operate through the pathway of risk, thereby decreasing the likelihood of testing (assuming people are higher risk are less likely to test).

D. **Unity (cathexis/social norms).** Unity will be positively associated with HIV testing uptake among men and women. Aspects of unity such as communication, reciprocity, and love will foster a more supportive environment for couples to discuss testing and get tested. Therefore, individuals in relationships with higher levels of unity will be more likely to test for HIV.

E. **Mistrust/partner infidelity.** This variable emerged as an underlying construct of the discordance subscale. In Chapter 4, trust was perceived as an important social norm related to unity (cathexis); thus more trust, higher power. As such, mistrust (lack of trust) will be negatively associated with the act of testing.

F. **Perceived risk:** Perceived risk of self and partner will be negatively associated with getting tested for HIV. For both men and women, those who believe they are at higher risk for HIV will fear being blamed for infidelity and therefore less likely to test.
Hypothesis #2

I hypothesize that each power variable will also be associated with HIV testing disclosure to a primary sexual partner. In addition, I hypothesize that perceived HIV status concordance will be associated with HIV testing disclosure.

A. *Socio-economic inequalities (division of labor):* Individuals in a lower socio-economic position relative to their partners will be less likely to disclose their test results since they will more likely to fear divorce or abandonment—and loss of financial support—as a consequence of disclosure. Conversely, individuals in a higher socio-economic position relative to their partner will be more likely to disclose their test results.

B. *Relationship dominance (division of power):* Being in a male-dominated relationship as compared to an egalitarian relationship will make women less likely to disclose their test results out of fear of the violence that is associated with dominance. I also hypothesize that men in male-dominated relationships as compared to egalitarian relationships will be less likely to disclose their test results.

C. *Relationship violence (division of power):* Having a history of relationship (physical and sexual) violence will reinforce fears of abuse, thereby decreasing the likelihood of disclosing HIV test results. Even if they tested negative, individuals in violent relationships may still avoid disclosure if they did not inform their partners of their plans to test.

D. *Unity (cathecsis).* Unity will be positively associated with disclosure of HIV status to a sexual partner, that is, couples with more unity will be more likely to disclose.
E. *Perceived HIV status concordance:* The decision to disclose one’s HIV status depends upon the test result (positive or negative) and whether or not the result is perceived to be similar or different to a partner’s HIV status. Individuals who test positive but perceive their partners to be negative will be less likely to disclose than those who test negative and also perceive their partners to be negative.

**Summary of Analysis Approach**

For the HIV testing uptake hypotheses, I used self-reported HIV testing histories collected over a 16-month period to test whether relationship power was associated with future uptake of HIV testing. Decisions to test for HIV do not necessarily occur immediately in response to certain social stimuli and thus I wanted to track people over time to give these relationship characteristics a chance to play out in everyday life and affect HIV testing behavior. Random effects models were used to estimate predictors (i.e., socio-economic inequality between partners, male dominance, relationship violence, unity, perceived risk, and perceived infidelity) of having a new HIV test over this period. For the disclosure hypotheses, I took advantage of the fact that a group of TLT respondents were randomized to receive testing as part of the TLT study. I investigated whether relationship power measured *before* testing influences whether respondents disclosed their test results to their main sexual partner. In my analysis, I used multivariate logistic regression to model predictors of disclosure (i.e., socio-economic inequality, male dominance, relationship violence, unity, and perceived partner HIV concordance).
Before proceeding with the results, I would like to reintroduce the table from Chapter 3 containing the variables used in both the HIV testing uptake and disclosure models (duplicated as Table 5.1).
Table 5.1: Independent and dependent variables for the two statistical models of uptake and disclosure

<table>
<thead>
<tr>
<th>Variable</th>
<th>HIV testing uptake models</th>
<th>HIV test disclosure models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Included in model?</td>
<td>Type</td>
</tr>
<tr>
<td>Independent variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Years of education</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Household goods</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Age inequality</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Education inequality</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Income inequality</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Unity</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Relationship dominance</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Physical violence</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Perceived risk (self)</td>
<td>X</td>
<td>Categorical</td>
</tr>
<tr>
<td>Perceived risk (partner)</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>HIV status concordance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived partner infidelity</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>New antenatal care HIV test</td>
<td>X</td>
<td>Binary</td>
</tr>
</tbody>
</table>
Table 5.1, continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>HIV testing uptake models</th>
<th>HIV testing disclosure models</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Included in models?</td>
<td>Type</td>
</tr>
<tr>
<td>Independent variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous number of TLT tests</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Previous number of external tests</td>
<td>X</td>
<td>Continuous</td>
</tr>
<tr>
<td>Tested at TLT’s wave 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New HIV test (since previous wave)</td>
<td>X</td>
<td>Binary</td>
</tr>
<tr>
<td>Disclosure to sexual partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Characteristics of the Couple Sample

A total of 932 men and women (466 couples) were asked the relationship power questions at TLT’s wave 3. Table 5.2 presents the descriptive statistics for the analytic sample. ANOVA was used to test for gender differences in continuous variables including age, years of education, and household wealth. The majority of the sample reported being married (91.4%). Close to three quarters (73.5%) of all couples reported having at least one child together (the mean number of shared children was 1.2). On average, couples had been together for 5.2 years.

The mean age for the study population was 24.8 years. Men were on average 5.5 years older than women and differences by gender were significant ($p=0.000$). In 41.4% of couples, the man was over 5 years older than his female partner. Note that 1.8% of women were older than their male partners, but the age difference was never greater than 2 years (results not shown). The mean years of education was 7.3 years, reflecting a primary school education. Men had approximately 1.3 more years of education than women and differences by gender were significant ($p=0.000$). In approximately 14.0% of couples, both members had the same level of education, in 62.2% of couples the man had more education, and in 23.8% of couples the woman had more education. The mean number of owned household items, a measure of household wealth ranging from 0 to 9, for the total sample was 3.0. Men also reported slightly higher household goods (3.1) as compared to women (2.8) and the difference by gender was significant ($p=0.000$). In 8.4% of couples, both members were unemployed. In 2.4% of couples, the wife worked but the husband did not. In 54.7% of
couples, the husband worked but the wife did not. Finally, in 34.6% of couples, both couple members were employed.

The cross-sectional TLT wave 3 sample would have allowed me to make stronger conclusions about the larger population of rural Malawians—at least for the women, who were randomly selected from a household listing. The couple sample is inherently different from the cross-sectional wave 3 sample because of self-selection—but to what extent? To determine this, I compared the wave 3 couple sample (466 women) to the wave 3 individual-level sample (1,371 women) using an ANOVA on key demographic variables: age, marital status, and household economic status (results not shown). Significant differences were noted on marital status ($p=0.000$). The individual-level sample was significantly less likely to be married (46.3%) as compared to the couple sample (90.8%). In order to be considered part of the couple sample, both partners were required to answer the power questions and thus the sample was biased towards more serious partnerships (i.e., with serious male partners more likely to participate than causal partners). The individual-level sample of women was slightly younger with a mean age of 20.6 years as compared to 22.1 for the couple sample. They were also slightly wealthier with a mean number of household goods of 3.2 as compared to 2.8 for the couple sample. Differences in age ($p=0.000$) and household economic status ($p=0.000$) were statistically significant.
Table 5.2: Selected characteristics of the baseline sample of couples, TLT wave 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (N=932)</th>
<th>Women (N=466)</th>
<th>Men (N=466)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Mean (SD)</td>
<td>%</td>
</tr>
<tr>
<td>Individual characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (16-57)</td>
<td>24.8 (4.8)*</td>
<td>22.1 (2.7)</td>
<td>27.6 (4.9)</td>
</tr>
<tr>
<td>Years of education (0-13)</td>
<td>7.3 (3.0)*</td>
<td>6.6 (2.6)</td>
<td>7.9 (3.1)</td>
</tr>
<tr>
<td>Household goods (0-7)</td>
<td>3.0 (1.5)*</td>
<td>2.8 (1.5)</td>
<td>3.1 (1.5)</td>
</tr>
<tr>
<td>Couple characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>91.4</td>
<td>90.8</td>
<td>92.1</td>
</tr>
<tr>
<td>Relationship duration (1-14)</td>
<td>5.2 (2.9)</td>
<td>5.2 (2.9)</td>
<td>5.2 (3.0)</td>
</tr>
<tr>
<td>At least one living child with partner</td>
<td>73.5</td>
<td>72.3</td>
<td>74.7</td>
</tr>
<tr>
<td>Age difference (age inequality)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>58.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6+ years</td>
<td>41.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education inequality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same education</td>
<td>14.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male higher education</td>
<td>62.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female higher education</td>
<td>23.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment inequality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both unemployed</td>
<td>8.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female employed, male unemployed</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male employed, female unemployed</td>
<td>54.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both employed</td>
<td>34.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unity (total score)</td>
<td>3.77 (0.41)</td>
<td>3.77 (0.45)</td>
<td>3.77 (0.37)</td>
</tr>
<tr>
<td>My partner shows that they care about me</td>
<td>3.87 (0.40)</td>
<td>3.86 (0.44)</td>
<td>3.88 (0.35)</td>
</tr>
<tr>
<td>When I need my partner's assistance, he/she is there to help me</td>
<td>3.63 (0.69)</td>
<td>3.65 (0.67)</td>
<td>3.60 (0.70)</td>
</tr>
<tr>
<td>My partner and I discuss important matters together</td>
<td>3.80 (0.47)</td>
<td>3.78 (0.51)</td>
<td>3.82 (0.43)</td>
</tr>
<tr>
<td>Variable</td>
<td>Total (N=932)</td>
<td>Women (N=466)</td>
<td>Men (N=466)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>Mean (SD)</td>
<td>%</td>
</tr>
<tr>
<td>Relationship dominance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male-dominated</td>
<td>85.0*</td>
<td>81.5</td>
<td>88.4</td>
</tr>
<tr>
<td>Female-dominated/egalitarian</td>
<td>15.0</td>
<td>18.5</td>
<td>11.6</td>
</tr>
<tr>
<td>Relationship violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever experienced forced sex by partner</td>
<td>16.5*</td>
<td>21.5</td>
<td>11.6</td>
</tr>
<tr>
<td>Ever been physically abused by partner</td>
<td>4.0*</td>
<td>6.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Perceived risk of self for HIV (1-10)</td>
<td>1.73 (2.43)</td>
<td>1.63 (2.48)</td>
<td>1.82 (2.39)</td>
</tr>
<tr>
<td>Perceived risk of partner for HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No or low likelihood of infection</td>
<td>93.9*</td>
<td>91.3</td>
<td>96.4</td>
</tr>
<tr>
<td>Medium likelihood of infection</td>
<td>2.5</td>
<td>3.8</td>
<td>1.4</td>
</tr>
<tr>
<td>High or certain likelihood of infection</td>
<td>3.6</td>
<td>4.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Perceptions that partner is having affair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree/disagree</td>
<td>85.7*</td>
<td>81.8</td>
<td>89.7</td>
</tr>
<tr>
<td>Strongly agree/agree</td>
<td>14.3</td>
<td>18.2</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Unity: 1=Strongly Disagree; 2=Disagree; 3=Agree; 4=Strongly Agree. Higher scores indicate more unity. Unity scores were created by taking the mean across all three unity items. *Chi-square and ANOVA differences for gender were significant at $p<.05.$
Gender Differences in Relationship Factors

A multivariate MANOVA was used to test for gender differences in the unity variable using all three unity items as dependent variables. As illustrated in Table 5.2, the mean score for unity was almost exactly the same for men and women (3.77), indicating that most people either agreed or strongly agreed with the unity statements (range: 1-4). The results showed that men and women’s responses were not significantly different from each other ($p=0.137$).

Chi-square tests were used to test for gender differences in categorical variables including relationship dominance and the two IPV measures. ANOVA was used for continuous variables. The majority of respondents indicated that their relationships were male-dominated (85.0%). Men were more likely to state that their relationship was male-dominated (88.4%) as compared to women (81.5%) and the difference was significant ($p=0.003$). Approximately three-quarters (74.9%) of couples were concordant in their responses to the relationship dominance question, e.g., if a wife said that her partner was the dominant one then the husband said that he was the dominant one. Couple members never agreed that a wife was dominant.

Less than one-fifth (16.5%) of respondents reported a history of sexual IPV. Statistically significant gender differences ($p=0.000$) in sexual IPV were found with women indicating higher levels of sexual coercion (21.5%) than men (11.6%). It is noteworthy that almost 12% of men reported feeling pressured to have sex when they did not want to. Overall, 4.0% of respondents reported being physically abused by their partners. Statistically significant
gender differences were also found for physical IPV ($p=0.001$), with women reporting higher levels of abuse (6.0%) than men (1.9%). With regard to reciprocal violence, around 3.0% and 1.0% of couples reported that both couple members had experienced either sexual or physical IPV, respectively. Reciprocal violence was also calculated as a proportion of total violence (either sexual or physical IPV). In 18.2% of all sexually violent couples, both couple members reported sexual coercion. In 5.4% of all physically violent couples, both couple members reported physical abuse. Physical IPV only occurred within married couples.

Sexual and physical IPV were moderately correlated in the overall sample ($r=0.22$) indicating that for some couples, physical abuse and sexual abuse may occur simultaneously or in serial.

Overall, respondents reported a low likelihood of being infected with HIV, with a mean of 1.73 (range: 0-10). Women reported lower levels of perceived risk for HIV (mean=1.63) than men (mean=1.82) but the difference was non-significant ($p=0.211$). Among the total sample, 93.9% reported that their partner had no or low likelihood of HIV infection, 2.5% believed their partners had a medium likelihood of HIV infection, and 3.6% believed their partners had a high or certain likelihood of HIV infection. The distribution for women was slightly different than for men. The majority (91.3%) of women reported that their partners had no or low likelihood of HIV infection, 3.8% reported a medium likelihood, and 4.9% reported a high or certain likelihood of a partner’s HIV infection. The corresponding figures for men were 96.4%, 1.4%, and 2.3%, respectively. Gender differences in perceived risk of a partner were statistically significant when the variable was trichotomized as no risk/low risk, medium risk, and high/certain risk ($p=0.007$). When the perceived infidelity measure was
dichotomized as strongly agree/agree and strongly disagree/disagree, most respondents (85.7%) believed that their partners were faithful. Women were more likely to believe that their partner was having an affair than men (18.2% vs. 10.3%) and the gender difference was significant ($p=0.001$).

Table 5.3 shows couple HIV status for those tested as part of TLT at wave 4 (at the individual level). For 444 respondents (222 couples), HIV serostatus was on file for both partners. As shown in the first column of the table, 92.0% of couples were seroconcordant negative, meaning both couple members tested negative. Approximately 2% of couples were seroconcordant positive, meaning both couple members tested positive. In 2.5% of couples, the man was positive and the woman was negative. In the remaining 3.5% of couples, the man was negative and the woman was positive. For the entire sample, I used the combined measure of HIV status that included perception of HIV status for those not tested as part of TLT at wave 4. Therefore, respondents were considered to be HIV positive if they had tested positive via TLT at any point up to and including wave 4 or if they reported that they were 100% likely to have HIV at wave 5 (i.e., 10 beans on a scale of 0 to 10). The figures for estimated HIV status were very similar to those for actual serostatus.

**Table 5.3: Couple HIV status, TLT wave 4**

<table>
<thead>
<tr>
<th></th>
<th>Actual HIV serostatus data (%)</th>
<th>Estimated HIV serostatus data (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both are negative</td>
<td>92.0</td>
<td>91.4</td>
</tr>
<tr>
<td>Both are positive</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Man positive, woman negative</td>
<td>2.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Man negative, woman positive</td>
<td>3.5</td>
<td>3.9</td>
</tr>
<tr>
<td>N (individuals, not couples)</td>
<td>400</td>
<td>880</td>
</tr>
</tbody>
</table>
HIV Testing Histories

Figure 5.3 shows the baseline HIV testing history for all 932 respondents when they first enrolled in the TLT study. Respondents were asked the question, “I don’t want to know the results, but have you ever tested for HIV and received the results?” Almost three-quarters (71.6%) of the total sample had previously been tested for HIV. More men than women had previously tested for HIV (63.2% compared to 79.8%), which reflects national statistics from the Malawi Demographic Health Survey (MDHS, 2011).

![Figure 5.3: Percent of TLT Respondents Who Had Ever Tested for HIV at Baseline](image)

Figure 5.4 illustrates the percent of respondents who had a new HIV test (outside of the TLT study) since the previous wave. Since respondents were not asked to provide specific details on their last test, external testing could include voluntary counseling and testing.
(VCT), antenatal care testing, home-based testing, or other possible testing modalities. The sample size (N) listed under the wave number refers to the total number of respondents participating in that particular wave. At wave 4, approximately 24% (or 217 respondents) of the 902 respondents who participated at that wave had a new HIV test since wave 3. The percentage of participating respondents who received a new HIV test since the previous wave appeared to slightly increase from wave 5 to 7. Approximately 20% (or 175 respondents) had a new test during the period from wave 4 to 5. Approximately 22% (or 189 respondents) had a new test during the period from wave 5 to 6. Finally, approximately 25% (or 210 respondents) had a new test during the period from wave 6 to 7. Table 5.4 provides the breakdown by gender for the overall numbers presented in Figure 5.4. Higher rates of external testing among women across all four waves are attributed, in part, to antenatal care testing. Between waves 3 and 4, 30 pregnant women (13.8% of all who tested) had tested for HIV through antenatal care. Between waves 4 and 5, 33 pregnant women (18.9% of all who tested) had tested through antenatal care. Between waves 5 and 6, 25 pregnant women (13.2% of all who tested) had tested through antenatal care. Finally, between waves 6 and 7, 21 pregnant women (10.0% of all who tested) had tested through antenatal care.
Figure 5.4: TLT Respondents Who Had a New HIV Test Since the Previous Wave

Table 5.4: HIV testing history by gender, TLT waves 3-7

<table>
<thead>
<tr>
<th>Wave</th>
<th>Total Sample N</th>
<th>Total Sample New HIV test since previous wave N (%)</th>
<th>Women New HIV test since previous wave N (%)</th>
<th>Men New HIV test since previous wave N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>932</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>902</td>
<td>217 (24.1)</td>
<td>138 (30.1)</td>
<td>79 (17.8)</td>
</tr>
<tr>
<td>5</td>
<td>867</td>
<td>175 (20.2)</td>
<td>111 (24.9)</td>
<td>64 (15.2)</td>
</tr>
<tr>
<td>6</td>
<td>861</td>
<td>189 (22.0)</td>
<td>112 (25.3)</td>
<td>77 (18.4)</td>
</tr>
<tr>
<td>7</td>
<td>836</td>
<td>210 (25.1)</td>
<td>123 (28.5)</td>
<td>87 (21.5)</td>
</tr>
</tbody>
</table>

Figure 5.5 illustrates the distribution of cumulative new HIV tests (outside of the TLT study) recorded at wave 7 over the course of 16 months. Note that these data only include respondents who had complete data for all of the waves (N=799). The number of cumulative new HIV tests ranged from 0 (no new tests) to a maximum of 4. Over half
(52.7%) of participating respondents had no new tests over the 16-month period, 21.8% had 1 new test, 12.6% had 2 new tests, 8.1% had 3 new tests, and 4.8% had 4 new tests.

![Cumulative new HIV tests (%)](chart.png)

**Figure 5.5: Cumulative Number of New HIV Tests from Waves 4 to 7**

**Predictors of HIV Testing Uptake**

Table 5.5 presents the crude and adjusted odds ratios predicting a new HIV test from wave 4 to 7. The adjusted models included all predictor variables and statistical controls for marital status, age, years of education, the household goods index, previous number of TLT HIV tests, previous number of external HIV tests, and whether or not pregnant women tested for HIV through antenatal care at each wave. I present exact *p* values for associations that were approaching statistical significance (with a *p* less than 0.10).
Hypothesis 1A: Socio-Economic Power and Testing Uptake

I hypothesized that individuals in a lower SES position as compared to their partner would be less likely to test; similarly, those who were in a higher SES position as compared to their partners would be more likely to test. The results for women are discussed as follows. In the unadjusted models, women whose partners were at least 6 years older were 34% less likely to test than women paired with men of a similar age (the reference group). After controlling for covariates, the results showed that women with partners who were at least 6 years older were 30% less likely to test for HIV as compared to the reference group ($p=0.092$). Regarding education inequality, being in a more disadvantaged state as compared to a male partner did not appear to play a significant role in women’s uptake of testing; both the crude and adjusted odds ratios were non-significant. Nor did having more education than a partner influence women’s uptake of testing. Regarding employment inequality, women who were unemployed when their male partner was employed were 55% less likely to test than when both women and their partners were unemployed (reference group). This association, however, was attenuated and became non-significant when other variables were added to the model. Conversely, being employed when a partner was unemployed did not appear to give women the advantage to test. Finally, dual employment (both men and women were employed) did not significantly influence women’s uptake of HIV testing.

The results for men are as follows. In the bivariate models, men who were at least 6 years older than their partners were 50% less likely to test for HIV than men of a similar age as their partners (reference group). Yet this association was attenuated and became non-
significant after controlling for other covariates. In the multivariate models, men who had higher education levels than their female partners were 2.1 times more likely to test than men in couples with the same level of education ($p=0.059$). However, men who had lower education levels as compared to their partners were not less likely to test after controlling for the other covariates. Regarding employment inequalities, no significant associations were found in the bivariate or multivariate models for men. This means that, for men, being employed or unemployed as compared to one’s partner did not affect HIV testing uptake; similarly, dual employment did not play a significant role in men’s decisions to test.

Hypothesis 1B: Relationship Dominance and Testing Uptake

It was hypothesized that if the division of power was imbalanced such that men dominated the relationship, women would be less likely to get tested for HIV as compared to women in egalitarian relationships. To the contrary, the results for women show that being in a male-dominated relationship significantly increased the odds of testing by 70% as compared to women in egalitarian relationships. For men, it was hypothesized that male-dominance would be negatively associated with men’s uptake of testing since these men may be more likely to adhere to traditional beliefs about masculinity and therefore feel disinclined to test. However, being in a male-dominated relationship was not significantly associated with HIV testing uptake for men in the crude or adjusted models.

Hypothesis 1C: Violence and Testing Uptake

For women, the unadjusted results show a trend towards significance for the association between having a history of sexual coercion and receiving a new HIV test. Women who
reported being coerced into having sex when they did not want to had a 53% higher odds of getting tested for HIV than women who did not report a history of sexual violence. This result conflicts with the hypothesis that women in sexually violent relationships may be less likely to test out of fear of violence. It is possible that these women may be more likely to test due to heightened risk for HIV. In the multivariate models, this association was attenuated after controlling for perceived risk and was no longer statistically significant. In accordance with the hypothesis, women with a history of physical violence were less likely to test for HIV both in the bivariate and multivariate models. However, the associations failed to achieve statistical significance in both cases.

Interestingly, men who reported being pressured to have sex with their partners when they did not want to were 66% less likely to receive a new HIV test, net of perceived risk. The same association did not hold for physical abuse, which may be an artifact of low rates of physical abuse among men in the sample.

**Hypothesis 1D: Unity and Testing Uptake**

In contradiction with the hypothesis that individuals with higher levels of unity in their relationships would be more likely to test due to the supportive environment it promotes, the results demonstrated that unity was negatively associated with having a new HIV test in the multivariate models for women. For each one-unit increase in unity, the odds of having a new HIV test decreased by 41% after controlling for other factors. The same hypothesis was thought to apply to men. Yet similar to the women, each one-unit increase in unity decreased the odds of men’s testing by 47% after controlling for other factors ($p=0.092$).
Hypothesis 1E: Mistrust/Infidelity and Testing Uptake

In contradiction to the hypothesis that perceived partner infidelity was an indicator of lower power, and thus a reduced likelihood of testing, women were slightly more likely to test if they suspected that their partner could be cheating. However, this relationship was not significant in the bivariate or multivariate models. Similarly for men, mistrust was not significantly associated with testing uptake in either the bivariate or multivariate models.

Hypothesis 1F: Perceived Risk and Testing Uptake

I hypothesized that individuals who perceived themselves to be at a higher risk for HIV would be less likely to test for HIV. For women, the bivariate results for perceived risk of self were statistically significant and demonstrated that women who reported a low likelihood of HIV infection were 35% less likely to test than those who were sure they were HIV negative. Similarly, women who reported a medium likelihood of HIV infection were 50% less likely to test than women who were sure they were HIV negative ($p=0.069$). However, these associations failed to retain their statistical significance in the multivariate models. In addition, women who perceived that their partners were more likely to be HIV infected were 49% less likely to test for HIV as compared to women who perceived that their partners had no or low likelihood of HIV infection—net of perceived risk of self.

In the bivariate models, men who perceived themselves to be a medium risk for HIV were 47% less likely to test for HIV as compared to men who considered themselves at no risk for HIV. This relationship was attenuated and became non-significant in the multivariate
models. The bivariate and multivariate results also showed that there was no association between perceived risk of partner and uptake of HIV testing among men.
Table 5.5: Odds ratios predicting a new HIV test among women and men, TLT waves 4-7

<table>
<thead>
<tr>
<th>Variable</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socio-economic inequality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years difference</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>6+ years difference</td>
<td>0.66 (0.45, 0.96)*</td>
<td>0.50 (0.27, 0.91)*</td>
</tr>
<tr>
<td><strong>Education inequality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same education (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Male higher education</td>
<td>0.75 (0.44, 1.28)</td>
<td>1.71 (0.71, 4.13)</td>
</tr>
<tr>
<td>Female higher education</td>
<td>0.77 (0.42, 1.42)</td>
<td>0.82 (0.30, 2.28)</td>
</tr>
<tr>
<td><strong>Employment inequality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both members unemployed (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Male employed, female unemployed</td>
<td>0.45 (0.24, 0.87)*</td>
<td>0.46 (0.16, 1.28)</td>
</tr>
<tr>
<td>Both members employed</td>
<td>0.59 (0.30, 1.17)</td>
<td>0.46 (0.16, 1.33)</td>
</tr>
<tr>
<td><strong>Relationship unity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship dominance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female-dominated/egalitarian (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Male-dominated</td>
<td>1.36 (0.84, 2.21)</td>
<td>1.08 (0.44, 2.67)</td>
</tr>
<tr>
<td><strong>Relationship violence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever been sexually coerced by partner</td>
<td>1.53 (0.99, 2.38)†</td>
<td>0.33 (0.12, 0.89)*</td>
</tr>
<tr>
<td>Ever been physically abused by partner</td>
<td>0.85 (0.39, 1.86)</td>
<td>0.31 (0.02, 4.73)</td>
</tr>
<tr>
<td><strong>Perceived risk for HIV (self)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No likelihood (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Low likelihood</td>
<td>0.65 (0.45, 0.92)*</td>
<td>0.82 (0.51, 1.30)</td>
</tr>
<tr>
<td>Medium likelihood</td>
<td>0.50 (0.32, 0.78)**</td>
<td>0.53 (0.29, 0.98)*</td>
</tr>
<tr>
<td>High likelihood</td>
<td>0.65 (0.29, 1.47)</td>
<td>0.77 (0.26, 2.27)</td>
</tr>
<tr>
<td>Certain likelihood</td>
<td>0.87 (0.41, 1.87)</td>
<td>0.35 (0.09, 1.37)</td>
</tr>
<tr>
<td><strong>Perceived risk for HIV (partner)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No or low likelihood (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Medium, high, or certain likelihood</td>
<td>0.62 (0.30, 1.29)</td>
<td>0.31 (0.05, 1.90)</td>
</tr>
<tr>
<td>Perception that partner is having an affair</td>
<td>0.96 (0.59, 1.54)</td>
<td>1.00 (0.38, 2.60)</td>
</tr>
</tbody>
</table>

† trend towards significance (*p<0.10; **p<.05; ***p<.01; ****p<.001)

1 Adjusted models control for all other predictor variables and marital status, age, years of education, household goods index, previous testing through the TLT study, previous testing outside of the TLT study, and testing for HIV through antenatal care (women only). Time-varying predictors include perceived risk of self, marital status, and all three testing controls.

Unity scores ranged from 1 to 4, with higher values indicating more unity.

[^1]: Table 5.5: Odds ratios predicting a new HIV test among women and men, TLT waves 4-7

[^1]: Adjusted models control for all other predictor variables and marital status, age, years of education, household goods index, previous testing through the TLT study, previous testing outside of the TLT study, and testing for HIV through antenatal care (women only). Time-varying predictors include perceived risk of self, marital status, and all three testing controls.

[^1]: Unity scores ranged from 1 to 4, with higher values indicating more unity.

[^1]: † trend towards significance (*p<0.10; **p<.05; ***p<.01; ****p<.001)
Disclosure of HIV Test Results

Unlike a typical “repeated event” such as HIV testing, disclosure of test results is conceptually different and methodologically more complicated. For example, would only disclosure of a new HIV test result be considered an “event”? Or should every time a respondent states that they disclosed be considered a repeated event? Unlike common medical or social events studied by sociologists or epidemiologists, disclosure is different—the event is dependent upon whether a person decides to test and thus the number of people eligible at each wave depends upon who was tested. This would have implications for sample size, which is already limited to those who have previously been tested for HIV. Therefore, I chose to conduct a more straightforward analysis using a cross-sectional sample of respondents—starting with the baseline set of couples at wave 3—who had ever tested at any time prior to wave 5. This allowed me to make use of a larger sample size than would otherwise be possible if I limited the sample to only those who had a new HIV test at each wave. While I realize the inherent limitations of cross-sectional analyses such as when predictors are collected at the same time as outcome variables, I did take advantage of the fact that power and many of the relationship variables were collected prior to when disclosure occurred. This provides a stronger argument that relationship factors may influence decisions to disclose instead of the other way around—that the act of disclosure changes relationship dynamics. As such, I used relationship variables from wave 3 to predict disclosure as reported at wave 5.
Of the 799 respondents eligible for the disclosure analysis, 85.7% reported that they had told either their spouse or sexual partner the results of their last HIV test. Among women, 87.5% reported disclosing their test results. Men disclosed less often than women (83.7%), but gender differences were not significant ($p=0.121$). Table 5.6 shows rates of disclosure broken down by marital status, HIV status, and whether or not respondents had their last HIV test at TLT. Chi-square tests were used to test for differences in rates of disclosure by these three variables. For the total sample, married respondents were significantly more likely to disclose their HIV test results than unmarried respondents (87.1% vs. 59.0%; $p=0.000$). The same pattern of disclosure by marital status persisted for both women ($p=0.002$) and men ($p=0.000$).

**Table 5.6: Disclosure of last HIV test to main partner, TLT wave 5**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total Sample (N=799)</th>
<th>Women (N=432)</th>
<th>Men (N=367)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital status (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>87.1*</td>
<td>88.6*</td>
<td>85.3*</td>
</tr>
<tr>
<td>Unmarried</td>
<td>59.0</td>
<td>65.0</td>
<td>52.6</td>
</tr>
<tr>
<td>HIV status (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV positive</td>
<td>80.0</td>
<td>80.0</td>
<td>80.0</td>
</tr>
<tr>
<td>HIV negative</td>
<td>86.1</td>
<td>88.1</td>
<td>83.9</td>
</tr>
<tr>
<td>TLT test at wave 4 (%)</td>
<td>N=469</td>
<td>N=258</td>
<td>N=211</td>
</tr>
<tr>
<td>Yes</td>
<td>89.1*</td>
<td>87.6</td>
<td>91.0***</td>
</tr>
<tr>
<td>No</td>
<td>80.9</td>
<td>87.4</td>
<td>73.7</td>
</tr>
</tbody>
</table>

Chi-square differences were significant at *$p<.05$; **$p<.01$; ***$p<.001$

Differences in disclosures rates were also examined by HIV status. Of those with serostatus data (N=469), 6.2% were HIV positive. Of those who had never tested at TLT (N=330), 6.4% were estimated to be HIV positive. The combined measure of HIV status
showed that 6.3% of all respondents (N=799) were HIV positive. Rates of disclosure among HIV positive and negative individuals were surprisingly similar (refer to Table 5.6). Four-fifths (80%) of all respondents who were HIV positive reported disclosing to either their spouse or primary sexual partner. Rates of disclosure among HIV negative respondents were slightly higher, at 86.1%. Chi-square tests revealed that HIV status was not significantly associated with decisions to disclose ($p=0.231$).

For two-thirds of the wave 5 couple sample, their last HIV test was administered at TLT’s wave 4. When disclosure rates were stratified by whether or not respondents were tested via TLT at wave 4, the overall figures showed that TLT testers were slightly more likely to disclose to a sexual partner (refer to Table 5.6). At wave 4, 469 respondents had tested through TLT and approximately 89.1% reported that they disclosed their test results to their spouse or sexual partner. Of those not tested at TLT’s wave 4, approximately 80.9% reported that they had disclosed. For the overall sample, chi-square tests showed that rates of disclosure varied significantly by whether respondents had their last HIV test at TLT ($p=0.001$). Men who tested at TLT’s wave 4 were significantly more likely to disclose than men who tested elsewhere (91% compared to 73.7%) ($p=0.000$). However, there were no differences in rates of disclosure between women who tested at TLT’s wave 4 and women who tested outside the study ($p=0.941$).
Reliability of Disclosure Reports

The disclosure data were self-reported. Naturally, this prompts the questions, do respondents really disclose if they say they do and do their partners believe them? And do respondents tell their partners their actual HIV test result? Consider the example of an HIV positive man who reported that he told his wife his status. We can examine her perception of his status to see if what she thinks about his status matches his actual HIV serostatus. If she reports that she is unsure about whether he is positive or negative, this would indicate that he did not really disclose (or it could reflect that she doesn’t believe what he told her). If she believes that he is positive (and he is), then it is more likely that he told her the correct test result. Yet another explanation could explain these discrepancies, particularly with regard to gaps between the time of disclosure and the time perceptions of a partner’s risk were ascertained. For instance, if a woman told her partner that she tested negative for HIV in January and was shortly thereafter found to be cheating on her husband, his perception of her risk for HIV in April may no longer be “no likelihood” given that he knows she has put herself at risk for HIV through an extramarital affair.

In order to assess whether respondents really disclose and if their partners believe what they tell them, I examined disclosure of HIV test result at wave 5 (partner’s report) and perceived risk of partner at wave 5 (respondent’s report of their partner). Respondents from the disclosure dataset were included in the analysis if they had complete data for both measures (N=723). To briefly recap, perceived risk of a partner was captured with the statement: “What is the likelihood that your partner is currently infected with HIV?”
Response options included no likelihood, low, medium, high, and “I know she/he is” (infected with HIV). In theory, respondents who were truly informed of a partner’s negative or positive result would have either responded “no likelihood” (told negative result) or “I know he/she is” (told a positive result). From this measure, I first created a three level categorical variable, where 1=HIV negative (no likelihood), 2=HIV positive (“I know she/he is”), and 3=uncertainty of a partner’s status (low, medium, or high likelihood). I then checked whether uncertainty about a partner’s status was less common in the group of respondents whose partners reported that they disclosed by using chi-square tests (refer to Table 5.7). Note that for this test, I combined categories 0 and 1 to measure “certainty” (i.e., HIV positive or HIV negative) about a partner’s status (so that 0 equaled “certainty” and 1 equaled “uncertainty”). Overall, uncertainty about a partner’s status was higher among respondents whose partners did not disclose than among those whose partners did disclose (19.6% vs. 16.2%). For women, uncertainty about a partner’s status was more common among women whose partners did not disclose than among women whose partners did disclose (28.9% vs. 22.9%). However, chi-square tests demonstrated that the relationship was not significant ($p=0.359$). For men, uncertainty about a partner’s HIV status was more common among men whose partners had disclosed rather than not disclosed (10.9% vs. 7.5%). However, chi-square tests did not reveal a significant relationship ($p=0.512$).

Note that the level of certainty of a partner’s status may not be accurate if partners are reporting disclosure based on a non-recent HIV test. Therefore, I also ran the analysis for respondents whose partners had a recent external HIV test (wave 4 or 5) or a TLT test at wave 4. Similar results were found as compared to the numbers presented above.
Table 5.7: Do respondents really disclose and do their partners believe their reports?

<table>
<thead>
<tr>
<th>Perception of partner's HIV status (%)</th>
<th>Total Sample (N=723)</th>
<th>Women (N=331)</th>
<th>Men (N=390)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partner disclosed?</td>
<td>Partner disclosed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes (N=629)</td>
<td>Yes (N=279)</td>
<td>Yes (N=350)</td>
</tr>
<tr>
<td></td>
<td>No (N=92)</td>
<td>No (N=52)</td>
<td>No (N=40)</td>
</tr>
<tr>
<td>Sure of partner's HIV status</td>
<td>83.8</td>
<td>77.1</td>
<td>89.1</td>
</tr>
<tr>
<td></td>
<td>80.4</td>
<td>71.2</td>
<td>92.5</td>
</tr>
<tr>
<td>Unsure of partner's HIV status</td>
<td>16.2</td>
<td>22.9</td>
<td>10.9</td>
</tr>
<tr>
<td></td>
<td>19.6</td>
<td>28.9</td>
<td>7.5</td>
</tr>
</tbody>
</table>

For respondents whose partners reported disclosing their test results, I next checked the level of concordance between perceived risk of partner at wave 5 (respondent’s report of their partner) and actual HIV serostatus at wave 4 (partner’s data) (refer to Table 5.8). My tabulations for perceived risk of partner only included those who reported with certainty on their partner’s status (HIV positive or negative). Overall, for partners who tested negative, 99.3% of the respondents believed that their partners were indeed negative. For partners who tested positive, only 55.3% of respondents believed that they were indeed positive. Similar trends were found by gender. Almost all women (98.4%) whose partners tested negative believed that they were HIV negative; while only 50% of women whose partners tested positive believed them to be HIV positive. All men (100%) whose partners tested negative believed that they were indeed HIV negative. Only half (55.6%) of men whose partners tested positive believed that these women were HIV positive. All chi-square tests showed significant differences at $p=0.000$.

Uncertainty about a partner’s status was lower among those whose partners had not disclosed but the difference was non-significant.
Table 5.8: Are respondents told the correct test result by their partners?

<table>
<thead>
<tr>
<th>Perception of partner's HIV status (%)</th>
<th>Total Sample (N=325)</th>
<th>Women (N=133)</th>
<th>Men (N=192)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV positive</td>
<td>Partner serostatus</td>
<td>Partner serostatus</td>
<td>Partner serostatus</td>
</tr>
<tr>
<td>(N=15)</td>
<td>HIV positive (N=310)</td>
<td>HIV positive (N=6)</td>
<td>HIV positive (N=9)</td>
</tr>
<tr>
<td>HIV negative</td>
<td>HIV negative (N=127)</td>
<td>HIV negative (N=127)</td>
<td>HIV negative (N=183)</td>
</tr>
<tr>
<td>HIV positive</td>
<td>55.3</td>
<td>50.0</td>
<td>55.6</td>
</tr>
<tr>
<td>HIV negative</td>
<td>46.7</td>
<td>99.3</td>
<td>44.4</td>
</tr>
</tbody>
</table>

Predictors of HIV Status Disclosure

Table 5.9 presents the crude and adjusted odds ratios predicting disclosure at wave 5.

The adjusted models included all other predictor variables and statistical controls for marital status, age, years of education, the household goods index, and having a TLT test at wave 4. Exact \( p \)-values are presented for associations approaching statistical significance.

Hypothesis 2A: Socio-Economic Power and Disclosure

It was hypothesized that individuals in a lower socio-economic position relative to their partners would be less likely to disclose their test results since they would be more likely to fear divorce or abandonment—and loss of financial support—as a consequence of disclosing. Regarding age inequality, having a partner who was greater than 5 years older was not associated with disclosure for women in the multivariate models. Regarding education inequality, women who were less educated than their partners were not any more likely to disclose than women who had a similar education level as their partners. In the bivariate models, unemployed women paired with employed men were approximately 3.8 times more likely to disclose than the same women paired with unemployed men; however, this association was attenuated and became non-significant after adding other variables to the
model. Women who were a part of a dual income-earning couple were not any more likely to disclose than those in an unemployed couple.

The results for men are as follows. Men who were greater than 5 years older than their partners were not any more likely to disclose than men of a similar age as their partners. For education inequality, men who were more (or less) educated than their partners were not any more likely to disclose than men paired with women of equal education. Finally, regarding employment inequality, differences between partners were not significantly associated with disclosure—with one exception. Men in relationships where both couple members were employed were approximately 5.4 times more likely to disclose than men in relationships where both couple members were unemployed, after adjusting for other covariates.

**Hypothesis 2B: Relationship Dominance and Disclosure**

In the multivariate models, women in male-dominated relationships were not any less likely to disclose as compared to women in egalitarian or female-dominated relationships. This conflicts with the hypothesis that male-dominance deters women from telling their partners their HIV test results. In fact, the odds ratios were in the opposite direction of what was hypothesized. For men, the direction of the association was similar to that found for women such that being in a male-dominated relationship increased the odds of disclosure as compared to men in egalitarian or female-dominated relationships; however, like for women, it was also non-significant.
Hypothesis 2C: Violence and Disclosure

It was hypothesized that having a history of relationship violence (physical and sexual) would reinforce fears of abuse, thereby decreasing the likelihood of disclosing HIV test results. In support of this prediction, the results showed that women who had been physically abused by their partners were 68% less likely to disclose their test results than women who had never experienced physical violence—even after controlling for other covariates ($p=0.077$). Yet in contradiction to the violence hypothesis, women who had experienced sexual violence were 2.25 times more likely to disclose than women who had not ($p=0.097$).

Regarding physical abuse, men who had experienced physical abuse in their relationship were 93% less likely to disclose after controlling for other factors ($p=0.056$). I question the conclusiveness of the finding for physical abuse given the low occurrence of abuse reported by men in the sample (only 2%). For sexual violence, the bivariate models showed that men who had experienced sexual violence were 54% less likely to disclose than men who had not; however, this association was attenuated and became non-significant after controlling for other factors in the model.

Hypothesis 2D: Unity and Disclosure

It was hypothesized that unity would be positively associated with disclosure of HIV status to a sexual partner. As expected, the multivariate models demonstrated significant associations between unity and disclosure for women and men. The models for women showed that for each one-unit increase in unity, the odds of disclosure increased by 216%
after controlling for other covariates. For men, the odds of disclosure increased by 243% for each one unit increase in unity ($p=0.084$).

**Hypothesis 2E: Couple HIV Status and Disclosure**

I predicted that an individual's decision to disclose HIV status would depend upon the perception of his or her partner’s status. After controlling for other covariates, women who tested positive and perceived their partners to be positive were 80% less likely to disclose than women who were found HIV negative and perceived their partners to be negative (reference group). In addition, women who tested positive but perceived their partners to be HIV negative were 69% less likely to disclose than women in the reference group. HIV negative women were 22% less likely to disclose if they perceived their partners to be HIV positive; however, the association failed to reach statistical significance in the multivariate models. After controlling for other factors, men who tested positive and perceived that their partners were HIV negative were 84% less likely to disclose as compared to men who tested negative and perceived their partners to be HIV negative (reference group). Men paired with suspected HIV positive partners were not any more or less likely to disclose than the reference group.
### Table 5.9: Odds ratios from logistic regression models predicting disclosure among women and men, TLT wave 5

<table>
<thead>
<tr>
<th>Variable</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude OR (95% CI)</td>
<td>Adjusted OR (95% CI)</td>
</tr>
<tr>
<td>Economic inequality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>6+ years</td>
<td>1.07 (0.60, 1.91)</td>
<td>1.09 (0.54, 2.18)</td>
</tr>
<tr>
<td>Education difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same education (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Male higher education</td>
<td>1.12 (0.48, 2.54)</td>
<td>1.41 (0.49, 4.09)</td>
</tr>
<tr>
<td>Female higher education</td>
<td>0.97 (0.38, 2.47)</td>
<td>0.80 (0.26, 2.49)</td>
</tr>
<tr>
<td>Employment difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both members unemployed (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Female employed, male unemployed</td>
<td>note 1</td>
<td>note 1</td>
</tr>
<tr>
<td>Male employed, female unemployed</td>
<td>3.38 (1.35, 8.47)**</td>
<td>2.10 (0.65, 6.86)</td>
</tr>
<tr>
<td>Both members employed</td>
<td>1.36 (0.56, 3.32)</td>
<td>0.71 (0.22, 2.29)</td>
</tr>
<tr>
<td>Relationship unity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship dominance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female-dominated/egalitarian (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Male-dominated</td>
<td>1.56 (0.81, 3.04)</td>
<td>1.65 (0.74, 3.68)</td>
</tr>
<tr>
<td>Relationship violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever been sexually coerced by partner</td>
<td>1.10 (0.55, 2.23)</td>
<td>2.25 (0.86, 5.85)†</td>
</tr>
<tr>
<td>Ever been physically abused by partner</td>
<td>0.30 (0.10, 0.94)*</td>
<td>0.32 (0.09, 1.13)†</td>
</tr>
<tr>
<td>Perceived HIV status concordance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R is HIV negative, P is perceived HIV negative (ref)</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>R is HIV positive, P is perceived HIV positive</td>
<td>0.20 (0.07, 0.63)**</td>
<td>0.20 (0.05, 0.75)*</td>
</tr>
<tr>
<td>R is HIV positive, P is perceived HIV negative</td>
<td>0.34 (0.15, 0.78)**</td>
<td>0.31 (0.12, 0.78)*</td>
</tr>
<tr>
<td>R is HIV negative, P is perceived HIV positive</td>
<td>1.42 (0.18, 11.17)</td>
<td>0.78 (0.09, 6.52)</td>
</tr>
</tbody>
</table>

1 Adjusted models control for all predictor variables and marital status (married/unmarried), age, years of education, household goods index, and having a TLT test at wave 4.

Unity scores ranged from 1 to 4, with higher values indicating more unity.

R refers to respondent; P refers to their partner.

† trend towards significance; *p<.05; **p<.01; ***p<.001

note 1: omitted due to multicollinearity.
Discussion

HIV Testing Uptake

The hypothesis-testing phase of this dissertation focused on whether relationship power predicted HIV testing uptake and disclosure among young couples approaching peak ages of HIV infection in Malawi. The results suggest that people are indeed getting tested at relatively high rates, repeatedly, and not just during pregnancy. In stark contrast to a host of studies from sub-Saharan Africa that show low levels of lifetime testing among nationally representative samples (e.g., Sambisa, Curtis, and Mishra 2012; MacPhail et al. 2007; Peltzer et al. 2009), most respondents in this study had received at least one HIV test prior to enrolling in the TLT study. Rates of testing exceeded population-based estimates from the Malawi Demographic Health Survey, which found that 64% of women and 43% of men aged 15 to 24 had ever tested for HIV in 2010 (National Statistical Office & ORC Macro 2011). This suggests that young people in southern Malawi currently have good access to HIV testing and counseling services, which is likely to improve in upcoming years as testing becomes more integrated into routine health care.

The use of longitudinal, HIV testing history data as opposed to a one-time event of “ever tested” was a unique feature of this study that allowed for the investigation of predictors of HIV testing over a 16-month period. This is an important contribution to the literature, above and beyond the ability to circumvent methodological problems associated with temporality and cross-sectional data (Singleton & Straits, 2005). With the recent scale-up of ART and HIV testing services in sub-Saharan Africa, more people are returning to
health care centers for another HIV test (refer to Fiorillo et al. 2012 for an example in Tanzania) and thus it becomes critical to study how relationship factors influence repeated testing for HIV. Regular HIV testing and counseling is also important from an HIV prevention perspective; a single HIV test is not enough information to make safe sex decisions throughout the reproductive years. Repeated HIV testing and counseling is also crucial for “treatment as prevention” interventions that rely on high rates of regular HIV testing in order to identify new seroconversions (Isingo et al. 2012).

Still, few studies from sub-Saharan Africa have measured the number of times people have ever been tested for HIV at the population level—with a few exceptions. In South Africa, Kalichman and Simbayi (2003) reported that 29% of their cross-sectional sample of men and women had tested twice and 19% had tested three times for HIV. Venkatesh and colleagues (2011) reported that approximately 58% of their Tanzanian respondents who had ever tested for HIV received multiple HIV tests in the past. Another study from Uganda found that 39% of respondents who agreed to be tested as part of the study were repeat testers (Matovu et al. 2007). While the current study captured HIV testing histories in a relatively short time period (as compared to lifetime history of testing), high rates of repeat testing were reported: almost 13% had reported two new HIV tests and another 13% had tested more than twice. This indicates that lifetime history of repeat testing is likely to be high in this population.

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8 Note that while the sample in the current study is not a “true” population-based sample due to inherent biases present in a couple sample, it is likely to be more representative of the larger population than clinic patients or other convenience samples used in studies elsewhere.
Hypothesis 1A: Socio-Economic Power and Testing Uptake

Power and its effect on HIV testing was hypothesized to operate through the sexual division of labor, that is, socio-economic inequalities between partners could either enable or inhibit uptake of testing depending on a couple member’s relative position. There was some suggestion that women paired with significantly older partners were less likely to test for HIV. Similarly, older men were less likely to test for HIV than men closer in age to their partners. From the broader literature from Africa, we know that age confers social status and respect. Brown and Levinson (1987) argue that the social distance between two people influences an individual’s communication strategy with a conversation partner. In this case, women may elect not to discuss HIV testing with older partners in order to avoid offending or disrespecting their partner. Older men, on the other hand, may be less pressured or persuaded by their younger female partners to test for HIV.

Economic inequalities, on the other hand, can be more closely mapped to the TGP’s sexual division of labor. There was some evidence that being an unemployed women paired with an income-generating man creates a situation of economic dependence that could limit women’s use of HIV testing services. In Figure 5.1, this finding maps to a tradition orientation of labor. No support was found to indicate that equal economic power promotes HIV testing in the relationship (the unity orientation in Figure 5.1).
Hypothesis 1B: Relationship Dominance and Testing Uptake

Through the sexual division of power, being in a male dominated relationship (versus an egalitarian or female dominated relationship) was hypothesized to act as a barrier to testing through the mechanism laid out by Maman et al. (2001). In contradiction to this hypothesis, the results showed that being in a male-dominated relationship was associated with higher rates of HIV testing for both genders. Particularly, the results appear to be more conclusive for women. The association between male-dominance and higher testing conflicts with other research that suggests that male control over men’s use of HIV testing services prevents women from getting tested (Perez et al. 2006; Dahl et al. 2008; Kranzer et al. 2009; Baiden et al. 2005). These studies did not measure male dominance directly, but rather it is implied to be the underlying mechanism that affects women’s ability to say yes when offered an HIV test. It is possible that traditional marital power structures may facilitate testing, particularly, if men take ownership over their responsibility for the family’s health and well-being. Hence, men in relationships characterized as male dominant may be more likely to accompany their wives for testing and test with them.

Hypothesis 1C: Violence and Testing Uptake

Relationship violence is one of the most widely studied manifestations of the TGP’s division of power. Interestingly, for women, a history of physical abuse was not predictive of HIV testing. This differs from studies that cite fear of abuse as a possible reason for why women may refuse testing (Irungu et al. 2008; Maman, Hogan, and Kilonza 2001). However, others scholars point out that the perceived negative consequences of HIV testing and
disclosure of results are not always the negative consequences that occur in reality (King et al. 2008). In Malawi, the same relationship may be true; being in an abusive relationship does not necessarily prevent women from testing or conversely, motivate them to get tested because of heightened risk for HIV.

Interestingly, this study also found that men who had ever been pressured to have sex by their partners were significantly less likely to get tested—net of perceived risk. It is difficult to attempt to understand this finding without supporting data from other research. Men’s experiences of IPV are not well studied in Malawi or sub-Saharan Africa despite some accounts of men being coerced into sex by more powerful women (Simpson 2009; Dunkle et al. 2007; Sikweyiya and Jewkes 2009). There may be other unmeasured characteristics of men who are unable to refuse sex, making them less likely to get tested for HIV. Regardless, women’s power over men in the sexual realm appears to be harmful for men’s health when it comes to testing for HIV. Future studies should explore men’s experiences of sexual coercion in more depth and how this may relate to their use of HIV services.

Hypothesis 1D: Unity and Testing Uptake

Although unity could exist at each of the TGP’s three social structures, it was specifically examined at the structure of cathexis or social norms around gender and relationships. Unexpectedly, unity was associated with lower rates of HIV testing for both genders. It is possible that individuals who report more unity with their partners (i.e., caring for partner, working together, and good communication) find less reason to get tested for HIV in the first place because the act of testing violates the very thing their relationships are
built upon. Parallels can be drawn from the condom literature in Malawi. Chimbiri (2007) concludes that condoms are understood largely as “an intruder in the domestic sphere,” which may be attributed to public health advocacy for condom use in risky sexual partnerships—not within marriage. In another study using a set of qualitative, conversational journals from rural Malawi, condoms appeared to take on a symbolic meaning such that, “if a relationship is defined as love, the connection between condom use and trust is inverted, as condom use signifies the absence of love, trust, and intimacy” (Tavory and Swidler 2009).

Though we did not see a strong association between mistrust and testing uptake, the inverse relationship found between unity and testing reflects what has been discovered for condom use.

**Hypothesis 1E: Mistrust/Infidelity and Testing Uptake**

Women were slightly more likely to test if they suspected that their partner could be cheating, however, this relationship was also not significant. Showing a relationship between mistrust and testing is challenging because this variable is inextricably linked with perceived risk, which showed a negative relationship with HIV testing. Thus, the predictive ability of the “mistrust” component of the perceived infidelity measure may have been cancelled out by risk.

**Hypothesis 1F: Perceived Risk and Testing Uptake**

Overall, perceived risk of self and partner were negatively associated with HIV testing uptake among both genders, but failed to reach statistical significance in the multivariate models. The direction of this association for women and men is consistent with what others
have found elsewhere in Africa (MacPherson, Corbett et al. 2012; Pool, Nyanzi, and Whitworth 2001).

**HIV Testing Disclosure**

This study is one of a few to report on relationship factors that influence both women and men’s experiences of HIV status disclosure in sub-Saharan Africa. Overall, respondents were very forthcoming about their HIV test results with their sexual partners. Over 80% of women and men reported disclosing their test results to their partner. This is in contrast to a large body of research that suggests that rates of disclosure to sexual partners are generally low (Obermeyer and Osborn 2007). However, these results coincide with findings from another study in rural Malawi that found similarly high rates of disclosure among ever-married respondents. In this study, 85% of women and 92% of men reported that they had disclosed their HIV status to their spouse (Anglewicz and Chintsanya 2011).

It has been noted by others that self-reported disclosure data are sometimes unreliable (Anglewicz and Chintsanya 2011). The use of couples data in this study allowed me to assess the reliability of disclosure reports. Respondents were slightly more certain about a partner’s status when their partners reportedly disclosed, however, the rates were not substantially different from partners who did not disclose. Thus, I cannot draw strong conclusions about whether people really disclosed their test results when they said they do. The findings are, however, more consistent when it becomes a question of who is more likely to disclose. When respondents tested positive, half of the time they told their partners they were HIV positive; the other half of the time they told their partners they were HIV negative. But
respondents who tested negative almost always told their partners that they were HIV negative.

**Hypothesis 2A: Socio-Economic Power and Disclosure**

As with the HIV testing uptake results, socio-economic inequalities between partners appear to play a role in decisions to disclose for women. The fear of abandonment is widely cited in the literature as a barrier to women’s disclosure of HIV status. It is not unreasonable to assume that these fears are inextricably tied to one’s financial situation. I suspected that women who had more education or were the family breadwinners would be less concerned if their relationships dissolved after disclosing test results. The results did not support this hypothesis. However, one exception was found for men. Men in dual income-earner relationships were significantly more likely to disclose their HIV status. Recall that in Chapter 4 some of the male respondents reported that they were relieved when their wives could help contribute to the family income; it reduced the pressure upon them to be the sole breadwinner for the family. It is possible that men who have wives that help to support the household may have more time to take care of their own health, such as by testing for HIV. Other male respondents noted how when both spouses are working, it builds love and openness in the relationship and allows both spouses to contribute to family decision-making. When economic equality is present, it can help to build *unity* that fosters a more supportive environment for disclosure of HIV test results.
Hypothesis 2B: Relationship Dominance and Disclosure

Power imbalances that favor men were thought to create barriers for women to disclose their HIV status. However, no support was found for the idea that being in a male-dominated relationship compared to an egalitarian one would limit disclosure.

Hypothesis 2C: Violence and Disclosure

As hypothesized, women with a history of physical violence in their relationships tended to be less likely to disclose test results to their primary partners. The combined findings of this chapter suggest that relationship violence may not necessarily constrain women’s ability to test, but rather their decisions to disclose the test results. The negative association with disclosure is consistent with numerous studies from sub-Saharan Africa that cite fear of violence is a major barrier to disclosure among women (Nebie, Meda, and Leroy 2001; Maman et al. 2003; Kilewo et al. 2001; Farquhar et al. 2000). Men who had been victims of physical abuse were also less likely to disclose their test results, presumably for the same reasons. For women, the opposite relationship was found for sexual violence; women who reported sexual coercion in their relationship tended to be more likely to disclose their HIV test results. Clearly, sexual IPV appears to operate very differently from physical IPV with regard to its influence on disclosure.

Hypothesis 2D: Unity and Disclosure

The unity factor appears to play an important part in both women’s and men’s decisions to disclose to each other. While unity was found to be a barrier to uptake of testing, it served as an enabling factor for disclosure of HIV test results. Individuals in relationships with
higher levels of unity were more likely to discuss their HIV test results with their primary sexual partners. Aspects of unity may facilitate communication and provide the necessary social support needed for couple members to share their status with partners, particularly for HIV positive individuals who may be more susceptible to the negative consequences.

**Hypothesis 2E: Couple HIV Status and Disclosure**

HIV status did not play a significant role in decisions to disclose for men or women in bivariate analyses. The results for HIV status conflict with other studies that find HIV positive individuals are less likely to disclose than their HIV negative counterparts (Maman et al. 2003; Anglewicz and Chintsanya 2011). It is possible that some HIV positive respondents knew about their HIV infection for quite some time, such as those who might have tested positive at an earlier TLT wave or agreed to re-test via TLT when they already knew they were HIV positive. Thus, respondents may have been re-disclosing what their partners already knew.

Others have found that knowledge of a partner’s status plays a role in decision to disclose (King et al. 2008). In this study, the choice to disclose appears to depend on whether a respondent’s status is similar to or different from the perceived status of a partner. Women who tested positive but perceived their partners to be HIV negative were significantly less likely to disclose. Similar results were found for men. HIV positive women were also less likely to disclose if they perceived their partners to be negative as compared to when both partners were perceived to be HIV negative. In this scenario, these women may be concerned with transmission to their partner if they failed to disclose.
One additional finding that was not part of the primary analysis but has important implications is worth a discussion. Men who tested through TLT as opposed to on their own were significantly more likely to disclose their test results to spouses and partners. For women, it did not matter whether they were tested at TLT or elsewhere—rates of disclosure remained constant between the two groups. A few explanations are possible. First, men tested at TLT may have been pressured by their wives to disclose if their wives also tested and expected to hear their partners’ results. This is important because it suggests that men who test on their own—perhaps without their partners’ knowledge—may be less likely to share their results. Women, on the other hand, may be equally likely to disclose their results regardless of whether they tested at TLT or on their own because their partners are typically more aware of their plans to test and expect to hear the results. There may also be an underlying obligation to inform male partners out of respect and obligation for their role as the family leader. Couples testing may be an important intervention to increase rates of disclosure specifically among men who may be more sensitive to their partner’s participation in the testing experience, if it can be done in a way that minimizes the negative consequences.

**Limitations**

As with any study, the hypothesis-testing phase is subject to a number of limitations—many of which have already been mentioned throughout this dissertation. The first set of limitations centers on the relationship power scale. As already discussed, there are likely to be other uncovered forms of power not covered by the unity and discordance subscales.
Though inductive forms of power could emerge using the semi-structured couple interviews collected in 2009, the dominant theory guiding the line of questioning was the TGP. I have already described the limitations of using this theory. The reliability of the unity scale could also be improved upon. This would likely occur as a natural consequence of more measure development work that refines the unity construct. The scale development research was conducted in the southern region of Malawi with a matrilineal/local orientation (as opposed to the patrilineal/local north), which may limit the generalizability of the findings. The main power difference between the two regions may be women’s ability to leave their relationships (i.e., divorce) with more control over land. Although this was accounted for in the preliminary scale, these items did not make it into the final scale; they dropped out during the factor analysis. It is possible that if the same factor analysis was run using a sample from the patrilineal areas, these underlying constructs may have been more salient. At the same time, it could be argued that lineage structure plays less of a role given the colonial influences of patriarchy on power relations across Malawi.

A second limitation relates to the data used in the hypothesis-testing stage for HIV testing behavior. The HIV testing uptake measure included HIV testing through multiple possible venues, including home-based and workplace testing, client-initiated testing (or VCT), provider-initiated testing through other health services, and antenatal care testing (although this was controlled for). Thus, since it is difficult to disentangle the testing modality in this measure, it is unclear how relationship power influences decisions to test through these multiple venues. This limitation is not necessarily limited to this dissertation; a
vast number of studies that examine the outcome “ever tested” do not inquire further about where the test occurred and who initiated it.

Finally, it is possible that the disclosure results may be slightly biased by selection given that only respondents who had previously tested were included in the sample. This is in contrast to other studies where the entire sample was tested for HIV (as part of the study) and then asked about whether they disclosed the results of the test to their sexual partners (Anglewicz and Chintsanya 2011). The bias in the current study is mitigated to some extent given that over half of the 799 respondents were tested at TLT’s wave 4.
CHAPTER VI

“WHEN THERE IS DOUBT IN THE HOUSE, THAT’S WHEN YOU GO FOR TESTING”: HIV TESTING PERCEPTIONS AND EXPERIENCES

In the previous chapter, I used quantitative data to show that an important form of relationship power called *unity*—a composite measure that embodied social norms of communication, collaboration, intimacy, love, and trust—was associated with HIV testing behavior. I discovered that *unity* served as a barrier to testing uptake, but facilitated disclosure. What might explain these findings? In this chapter, I present the results of specific aim 3—to understand the meaning of HIV testing within a sexual relationship. What emerged from the results was the importance of the theoretical construct of unity and its subcomponent of trust, which exist at the TGP structure of cathexis. This chapter offers more depth and explanation around the meaning of unity and how it shapes decisions to test and disclose. Through an inductive approach, Malawians’ narratives also charted how couples negotiate testing within the context of relationship formation, marriage, childbearing, and intimacy.

**Summary of Research Methods**

For the analysis, I drew upon two sets of qualitative data: 8 focus group discussions conducted in 2011 and 34 semi-structured interviews conducted with couples in 2009. In both sets of data, respondents were young, a mix of married and single individuals, and from the same villages in southern Malawi. Focus group respondents spoke about their perceptions of testing while the semi-structured interview respondents explained their actual
experiences with HIV testing in their current relationships. A series of vignettes were used to elicit responses among the focus group respondents, using a hypothetical young couple named “Lucy” and “Promise.” In four different scenarios, Lucy and Promise faced difficulties negotiating the terms of testing and the group was asked for their recommendations on what the couple should do and why. For example, Lucy thinks her husband Promise has another sexual partner and she is worried about HIV. A chain of questions followed such as, should she go for testing on her own? Or does she need her husband’s permission to test? What if the couple was not married but dating, is she still obligated to tell her partner of her plans? Subsequent scenarios asked other hypothetical questions about disclosure of test results and relationship dissolution or divorce. HIV testing also came up organically during early questions regarding relationship ideals and norms. In the semi-structured interviews, respondents were asked about their HIV testing history and to describe the events leading up to and following the act of testing (these respondents will be referred to as “semi-structured interview respondents” hereafter).

The Symbolic Meaning of an HIV Test

Through their social interactions, people learn the meanings and symbols that ultimately shape their thoughts, actions, and interactions with others (Ritzer and Goodman 2004). In this study, my analysis focused on the micro-level and followed how rural Malawians came to understand HIV testing as they interacted with each other and the larger social structures surrounding HIV testing. I conceptualized “social structures” to refer to physical structures such as VCT testing sites located in rural communities as well as intangible structures related
to national testing policies, the dominant gender hierarchy, and the institution of marriage. I specifically examined how these social structures were manifested at the relationship level.

Using a social interactionism perspective, Kathryn Rhine (2009) argues that an HIV test is not simply a tool employed to measure immunological malfunction. A diagnosis also illuminates a set of social facts. She suggests that the virtues and fears embedded in the act of taking a test are related to larger questions of how families and relationships might change in light of a positive result. Other qualitative research that interviews people who have been tested indicates that test results have meanings that are tied to relationships, faithfulness, and trust. Individuals often take HIV tests when they are ending a relationship or starting a new one and thus testing serves to mark these important life transitions (Lupton, McCarthy, and Chapman 1995).

In the current study, respondents revealed that HIV testing decisions were intimately connected to aspects of unity and trust. They described the relationship between HIV testing and trust as a reciprocal one. Testing could promote or destroy trust depending upon the results of the test, but trust (or lack thereof) could be the main motivating factor for seeking testing in the first place. Overall, study respondents perceived HIV testing as problematic if the topic was brought up at the wrong time in the relationship and in such a way that raised concerns about cheating. For some people, learning one’s HIV status provided solid answers to their questions of fidelity. But for others, it created more confusion and uncertainty about the future. Despite their trepidation around HIV testing, rural Malawians did see the value of learning their HIV status and invoked creative strategies to maintain important relationship
ideals such as love, trust, and intimacy while attempting to minimize their risk to HIV at the same time.

**The Relationship Ideal of ‘Testing before Marriage’**

Finding an HIV-negative partner is of critical importance to young people contemplating marriage (Clark, Poulin, and Kohler 2009). In today’s age of expanded access to HIV testing services, young people are likely to take advantage of more accurate ways to assess a partner’s HIV status. In the current study, respondents from six of the eight focus groups mentioned almost immediately after being asked to describe a perfect relationship about the importance of going for “VCT” together while dating. This relationship ideal transcended gender lines. Focus group respondents provided a variety of different reasons for why couples do and should get tested during the courtship phase of their relationship. Young people may go for testing while they are dating to determine if their *chibwenzi* is marriage material. In several focus groups, respondents recommended that couples get tested when they start to fall in love because they are probably going to have sex soon and early testing can help prevent HIV transmission if one partner is positive.

There was evidence among the semi-structured interview respondents that these ideals and recommendations are carried out in everyday life. Pre-marital testing was perceived as an important and often symbolic step towards advancing a relationship to the next level. Several single men informed us that they got tested during courtship as a way to demonstrate their trustworthiness and dedication to the relationship, and in some cases, to convince a partner

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9 *Chibwenzi* is the Chichewa word (gender neutral) for a sexual partner outside of marriage, usually the equivalent to a boyfriend or girlfriend.
to have sex. One young dating man named Andrew shared a conversation he had with his girlfriend about getting tested for HIV before having sex for the first time. He later explained how he eventually agreed to her suggestion to test because of the dangerousness of AIDS.

Interviewer: Who started this issue of VCT?
Andrew: The girl told me and we agreed not to have sex until we get tested. I asked her to sleep with me. She said first we were to get tested then continue with using chithubango (a popular brand of condoms in Malawi).

Interviewer: What was she afraid of?
Andrew: I can say two things. She was afraid of these venereal diseases, STIs and pregnancy. This time she was just a girl, still in school. Remembering the bad times we are in [referring to HIV/AIDS], I knew she was saying the truth and I agreed to go with her for VCT. (semi-structured interview, male #1)

It is notable that his initial reason for testing was to sleep with his girlfriend, not to prevent HIV. For other people, future aspirations around marriage and childbearing weighed heavily into their decisions to test. In the following passage, a married woman named Anna recalled about how she pressured her partner go for testing before she would officially commit to marrying him:

Anna: Before we got married, we went for HIV testing. After we went for testing, we got engaged.

Interviewer: What made you go for testing?
Anna: We wanted to know my and his status on HIV. I told him that if you want to marry me, we should go for HIV testing first.

Interviewer: What did he say?
Anna: He agreed and he said that he will go. So he went and before that time we didn’t do anything.

Interviewer: What are you trying to say when you say you didn’t do anything?
Anna: Um, before we started having sex. Yes. So we went for testing first so that we could know how our bodies are. (semi-structured interview, female #3)

Beyond fears of AIDS and perceptions of risk, important life projects like marriage and desires for intimacy, trust, and closeness with a premarital chibwenzi were deeply embedded in the way rural Malawians made decisions to test.
In high-fertility settings, it is customary for young couples to begin childbearing soon after the marriage begins. There is evidence from Malawi that knowledge of one’s HIV status plays a significant role in desires to have children (Yeatman 2009). Thus, HIV testing before marriage helps couples plan out their future families. In the next passage, a married woman named Edith believed that learning her and her fiancé’s HIV status would help them to bear healthy children after they got married.

Interviewer: May you explain to me the conversation you had about it [HIV testing]?
Edith: We said that our wedding day is near, and before it is reached, I would love if we could go for testing so that we can know how our blood is so that we can have a happy [meaning healthy] family. Then we agreed to go.

Interviewer: Who was saying that?
Edith: It was him but still we both had the same thoughts [idea to test] because these days you can’t just get married before going for blood testing. (semi-structured interview, female #15)

At first, Edith talked about how her husband insisted on testing so that they could have healthy children but as she continued, her reason for testing refocused on the marriage itself. One is left to wonder if Edith and her partner are really testing so that they can safely continue with their marriage plans. By using concerns about the children as a way to justify testing, the couple can effectively circumvent the negative association between trust and testing and avoid falsely accusing each other of sexual promiscuity.

But to the contrary, focus group respondents pointed out that not everyone gets tested during courtship and this is how a person can become entangled in a complicated web of love, sex, and HIV. Other research from rural Malawi shows that ideal relationship sequences, e.g., getting tested for HIV then having sex, do not always translate into real life events (Frye, Trinitapoli, and Namadingo 2011). This disconnect between ideals and practice is understandable for young people who may be worried about testing positive, social
rejection, and engaging in awkward conversations about sex and HIV testing. Other couples may simply get caught in the moment and end up having sex before they initially intended, as suggested by the man below. In this conversation, a group of four single men illustrated the problems of not going for testing in the beginning of the relationship:

Man #3: A good relationship is the one that when you have proposed each other and you go for testing. If you are really in love, you can have sex when you get married but also after you go for testing. That’s a good courtship.

Man #5: My idea is the same that in a relationship you should start sleeping with each other after you have gone for testing. But if you find that you are okay [without the virus], you should still use condoms. It can help.

Man #3: But perhaps we want to have sex with the woman before we know our status.

Man #8: Maybe the woman had sex with someone that is HIV positive and she did not go for testing. But maybe you went for testing and you are okay [HIV negative]. So you get caught in the cobweb and you are found in the group of people being infected. (FGD #8, single men)

In the passage above, the first man took on a relationship-centered as opposed to risk-centered narrative when discussing the benefits of early testing—evidenced by his references to “love” and the quality of the relationship ("a good courtship"). The other men perceived HIV testing as a way to avoid risk and determine who is considered a safe sexual partner. Regardless of their orientation towards risk or the relationship, all men in the group seem to concur that testing together at the start of the relationship is of critical value.

The Incompatibility of Testing with Marriage

While HIV testing was portrayed as a necessary precaution for dating couples to take before considering marriage, testing during marriage—outside of the antenatal care setting—was considered inherently problematic. From the respondents’ accounts, I conclude that HIV testing is largely incompatible with marriage because it goes against social norms of trust, love, and intimacy that couples strive for in their daily lives. Married couples who love
each other and have no reason to suspect cheating would have little reason to seek out HIV testing on their own accord. This conclusion was consistent across marital status and gender. In the following passage, a single man summarized the general belief of the group about how it is critical to go for testing at the beginning of the relationship because bringing up testing during marriage raises questions of faithfulness:

Testing has to start while in a relationship [dating]. You have to tell each other to go for testing while in a relationship not just when you are married because if you do [wait until marriage to test], you might start having doubts about the partner, for example, asking why all of a sudden she wants to go for testing? Has she been sleeping around with men? (FGD #3, single men)

When asked about why married people typically go for HIV testing, a female focus group respondent answered, “Mostly, it is because of the lack of trust in the relationship and in doing so, they are able to know the truth so that they live happily after knowing their status.” (FGD #1, married women)

Simply bringing up conversations around HIV testing with a spouse symbolizes mistrust and deception and can lead to major disagreements in the marriage. In the first HIV testing vignette, a young girl named Lucy ponders whether she should tell her husband she wants to go for testing (she thinks he is putting her at risk for HIV by his extramarital affairs). A married man shared his opinions with the group about the implications of bringing up testing unexpectedly with a spouse:

Because by just saying that we should go for testing, it means there is doubt in the house. You can go for testing, but it doesn’t just come up like “let’s go for testing”, no. But when there is doubt [mistrust] in the house, like how is my partner moving [behaving sexually]? If I think he is cheating, that’s when you go for testing. But if you are not doubting [trusting] each other, you’ll see that even if people say that others are getting tested over there [at the VCT clinics], you don’t regard [consider] it. (FGD #6, married men)
In this man’s account, he contrasted his opinion about testing with what he saw going on in his community, i.e., “others are getting tested over there” (referring to VCT clinics).

Worldwide, there have been tremendous attempts to normalize the experience of HIV testing in order to increase the number of people who know their HIV status. In Malawi, this conflicted with how rural villagers defined appropriate use of HIV testing services for themselves. As the young man in the passage above insinuated, testing during marriage was labeled as an unusual event, one reserved for special or problematic circumstances rather than for everyday, routine screening of disease.

The semi-structured interviews illustrated how negative perceptions of testing during marriage corresponded with people’s lived experiences. In the following account, a married woman named Ruth lamented how her husband thought HIV testing was for people who suspected they were positive and therefore he refused to go. As a consequence of his response, she started to question his faithfulness as well as his HIV status:

Interviewer: Ok! So when you went for testing did you tell your husband or you just went?
Ruth: I told him that there was no reason to be afraid of knowing how your blood is but he denied [refused to go], so I went by myself. So he was saying I was doubting myself. That was what he was saying.
Interviewer: Alright, so did you encourage him to go one day or did you just give up?
Ruth: No, I didn’t give up, I always tell him. The first time I went I told him that you should also go so that we can have proof that we are alright, but if you don’t then I will be having doubts that maybe my husband is positive or negative. I will not be sure. The second time I went I told him the same thing, but to no avail.
Interviewer: So what does he really say, I’ll go later or I can’t go?
Ruth: He says that he can’t go, that those who go for testing are doubting themselves [think they could be HIV positive because of past sexual behavior]. They don’t trust themselves.
Interviewer: Oh! How do you feel when he answers you that way?
Ruth: It pains me, I see that he is not helping me and the children. (semi-structured interview, female #9)
Ruth’s interview illustrates the paradoxical connection between risk, trust, and the perceived need to go for testing. Rural Malawians understand very well that risky sexual behavior warrants an HIV test. Yet it is the admission, or more likely suspicion, of guilt associated with the act of testing that may trump concerns with HIV infection. Not everyone views HIV testing from a western, public health lens that emphasizes disease prevention and early detection—or in the case of HIV testing, as a means to protect a spouse from HIV or to initiate ART. In rural Malawi, conceptions of “risk” carry deep social meanings tied to infidelity and promiscuity, which do not necessarily align with a purely biomedical or public health understanding.

Risk, Infidelity, and HIV Testing

In general, respondents talked about HIV status as if it was an absolute indicator of marital fidelity. Smith and Watkins (2005) found that Malawians vastly overestimated their chances of infection through a single sexual encounter with an infected person. Men worried about their extramarital partners as a source of infection while women worried about their husbands’ affairs. In another study from Malawi, marital infidelity was found to be the strongest correlate of overestimating one’s own and a spouse's risk for HIV (Anglewicz et al. 2008). According to this logic, married people who were cheating and found to be HIV positive would presumably have become infected through these extramarital affairs. On the other hand, some participants perceived HIV testing as a strategy to substantiate their own or their partner’s faithfulness. In one conversation about jealousy, single women shared their beliefs about how rural villagers could try to destroy a healthy marriage by spreading rumors
about a couple’s HIV status and sexual history. One woman pointed out that HIV testing was one way to prove to your spouse (and your accusers) that you weren’t cheating—and by extension, that you did not have HIV:

Interviewer: So people can go and say your woman has done this and that [referring to cheating]?
Woman #1: They can lie that the women has diseases when she doesn’t have diseases.
Woman #3: But, if you love each other you can go for testing. They can spread lies, but you can say [to your husband] that if you love me, let’s go for testing so that you believe that I don’t have [HIV]. (FGD #2, single women)

The use of HIV testing for “fidelity confirmation” resonated in the men’s narratives as well. In Malawi, men are cognizant of the dominant HIV prevention discourse that blames unfaithful married men for transmitting HIV to their wives. This topic also came up in a conversation I had with Joseph, a VCT counselor working at a private clinic in the Balaka town (see Chapter 2 for more details). His general impression for why men refuse to test was because he thought men believed and feared that they would be blamed for bringing HIV into the family. While this belief may deter some men from getting tested, it is likely to motivate others. In the following interview excerpt, a married man named George described how he used HIV testing as a way to prove his faithfulness to his wife:

Interviewer: Have you ever talked about being tested for HIV/AIDS?
George: Yes, we have tested for the virus.
Interviewer: Who started talking about this issue?
George: I am the one.
Interviewer: What made you to do this?
George: We wanted to promote trusting each other. We wanted to remove [stop] doubting each other. Just because many times the blame goes to the men, with women saying ‘you are the one who brought the virus to me’. Then I decided that we should just go and be tested.
Interviewer: What was her reaction to this issue?
George: She was happy and agreed. She said she will follow what I was saying because I am the head of the family.  (semi-structured interview, male #8)
Sometimes, HIV testing raised more questions than provided answers. A few focus group respondents pointed out that just because a person tests positive, it doesn’t mean they necessarily cheated; a spouse could have been positive before marriage and may have contracted HIV through non-sexual routes, such as by caring for a sick loved one, exposure to contaminated needles, or from their HIV positive mother during childbirth. One strategy to retrospectively assess when a spouse became infected with HIV was by going for testing together during the courtship phase. The following group of married men discussed how failing to go for testing at the start of the relationship can lead to false accusations of infidelity later on during marriage.

Man #2: The problem is when you are proposing a girl, she does not tell you that she has the virus.
Man ?: But together, you can make the decision of going for testing at that particular time.
Man #4: It just goes wrong in the beginning because you did not take each other for testing.
Man #7: Because we can think of the woman as being a bitch [meaning cheater] when she is not. The problem is really based in the beginning when you did not go for HIV testing.

(FGD #4, married men)

As the above passage suggests, early testing provides a baseline measurement to use in future judgment around cheating. For example, if a woman tested negative before marriage, but positive afterwards, her faithfulness could be questioned. Without this additional piece of knowledge, it becomes difficult for partners to assess their faithfulness to each other using current serostatus alone. They come to rely strongly on subjective assessments of a partner’s infidelity, which are often less reliable. When making life-changing decisions using this information, it becomes very important for partners to accurately evaluate the relationship integrity before moving forward. Indeed, in rural Malawi, Anglewicz and colleagues (2008)
found that couples’ perceptions of a partner’s risk and their actual risk are often mismatched, possibly leading to premature divorce or breakup.

Now that I have outlined the broader framework for how rural Malawians understand HIV testing as it intersects with their relationships, I move onto the role of gender and power in couple decisions to test for HIV. In what follows, I paid special attention to the broader set of beliefs respondents used to make sense of the relationship between power and getting tested for HIV.

**Tradition, Rights, and Unity**

In Chapter 4, I outlined three narratives respondents used to construct meaning around gender and power relations: *unity, tradition, and rights*. While I hypothesized that these three perspectives could intersect with the TGP’s divisions of labor, power, and cathexis, in this chapter, I specifically focus on the structure of cathexis. When presented with the hypothetical HIV testing scenarios, respondents used the same three narratives to verbalize their perspectives on relationship power and HIV testing. Broadly, I coded passages with *rights* when respondents talked about human rights and “the right to test.” The *tradition* code was applied to passages that referenced traditional gender roles (e.g., “she has to tell him, he is the head of the household”). I invoked the *unity* code when respondents talked about love, intimacy, couple communication, the need to test together, and the notion of a married couple as “one body.” I next discuss how these three narratives were invoked in discussions of testing autonomy, the refusal to test, and alternative testing strategies.
Testing Autonomy

In the first hypothetical vignette, focus group respondents were asked to comment on Lucy and Promise’s level of autonomy and decision-making power to test. Most focus group respondents drew upon a unity narrative to argue that both husbands and wives were supposed to tell each other about their plans for HIV testing, especially if they were married and loved each other. Other respondents contrasted tradition with rights in their justifications for whether women should inform a spouse of their plans to test and how women should respond if husbands impeded them from going. In their tradition narratives, respondents invoked language around traditional gender roles to argue that a woman could be in big trouble if she goes secretly for HIV testing because women were not supposed to be “moving around” without their husbands’ knowledge. Covert testing implied that one was hiding something from a partner—presumably a secret love affair.

Other tradition arguments suggested the importance of the division of labor. In the following passage, a married man argued that the man (husband) needs to know of family health matters and ultimately, a woman’s decision to test falls in his domain:

Because first of all, the man needs to know that, in our family we went to the clinic, we have tested and our status is like this or that. She doesn’t have the power to go on her own for testing. It will be like I do not have trust how she is regarding herself [perhaps as promiscuous or unfaithful]. But it will also depend whether they tell each other and with how things are, saying “What if we go to the hospital for testing?” So it should be a man’s decision after you have thought very well [deeply about the decision to test], and saying [to his wife] “let’s go.” [for testing] (FGD #6, married men)

Similar beliefs resonated among a group of single women who argued that the husband should know of a wife’s intentions of going for testing since he is considered the head of the household:
Interviewer: So she [Lucy] should tell the husband that she wants to go to the hospital for blood testing and then she should hear what the husband will say.

All: Yes.

Interviewer: Why should she ask the husband?

Woman #1: Because he is the household head. (FGD #2, single women)

Another group of single women reported that if Lucy goes for testing without telling her husband, her husband may challenge her intentions by saying, “what made you go for testing without telling me?” and the couple could quarrel—something that is highly undesirable and thought to cause the breakdown of marriage.

However, not everyone shared this belief. Several groups of female participants shared their opinion that many husbands do respect their wives’ decisions to test. Other respondents, notably men, contested the role of tradition with the belief that HIV testing was legal in Malawi, a human right, and therefore a husband could not prevent his wife from learning her status. In one particular conversation about Lucy, two married men argued with each other about whether a woman could rightfully go for testing without informing her husband:

Man #1: HIV testing is legal and I don’t think he can refuse her to go and do so. Saying, “do not go for testing because I am cheating on you.” Because HIV testing is a human right. He can say “do not go for testing” but because she really wants to go, one day or the other, she will make her own plans and go for testing.

Man #4: To be clear enough, if the woman went for HIV testing without telling him, her husband, and she has been found HIV positive, she is supposed to tell him, but it is at the same time difficult on how to tell him because maybe the man can question her saying: “why you were going for testing?” It is true that testing is her right but as the head of the household, she is supposed to let him know. He can ask that “when you were going for HIV testing, did you tell me?” And she can say “no, I did not.” (FGD #4, married men)

These two men exemplify the difficult dilemma that couples face when making decisions to test. Human rights advocacy in Malawi has provided women with the legal freedom to learn their HIV status, however, this structural change collides with the everyday realities of
couples on the ground. As the men in the focus groups suggest, exercising global human rights to test has local implications—particularly between husbands, who have been granted cultural rights to the family leadership role, and their wives who should respect them.

Research from Malawi indicates husbands may prevent their wives being tested (Kranzer et al. 2009), even when pressured by antenatal care staff to test during pregnancy (Angotti, Dionne, and Gaydosh 2010). Interestingly in the couple interviews, I did not find a single instance of a man prohibiting his wife or girlfriend from getting tested even if he refused testing himself. The following semi-structured interview excerpts provide candid examples of women’s ability learn their HIV status when they so desired. In the first passage, a single woman replied how she was free to get tested even if her boyfriend refused to go. When she showed him her results, she said she could use it as a teachable moment to convince him to test.

Interviewer: Let’s just go back on the issues of HIV, if you tell your boyfriend that you should both go for testing and he refuses, can you still go on your own?
Agnes: If it can be that I have told him to go for testing and he refused, I can go on my own for testing. Maybe we agreed earlier on to go and he has just changed his mind, so I can go. And when I come back I can show him my test results so that I can encourage him to go for testing as well. (semi-structured interview, female #10)

In the second passage, a married woman named Ellen told the interviewer how she faced no resistance from her husband when she wanted to go for testing:

Interviewer: So when you are going for testing, when you tell him [that you are going], does he agree that you should go or does he not want you to go?
Ellen: He lets me go, he doesn’t care. (semi-structured interview, female #11)

Finally, a third woman explained how she could go for testing as many times as she wanted, especially if she suspected that he was cheating:

Interviewer: So you trust your husband, you don’t think there is anything he can do [referring to
Catherine: He can have an affair behind my back, but if there is any doubt I can go and get tested again. (semi-structured interview, female #0)

In contrast to some of the earlier narratives in this chapter on the negative associations of testing with mistrust, these women spoke of testing as if it were any other normal activity and encountered little opposition from their male partners. Yet none of these women went covertly for testing (as least that we know of) and partner reactions could be very different if he found out she went for testing without his knowledge. Informing a male partner out of respect and to maintain transparency may be a wise strategy for women to exercise their rights while maintaining norms around tradition at the same time.

**Refusing to Test**

Just as the act of bringing up testing with a partner conveyed underlying meaning regarding the status of the relationship, so did refusing to go with a partner for testing. Focus group respondents provided a variety of different reasons for why young people might refuse to go for testing with their partners. A few respondents mentioned that fear of testing positive prevented people from testing. In addition, the belief that spouses share the same serostatus given they have had unprotected sex might lead some people to the conclusion that they can infer their own status from their partner’s test result—and thus why go yourself? For example, one single man said: “Mostly when in a relationship, one partner always refuses to go and when the other one has gone for testing and has come with the results, the other partner assumes he/she is also the same.” (FGD #3, single men)

Respondent talked about how if “Lucy,” the hypothetical wife, brought up testing with her husband and he wouldn’t go with her, she should interpret his reluctance as a sign of
unfaithfulness or HIV infection. Similarly, refusing to go for testing while dating signified that there was a problem and this could be a deal breaker. In the following excerpts, single men from two separate focus groups commented on how a partner’s refusal to test indicated a promiscuous past or a sign of infidelity:

Man #3: In the village where I am living, when people are dating they talk to each other about HIV testing and go for testing. In this case whereby one is afraid of going for testing, the relationship ends there. Because it is taken as though he/she does not have enough trust in his/her partner. (FGD #3, single men)

In the second focus group, a man responded:

Man #4: Even if she hears that the man is cheating, she should tell him that let’s go for testing. When he refuses, that’s when she has a point. Why has my husband refused? Then it must be true. (FGD #8, single men)

When a partner refused to test, it provided an important opportunity for people to re-evaluate the quality of their relationship and changing risk for HIV infection.

**Testing Together as a Workaround Strategy**

Overall, study respondents perceived HIV testing as problematic if the topic was brought up at the wrong time in the relationship and in such a way that raised concerns about cheating. For some people, learning one’s HIV status provided solid answers to their questions of fidelity. But for others, it created more confusion and uncertainty about their relationship. This is not to say that young Malawians did not see the value in getting tested for HIV. In fact, people offered various strategies to overcome perceived barriers to testing and to circumvent the negative associations between HIV testing and trust.

In their proposed solutions, focus group respondents primarily drew upon *unity* narratives. Seven out of eight focus groups suggested that a couple (i.e., Lucy and Promise) should ideally get tested together and sometimes the entire group came to this conclusion.
after debating back and forth about what Lucy should do. In one conversation, married women chatted about whether women should tell their partners about going for testing. The women stressed that it was important for couples to go together and learn their status:

Interviewer: She should tell her husband that she is going for testing?
All: Yes (group answer).
Woman #3: She should tell her husband that they should go together for HIV testing. If she doesn’t want to let the husband know, she should just go for the HIV test on her own and when she comes back, she should tell her husband that she went for HIV, stating and that she has been found negative. It’s now up to her husband to also take the same route [get tested] and be happy about his wife’s status.
Woman #8: The most important thing is to agree on one thing. Going for testing together and know their status together. (FGD #1, married women)

The same belief resonated among single women. In another conversation about whether Lucy should go for testing on her own, single women in a focus group emphasized the need to go together for testing—even if he initially refused:

Interviewer: So in the first place she told her husband, let’s go for testing and he refused, but she went on her own. She should still force or tell the husband to go to the hospital to be tested?
Woman #3: You go together for testing.
Interviewer: When you are tested you should go together?
All: Yes.
Interviewer: Ok, what if Lucy is found without the virus, should she tell the husband?
Woman #1: She should tell him so that they go together. (FGD #2, single women)

It is important to highlight the last woman’s response—the idea that Lucy should not tell him her status, but rather suggest that they go together. This strategy emerged in other interviews as well, as I will discuss in the paragraphs to follow.

Numerous benefits of couples testing were mentioned—mostly as they pertain to relationships, not risk avoidance. Male respondents, in particular, discussed how the act of testing together symbolized love, unity, and a strong marriage. For example, one focus group respondent described testing together as a way to demonstrate caring for a partner during a
time of intense worry. Others saw HIV testing as inseparable from the couple context. In
the next passage, a male focus group respondent shared his belief that when you are married,
you are one and therefore should learn your status together:

> With the way I see it [regarding] the scenario that says, this woman would like to go for testing so should she seek for permission from her husband or not? According to me, I think that she should tell him because once people are married they are considered as one. They should also go together and know their status. In a case whereby the two have not gone together, still, the woman should let her husband know and when she comes back from the hospital she should also let her husband know about the results. (FGD #3, single men)

Once married, HIV status becomes a couple-level issue that required collaboration between spouses. This understanding was repeated in another conversation among a different group of married men, who pointed out that spouses need to tell each other about their plans to test since “they are considered one.” The last man perceived testing together as the proper use of a man’s power.

Interviewer: What about man #2, you said she should seek permission from her husband [when going for testing]?
Man #2: Yes.
Interviewer: Why?
Man #2: She is supposed to seek permission because they are one and they are supposed to help each other when there is something that needs to be done. So she needs to ask because maybe the man can also go with her for HIV testing. Maybe this can help.

Man #1: There’s a need of asking for permission from her husband because if the man is using his powers properly, he can also join the woman and go for testing together. (FGD #4, married men)

In general, respondents perceived “permission” not as male control over female autonomy, but as an opportunity for couples to communicate with each other about HIV testing and assist each other out by testing together.

While a unity narrative was used to emphasize the importance of couples testing irrespective of marital status, focus group respondents were more likely to emphasize a rights narrative when it came to dating couples. Once married, HIV transitioned from a strictly
individual-level concern to a family health matter that required the involvement of both couple members to make health decisions. A group of married men concluded that Lucy should ultimately tell her husband about her plans to test, but they changed their mind when Lucy’s marital status was presented as single. Both narratives are contested in the following conversation:

Interviewer: What if Lucy is not married, should she ask for permission from her boyfriend before going?
Man #3: They should discuss before going.
Man #2: That is just a relationship [dating] and that is what she wants. If the man wants [to test], he will also go on his own because they do not know how their partner was behaving before they met each other.
Man #7: Because it is just a relationship, she has the right to go for testing and know her status.

At first the men talked about how each of the partners has the right to go for testing on their own—as unmarried individuals. But if an individual just exercises their right to test without considering their partner, there could be problems. The first man (#3) took issue with each of them going alone, particularly, regarding the inability to really know each other’s HIV status. Therefore, he argued they needed to go together for testing.

Man #3: You are saying she should just go because it is just a relationship, now tell me how will she know her partner’s status if she just goes without letting him know?
Man #4: Everyone has the right to go for testing when they want and where they want to go. And when she goes for testing, whether she has a boyfriend, she will not just go to her boyfriend and say “I went for HIV testing and they found that I am HIV negative.” Or “I went for testing and they found that I am HIV positive.” If there is a need of telling her boyfriend she needs to tell him that “we should go for HIV testing” not telling him that “I went for testing.” If she went for testing and she was found HIV negative or she was found HIV positive, she should just keep quiet because she did not inform him when she was going. But if she wants to tell her partner, she should say that they should go together. “What about we go for testing?” (FGD #4, married men)

The fourth man’s opinion came up in an earlier focus group. He explained in a very matter-of-factly manner that anyone could learn their HIV status for personal benefit. In order to avoid conflict, he stressed that there was a need to communicate with a chibwenzi about
testing only if the goal was to learn each other’s status together. With this strategy, unmarried young people could maintain their relationships and protect their own health and reputation by involving a partner only if necessary.

Another benefit of testing together was that it ensured that both partners learned each other’s HIV status given that the couple was told their test results in front of each other by an HIV counselor—thus avoiding a situation of deception or failure to disclose. In one of the married men’s focus groups, a man noted how a person doesn’t really know their partner’s HIV status unless they tested together. Respondents pointed out that if a woman went for testing on her own and tested positive, she risks being labeled as the cheater despite the fact that the status of her husband remains unknown. When asked how Lucy’s husband would respond to her positive test result, one man said: “The way I see it, the man will not accept what he has heard. Because of this, it shall be a burden to the man whereby the man will call her a bitch. You said you were HIV positive? Yes, that means that you are a bitch.” (FGD #4, single men).

Finally, testing together helped to avoid the uncomfortable situation of having to inform a partner of a positive test result without knowing the other’s status. When asked about whether a young man named Promise should tell his wife about testing, a young woman noted how if they were married, he should go with his wife for testing because it could be too difficult to tell her the results later on—if he tested positive:

If he loves her, he needs to tell her. Maybe his wife was not told that Promise was going for testing because of whatever reasons. So if they are married, it’s better they go together. Maybe the wife is also like that [sick] since they have stayed together [had sex] for a long time during marriage. So it’s difficult. If he goes alone, maybe he will be found positive. Now it’s going to be difficult to tell his wife that he is positive. (FGD #2, single women)
Again, there exists a widespread assumption that if one spouse is positive, the other person must be as well. In a setting where cell phones are becoming increasingly popular, one focus group respondent metaphorically used the phrase “the virus is in the voicemail” to mean that it was just a matter of time before the other couple member tested positive (FGD #8, single men). The young man, “Promise”, is presumed to dread telling his wife that he was positive because he believed he would be indirectly informing her that she had AIDS. No one wants to inform a loved one that they have an incurable, deadly disease. In this respect, testing together takes this burden off of his shoulders and shifts responsibility to the counselor’s domain.

Respondents offered many clever suggestions for Lucy to avoid confrontation with her husband over testing. One particularly ingenious strategy to use when worried about a partner’s infidelity was to go for testing secretly and then suggest to the spouse or chibwenzi that they go together—while acting as if one never tested on their own. This strategy is likely commonplace, as it came up during four different focus groups of different demographic characteristics. In the following quote, a single women suggested that Lucy could keep her status a secret while she tried to implicate her husband in giving her the disease by saying to him: “My husband, let’s go for testing, while already knowing that she has the virus so that he finds out that they both have the virus.” (FGD #2, single women). For dating couples, one partner might go secretly for testing on their own first and then if they tested negative, try to convince their partner to go with them for testing as if they never tested before. In this scenario, they had nothing to lose and could only gain by learning their partner’s status.
Love could also be used as a strategy to convince a reluctant partner to get tested. In a setting where men emphasized the importance of having a loving, respectful wife who took care of them, love could be a powerful tool for women to use to get what they want. One man pointed out that in an attempt to get a cheating man to go for testing, the wife could kindly make the argument that they haven’t been tested in a while and it was good to go for regular testing to know their status. In another example, a married woman suggested sitting down with the husband after eating and explaining to him in a loving manner that it would be a good idea for them to get tested again:

He does not know the status of the girlfriend that he has is sleeping around with. So he thinks that if you go for testing or maybe you went for testing together with him before he started cheating and you all tested negative then. Now, you ask him in a good [nice] way just to see what he will say then if he asks why, you just say that “I would like to see if it is going to be the same as last time.” If he knows [he is positive], he will not let you go because he knows that when you will be found HIV positive you will know that you got the virus from him. But he will refuse [deny] you. Yes, [ask him] in a good [nice] way. For example, after you have eaten, you say, “why don’t we go for testing.” Not in a harsh way, but in a loving way so that you can see whether he is going to allow [agree] or refuse to go. (FGD #7, married women)

If love failed, sex could be used as a bargaining platform. The Malawi Demographic Health Survey data from 2011 (National Statistical Office & ORC Macro 2011) demonstrates that almost 90% of women believed that a wife was justified in taking action to protect herself from HIV, for example, by refusing to have sex. A male focus group respondent (as if speaking from his personal experiences) suggested that a woman could withhold sex from her husband until he agreed to go for testing: “Here when she goes to the hospital and she is negative, she needs to tell him that I went to the hospital got tested. These are my results, I am negative. When he refuses, she should tell him that they will only have sex after he goes for testing.” (FGD #8, single men). In the following semi-structured interview passage, a
young man named Francis told the story of how his girlfriend withheld sex from him until they learned their HIV status together:

Interviewer: You said you got tested for HIV. Who started this issue and what happened?
Francis: I am the one who started the issue when I was angry. She was refusing to have sex with me, saying she was afraid of the virus and getting pregnant. I started scrutinizing my background [sexual history], what I have done before this lady? Of course this is not my first partner but the previous one was not as serious as this. You know how children are. We were doing *zawana* [children games where they decide one to be a father and one a mother, games like hide and seek] and we agreed and got tested. I was happy. I was more confident. Lucky enough, I was negative. (semi-structured interview, male #10)

**Antenatal Testing as an Alternative to Couples VCT**

While couples’ testing was considered the ideal by many respondents, alternative strategies were offered—specifically, antenatal testing. Any visit to a rural health center in Malawi reveals the overwhelming presence of pregnant women and sick children rather than men. Health facilities may be unresponsive to men, with little space for male partners to wait, limited access to patient rooms, and unfair treatment by health service workers. Research is currently trying to build a strong evidence base for the inclusion of men in women’s based health services (Baiden et al. 2005; Mlay, Lugina, and Becker 2008; Desgrees-du-Lou et al. 2009). In rural Malawi, modern day health care in Malawi is still considered a feminized space: a place where men generally feel unwelcome and overwhelmed by the unfamiliar and daunting task of navigating a disjointed health care system that privileges women and children.

Despite these challenges, couples testing via antenatal care may provide a promising alternative to traditional couples VCT (or ‘CVCT’). In Malawi, women of childbearing age are more likely to be tested for HIV through antenatal care than though any other venue.
(Angotti, Dionne, and Gaydosh 2010; National Statistical Office & ORC Macro 2011). This may provide an important opportunity for CVCT by recruiting men to participate in an already established system. Indeed, research has shown that couple counseling facilitated through couple-friendly antenatal care services should be explored as a potential alternative to VCT (Baiden et al. 2005; Mlay, Lugina, and Becker 2008). There have also been claims that antenatal care provides the chance for women to sensitize their male partners to the sexual risks around HIV/AIDS (Desgrees-du-Lou et al. 2009).

While antenatal care testing was not a central topic of discussion in the focus groups, some respondents suggested that when the authority to test comes from health care providers instead of their wives, men may be more inclined to test. In a lengthy conversation about antenatal care, a group of married men explained how men were recruited from the antenatal clinics when their pregnant wives were found with HIV. The first man stated:

Man #7: It is possible that Lucy has a child so she goes to antenatal clinic. At the clinic, the women are tested. They are not just weighed [on a scale] but they check their HIV status. So if she was at the antenatal clinic, it is a good reason to tell the husband that she was at the clinic and tested. So if in the first visit she was tested and found negative, she needs to tell her husband that. Then they are supposed to do another blood test at the clinic. So [let’s say] they test her and she doesn’t have the disease. The next time she tests negative and then after that, the next time she tests positive. And so then they call the man and tell him that he should come in on such such a day [to test]. So you the man, you follow not of your wife, but the one who sent Lucy to tell the husband to come. So it is up to that man to accept or refuse. So Lucy has no rule [authority], but the decision has come from the person who has sent Lucy [VCT counselor or medical professional].

The other men in the group agreed with this man’s assessment and offered up other strategies to increase men’s rates of testing via antenatal care:

Man #5: Indeed, maybe the person can feel uncomfortable to go but if the doctor finds a way of calling him, [he might agree to test].

Man #7: He can’t be uncomfortable.
Man #6: But for her to just say that she has been found positive, now he already finds [knows] the answer [his status]. So why would the person go? The doctor should write something that he is required [to come]. “There is something that we should discuss. But come with your wife.”

Man #5: But now when they go to the clinic they want the man. So if he doesn’t go, they send the woman back [without receiving the antenatal care she is supposed to receive at that appointment]. When they send her back, he knows he needs to go so that she can be weighed. They should test you together with the woman.

Man #1: Now, when the woman is expectant [pregnant], they can tell her when she comes back to please come with your husband so that we should also test him. (FGD#4, married men)

These men’s perceptions of antenatal care testing were corroborated by real experiences as documented in the semi-structured interviews. Several men were tested after doctors recommended to their pregnant wives that they bring in their partners for testing. In three different semi-structured interview excerpts with married women, Mary, Chisomo, and Rose recalled how their partners agreed to get tested during their pregnancies after receiving advice from health care providers. Perhaps this acted as a motivating factor for men who might have otherwise declined.

Mary: We talked about it before we had our baby, but he was refusing to go. He was afraid and not only him, I was also afraid. When I was pregnant, I was advised to get tested but I was afraid so I didn’t until the baby was born. Then we were living but we knew that we were supposed to go for HIV testing. That time I had a long-term cough and flu. So I went to the hospital to get tested for TB but it wasn’t. Then we just decided to go for HIV testing and when we went, they found me HIV positive and so was my husband. (semi-structured interview, female #4)

Chisomo: Yes, we went for testing. We talked. At that time we went because I was pregnant with our first child so I explained to him that we should go for testing. I went and I am HIV negative and so they told me to tell my husband to go for testing as well. So when I told him that he has to go for testing, he agreed. Lucky enough at his workplace there were people who test blood, so he just got tested there and came home with the results and he was found negative. (semi-structured interview, female #5)

Rose: Yes, when I was pregnant I was told to go for HIV testing so I went and I was found negative. When I came home I told my husband to go and get tested as well, at first he denied, but after encouraging him he went and was found negative too. (semi-structured interview, female #6)

In another semi-structured interview, a married man named Steven explained how he perceived HIV testing to be compulsory during pregnancy and per the doctor’s authority, he
Interviewer: On HIV/AIDS, have you ever discussed about it?
Steven: Yeah, this is a difficult issue and not a difficult issue. When we felt that we were trusting each other we discussed it. I bore two children, the issue now came during the pregnancy with this child, the third one. The doctors told her that whether you like it or not you have to be tested for HIV. We discussed it, “Ok if the doctors say that you need to do it, we have to” since they gave us motivation. She was tested and found negative. We have a VCT centre but we haven’t gone there for testing. So when my partner came with the results [from antenatal testing], I also went and got tested. I was negative. (semi-structured interview, male #5)

Succumbing to the advice of health care professionals who make testing difficult to refuse—instead of their wives—allows men to maintain their masculinity and household power. As noted in Chapter 4, men who obeyed every command of their wives could be seen as “been given a love potion” and looked down upon by their peers. Of course, both antenatal testing and couples’ testing carry their own set of barriers and costs. In an effort to avoid HIV infection, sometimes more dramatic strategies are required, including the option of leaving a dangerous partner altogether (refer to Schatz 2005 for other examples; Reniers 2005).

**Relationship Dissolution as a Fallback Strategy**

Divorce, separation, and breakup are not ideal alternatives. But if all else fails, it may be an effective strategy to avoid HIV infection in the absence of testing. In the southern region of Malawi, divorce rates are among the highest in the country with around 33% of all marriages ending before their 5th year anniversary (Reniers 2003). In her article entitled, “Take your mat and go!”, Schatz (2005) discusses how women will leave partners who refuse to reform their sexual behavior and threaten to bring HIV into the household. The exchange of meaning through interactions with a spouse or partner around HIV testing may provide another piece of information to use in decisions to leave a troublesome or risky partnership.
According to both men and women from five focus groups, refusing to test was grounds for terminating the *chibwenzǐ* and possibly the marriage because of its association with promiscuity. Many people believed that a person with nothing to hide would openly agree to go for testing. As previously mentioned, the refusal to test signifies sexual immorality: a trait that was highly undesirable in a potential spouse. Married people were not as worried about a partner’s sexual past as they were about their partner’s current sexual indiscretions—and the danger these actions presented to the family’s wellbeing. Overall, these beliefs about dissolution emerged in every type of focus group (women, men, married, dating). In the following passage, a single man commented on how relationships dissolve in his village when a partner refuses to test:

In the village where I am living, when people are dating they talk to each other about HIV testing and go for testing. In this case were by one is afraid of going for testing, the relationship ends there. Because it is taken as though she does not have enough trust on his/her partner. (FGD #3, single men)

In another conversation among single women, everyone agreed that if a man refused to test with his girlfriend, the relationship would end immediately since he was most likely concealing something about his sexual past.

Interviewer: That woman [another focus group respondent] has said that the two should go for testing. They have just started dating, the two should take each other and go for HIV/AIDS testing to see or know about their status. That is what she is saying. What if the man refuses?

All: It is going to end there.

Man #2: That just shows that there is a reason and that is why the man is refusing. (FGD #5, single women)

One married man told the story of how men set “traps” to catch women in cheating by asking her to test and then divorcing her if she refused because of her presumed unfaithfulness. He said, “When the man says we should go for testing, maybe the woman
refuses. But the refusal of the woman means the man has set a trap that if she refuses, I should [will] tell her that the marriage has ended.” (FGD #6, married men) It is unclear from the data, however, about whether the same strategy is common among women with their unfaithful partners. Furthermore, while breaking up with a chibwenzi who refuses to test may be feasible, divorcing over a partner’s unknown HIV status and presumed infidelity may be significantly more complicated—especially when children, land, and other marital assets are involved. For those who do, it is plausible that the decision to divorce over testing was just one piece of evidence in a couple’s larger story around infidelity and HIV infection.

Discussion

Rural Malawi is a setting where HIV risk is at constant odds with other important life and reproductive aspirations. What I presented in this chapter reinforced the notion that social responses to HIV testing programs go beyond perceptions of risk and are strongly influenced by factors at the couple level such as communication, love and trust, and what an HIV test means for the future of the relationship. I argued that for these young couples who are just beginning their sexual and reproductive lives, an HIV test is more than a marker of HIV serostatus; it also symbolizes the relationship status. Similar to what others have observed for condoms, HIV testing may violate core ideals around love and trust that couples strive for in their relationships (Chimbiri 2007; Tavory and Swidler 2009).

Bringing up testing. Refusing to test. Testing together as a couple. These testing behaviors provide a few examples of the symbolic acts that rural Malawians use to evaluate their current circumstances and react accordingly. As the data in this chapter illustrate,
Malawians do not dismiss the benefits of HIV testing altogether nor do they embrace it wholeheartedly. Instead, they actively responded to the HIV testing enterprise and created meaning around the act of testing that fits with their local realities. As they interacted with each other, rural Malawians utilized the local symbols and signs associated with the act of HIV testing as tools to simultaneously navigate the AIDS epidemic and their futures.

These conclusions are consistent with the association found in Chapter 5 using the quantitative TLT couples dataset. Couples with higher levels of unity were less likely to test for HIV as compared to others with lower levels of unity in their relationships—because they see less reason to do so. The narratives in the current chapter also suggest the presence of another possible association between mistrust, specifically the perception that a partner might be cheating, and increased rates of testing. Surprisingly, the quantitative analysis failed to find a strong association. Mistrust may still be a contributing factor, but could be less important as compared to the other factors in the model.

The social construction of gender is continually evolving in Malawi as notions of rights, unity, and tradition are contested at the local level. As social norms around gender, relationships, and HIV testing take on new shapes, rural Malawians are forced to grapple with how to make sense of this for their everyday lives. Therefore, a decision to test may be best understood as a process that involves constant evaluation of one’s circumstances as the world changes rather than an isolated event that occurs at one point in time. The process of creating new understandings was not straightforward either. Often, respondents invoked these three narratives in a contradictory fashion; for example, respondents believed that
people have the legal right learn their status at individuals, but should still follow cultural traditions and embrace unity with their loved ones. Men and women had to therefore walk a fine line as they attempted to balance imported western values around human rights with the preservation of local values and beliefs.

One particularly interesting finding was the overemphasis on the role of unity in testing decisions for married couples as opposed to single people. Why were respondents so adamant that married couples test together? In her study of dual-income earning families in Los Angeles, Linda Garro (2011) argues that studying health as a part of family life reveals the centrality of a socially embedded and relational view of health as “family well-being” that coexists with health construed as an individual-level concern. Regardless of which partner is the breadwinner and homemaker in Malawian marriages, both spouses depend on each other—just in different ways in order to meet their life aspirations and daily needs. This family or unity orientation carried over into their perceptions about how HIV testing should be undertaken. Among respondents, there was an overwhelming need to consider the broader couple context rather than just the individual when it came to HIV testing—yet this was not without its challenges. Indeed, there were times when unity could not win over a reluctant partner who was unwilling to test. Here, rural Malawians suggested the use of alternative strategies to navigate their risk for HIV while maintaining the very relationships so important to people’s livelihoods.
Public Health Implications

The narratives covered in this chapter suggest that there are important implications for public health related to the disconnection between the meaning of “risk” at the policy level and what it means to rural Malawians. Epidemiologists define risk as “the probability of a disease occurring in people exposed compared to the probability of the disease in non-exposed people.” (Gordis 2009). Rural Malawians are well aware that the exposed condition referred to here is related to “immoral sexual behavior”—but this is something that many people are not willing to own up to by having an HIV test. Early on in the epidemic when testing programs were rolled out in rural Malawi, prevention messages and mass-media campaigns may have inadvertently undermined their own initiatives by emphasizing the need for testing among people deemed to be a “high risk” for HIV, notably, commercial sex workers. Among rural Malawians, there are still strong attachments to the idea that HIV testing is only for people who exhibit these behaviors. Today, however, Malawians are targeted with public VCT advertisements containing vaguely worded phrases like “know your status” (I emphasize the “your” here) in an attempt to de-stigmatize the act of testing. Indirectly, these messages are appealing to the human right to know one’s HIV status.

But this is problematic for several reasons. First, as respondents in this study emphasized through their perceptions and experiences, HIV testing is not always considered an individual-level decision, especially during marriage. For some people, it was difficult to disentangle the individual from the married couple. There is an overwhelming need to
consider the couple context when targeting the average individual and their personal liberties and freedoms.

Second, western ideas of routine screening for disease are likely to conflict with local health beliefs shaped by the current health care system in Malawi. In the US, for example, there is strong public health advocacy around disease prevention and health promotion—which is based on the argument that it is more clinically- and cost-effective to treat infection earlier in the disease course. In settings with good access to screening and treatment services, people are more likely to see the value in prevention and early detection of disease. In Malawi, however, people required strong reasons to initiate HIV testing when they did not perceive that there were problems. HIV testing can be expensive, time-consuming, and requires much planning and calculation to ensure that the benefits outweigh the costs (Beardsell and Coyle 1996; Fylkesnes et al. 1999). Furthermore, AIDS-related concerns may simply not make the list of top priorities (Dionne, Gerland, and Watkins 2013). During the time when VCT was the primary diagnostic approach, Malawians often delayed learning their HIV status until they were very sick (Hatchett et al. 2004).

Globally, there have been increasing calls for universal access to effective HIV prevention, treatment, care, and support (UNAIDS, 2010). Specifically in Africa, Bunnell and Cherutich (2008) argue for the urgent scale-up of HIV testing with an emphasis on couples and a goal of universal coverage. In theory, the provision of universal testing could circumvent an otherwise exceptionally complex negotiation process for both women and men who desire to know their status. Advances towards universal testing are currently
underway in Malawi, starting with the mandatory screening for HIV of pregnant women seeking antenatal care (Office of the President and Cabinet and National AIDS Commission [Malawi] 2003). In addition, a new policy in Malawi referred to as “Option B+” allows all pregnant women who test HIV positive to be placed on ART for life regardless of their CD4 counts or clinical stage (Schouten et al. 2011). Despite this progress, widespread access to testing and treatment in the general population—especially among men—is far from a reality. Economic, logistical, and infrastructural limitations continue to impede progress towards universal coverage of HIV and AIDS services in Malawi.

Other public health implications of this chapter are noteworthy. Although rural Malawians generally possess high levels of knowledge of HIV/AIDS transmission (Watkins 2004), there are local nuances to these beliefs and understandings. Three additional insights gained from this chapter are relevant for public health and could be incorporated into new HIV testing media campaigns and programs, particularly:

- Perceptions of a shared serostatus among couples
- The belief that HIV status is an absolute indicator of marital fidelity
- Acceptance of antenatal care testing among men, when suggested by a health professional

The first two relate to risk. As described in Chapter 2, it is well documented that individuals use perceptions of their partner’s risk of HIV to inform perceptions of themselves. Although, their assessments of each other are not always correct (Anglewicz and Kohler 2009). Additionally, many people believe a person can become infected through a single
sexual encounter with an HIV positive individual; however, the likelihood of infection from one sex act is actually quite low (Gray et al. 2001). In the current study, respondents also believed that married couples share a single corporal body, at least in the symbolic sense. Given these beliefs together, it was not surprising to hear that people subscribed to the idea of a shared serostatus among married couples who presumably have had unprotected sex with each other—and regularly. Indeed, in most couples who are seroconcordant negative, they share a common HIV status. However, when one couple member tests HIV positive, it would be mistaken to assume that the other is HIV positive. The data presented in Chapter 5 showed that of those with actual HIV status data, 88.8% of respondents were seroconcordant (HIV positive or HIV negative), but only 12.2% were serodiscordant. These findings are, of course, biased in the fact that most people tested HIV negative and thus most couples would be seroconcordant by default. Yet in instances where at least one partner tested positive, couples were more likely to have different statuses than to both be positive (12.2% compared to 5.5%).

Similar to how people overestimate their chances of HIV infection, they were more likely to assume that if a spouse tested positive, it was because she or he became infected from an extramarital partner. In line with these beliefs, it would only make sense that HIV testing could be employed as a sure way to confirm a partner’s infidelity—and serostatus. Men knew they could win back a suspecting wife if they showed her a negative test result, as if saying, “I was faithful to you.” Along the same vein, husbands could refuse to go for
testing if they were indeed cheating and assumed that a positive test result would seal their fate with their wives.

Overall, these findings provide additional evidence for the broader understanding that local beliefs about risk and how risk is manifested at the couple level are important considerations for why people may accept or refuse to test. As others have argued (Anglewicz and Kohler 2009), it may be necessary to consider risk from the couple rather than individual level when improving HIV testing regimens in sub-Saharan Africa. In addition, counseling messages should work to clear up some of the more common misbeliefs about a shared serostatus and high transmission probability through extramarital sex.

HIV interventions should proceed carefully with more effective strategies to increase HIV status knowledge. There is currently an ongoing shift in Malawi—and within the region more broadly—from patient-initiated testing to routine, provider-initiated testing in all health care clinics. Tremendous advances (at least from a public health standpoint) have been made in the antenatal care sector to increase rates of testing among pregnant women, although not always in accordance with women’s and their partner’s desires to test (Angotti, Dionne, and Gaydosh 2010). On one hand, antenatal care testing allows couples to circumvent power issues around rights and tradition in their own relationships by shifting authority to the health care system level. Yet significant pressures are placed upon women to test during pregnancy to the point where they often forgo their rights to test in order to protect the health of their unborn children. While this is certainly not ideal, and in fact conflicts with the very notion of human rights, growing pressure for men to test through the
antenatal care sector may help to curb growing gender disparities in diagnosis, care, and treatment.
CHAPTER VII
IMPLICATIONS AND FUTURE DIRECTIONS

Theoretical and Policy Implications

Bertrand Russell observed that, “the fundamental concept in social science is power, in the same sense in which energy is the fundamental concept in physics. Like energy, power has many forms” (1938, as cited in Murphy and Meyer 1991). While it has been widely acknowledged among scholars and public health practitioners alike that power is multidimensional and varies by locale, the leading discourse on gender inequality and HIV/AIDS in sub-Saharan Africa continues to perpetuate a portrayal of overly dominant men paired with subordinate women—who have presumably little control over their lives. Beyond the influence of colonialism in the region, politics and a culture of altruism among western donors and policymakers may be partially to blame. Watkins and Swidler (2012) write that, “Western donors imagine women as poor and weak, victims who urgently need empowerment so that they can “just say no” to unsafe sex and thereby turn the tide of the epidemic in sub-Saharan Africa.” The data from this dissertation indicate that these depictions do not fully capture the nuances and complexity of power or instances of female agency and may have unintended consequences for men who fear being blamed as transmitters of HIV to their seemingly innocent wives.

Conceptions of power in this dissertation move our understanding of gender relations in an entirely new direction—away from relying solely on problematic stereotypes of gender towards the idea that power may be better understood as an dynamic factor related to the
couple itself. Using a unique combination of numbers and narratives, I found that the notion of unity—embodied by aspects of reciprocity, communication, trust, and love—emerged as a key construct in the measure of power for Malawian couples. Indeed, the statistics were supported by rural Malawians’ own voices about what makes them feel powerful in their sexual relationships. I believe that unity as a source of power goes beyond the receipt of social support to include intimacy—a broad term that consists of fertility, love, marriage, and sexual pleasure (Hunter, 2010). Though the relationship unity measure does not capture all aspects of intimacy as defined here, future studies can take what was learned in this dissertation to expand the unity construct more fully.

The reconstruction of power as something that is inextricably tied to the union largely diverges with how others have typically conceptualized and measured power in this region using constructs such as male dominance, control, or decision-making dominance. Perhaps research has been blinded by a western lens that fails to consider the nuances of gender and power relations in Africa. In an exception, Mbweza and colleagues (2008) found that men and women used a combination of gender-based cultural scripts (e.g., “husbands are the head of the household”) and non-gender based scripts that emphasized harmony and open communication to explain how decisions are made in everyday life. In the current study, respondents invoked similar cultural scripts to emphasize men’s legitimate authority to the household leader role (which I called tradition narratives), but when interviewers probed deeper about whether men could sell basic household possessions without their wife’s permission, they responded with “she will divorce me”—thus, emphasizing the need for
This suggests that there are important lessons to be learned from the differences between how people talk about gender in terms of ideals and how these ideals may be actualized in everyday life. Truly grasping the complexity of gender relations may require an ethnographer or a persistent interviewer to be able to tear away the layers of ideals and socially desirable conceptions of gender to find out what happens in real life.

Of course, everyday reminders of the female vulnerability/male dominance paradigm still reverberate across the Malawian gender landscape. Respondents told stories of men beating up their wives or secretly engaging in an extramarital love affair. Respondents also suggested the presence of many double standards around sex, infidelity, and autonomy that granted men privilege, but punished women for the very same behaviors. I do not intend to dismiss the importance of these findings. Malawian women continue to face many difficulties negotiating the terms of their relationships and navigating societal boundaries around gender. But at the same time, respondents provided examples of “docile” men who had been given love potions by their wives or respectful men who considered their wives’ opinions in family matters. In contrast to other studies that illustrate a more absolute or clear-cut gender hierarchy, the qualitative data from this dissertation paint a very different picture; one marked by shades of gray, uncertainty, and a state of flux rather than fixation. Through the use of different narratives around tradition, unity, and rights, rural Malawians actively debated with each other in a public forum about how men and women should behave. Through this process, there was much contestation and contradiction around the meaning of gender. Thus, I believe that a “one-size fits all” paradigm rooted in either
extreme position—that women have no agency or that women have unconstrained agency—is problematic given that gender relations are more likely to fall somewhere along the continuum at any given time.

**Final Conceptual Model for Relationship Power and HIV Testing**

I would like to briefly summarize the model building activities in this dissertation. Grounded theory was used not only as an approach for the qualitative phases, but as an overall theory-building method for this dissertation. First, I started with a preliminary model based on three social structures of the TGP: the sexual division of labor, the sexual division of power, and social norms or cathexis. Three constructs comprised the preliminary model of power: socioeconomic inequalities (division of labor), relationship violence (division of power), and relationship dominance (division of power). After running factor analyses, two additional aspects of power emerged: unity and discordance. The discordance factor was later deconstructed into separate measures of relationship violence (which I had already included) and mistrust/infidelity (new construct). In Chapter 4, I used grounded theory to inductively study aspects of relationship power not accounted for by the TGP. Through this process, rural Malawians illustrated that unity was an important component of relationship power. The measure of power now consisted of socio-economic inequalities (division of labor), relationship violence (division of power), relationship dominance (division of power), unity (cathexis), and infidelity (division of power). In Chapter 6, I again used grounded theory with qualitative data to inductively study how relationship factors influence HIV testing behavior. This process confirmed the importance of the constructs of unity and
infidelity (trust) in shaping HIV testing behavior. Future model testing activities could collect new measures related to unity to further unpack its underlying characteristics, which I believe includes aspects of love, intimacy, reciprocity/social support, and communication.

The final conceptual model that could be tested is presented in Figure 7.1.

![Figure 7.1: Final Conceptual Model on Relationship Power and HIV Testing Behavior](image)

Mixed support was found for the Theory of Gender and Power (TGP) in explaining HIV testing behavior (as indicated in Table 7.1). An important limitation of the TGP is that it takes on a western feminist perspective that emphasizes women’s vulnerability to HIV/AIDS as a result of patriarchal, male dominant social structures. There was some
support found for the economic dependence theory, that is, women with less economic power in the relationship would be less likely to test. For men, more education as compared to a partner resulted in a higher likelihood of testing. Economic factors related to division of labor were less important for disclosure. Although for men, being in an economically balanced relationship (a dual income earning relationship) increased the likelihood of men’s disclosure—perhaps by creating more unity in the relationship around labor.

The findings do strongly support the role of relationship unity in HIV testing behavior. Couples-based interventions that target everyday relationship factors may provide more immediate results as compared to longer term, economically-based approaches, especially for couples who just need to learn the right negotiation and communication skills. Findings from this dissertation also highlight the continued need for gender-based violence mitigation among both men and women, which should be incorporated into any unity-building exercise. Couples with high levels of discord who are not already protected by unity may need customized attention coupled with other structural approaches that address the root problem.

It is also interesting that male dominance actually facilitated HIV testing among women. If this is true, then we need to be cautious about assuming that traditional gender-based power structures are inherently problematic for women and men. There may be aspects of male authority and cultural legitimacy that are advantageous when it comes to health seeking behavior. Future programs should harness the positive aspects of masculinity to encourage
the adoption of health behaviors (also noted by Mankowski and Maton 2010) and not necessarily attempt to change them to fit with western notions of rights and equality.

Rural Malawians may be more likely to voluntarily test for HIV when they perceive problems in the relationship than when there is harmony. This is a good thing; we want people who are deemed to be at higher risk to be more likely to test. At the same time, the fact that decisions to test are based on subjective perceptions—which are highly imperfect—means that people are likely to fall through the cracks and perhaps present themselves at health clinics only after they have started to exhibit the physical signs and symptoms of AIDS.

Provider-initiated testing offers one promising solution to circumvent unreliable risk assessments if it can be done in a way that seriously considers the couple context. Additional training of clinicians and HTC counselors may be warranted in order to increase their sensitivity to issues around trust, intimacy, and the aftermath of status disclosure, and to encourage couples’ HIV testing. In instances when couples’ testing is not easily accessible, strategies that continue to increase rates of testing among women antenatal care or health services—without applying equal efforts to men—could create new gender disparities and ethical issues for women. Thus, partner recruitment will continue to be an essential approach to target men through the pathway of their wives.
<table>
<thead>
<tr>
<th>Number</th>
<th>Prediction and TGP construct</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypothesis #1: HIV testing uptake</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1A</td>
<td>Socio-economic disadvantage deters individuals from testing (division of labor)</td>
<td>Some support. Women: being significantly younger than a partner limits uptake of testing; being unemployed with an employed partner limits uptake of testing. Men: Being the older partner limits uptake of testing; being the more educated partner facilitates uptake of testing.</td>
</tr>
<tr>
<td>1B</td>
<td>Male dominance prevents individuals from testing (division of power)</td>
<td>Support found among men and women, but in the opposite direction of hypothesis (male-dominance, more testing).</td>
</tr>
<tr>
<td>1C</td>
<td>Physical and sexual violence prevents individuals from testing out of fear (division of power)</td>
<td>Physical abuse: no support found for men or women. Sexual abuse: Men who were sexually coerced were less likely to test. Women were more likely to test.</td>
</tr>
<tr>
<td>1D</td>
<td>Relationship unity creates a supportive environment for testing (catheysis)</td>
<td>Support found among men and women, but in opposite direction of hypothesis (more unity, less testing)</td>
</tr>
<tr>
<td>1E</td>
<td>Mistrust/perceived infidelity limits uptake of testing (division of power)</td>
<td>No support found for men or women.</td>
</tr>
<tr>
<td>1F</td>
<td>Perceived risk for HIV (self and partner) may be a barrier to testing.</td>
<td>Some support for men and women; higher risk, less testing.</td>
</tr>
<tr>
<td><strong>Hypothesis #2: HIV testing disclosure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A</td>
<td>Socio-economic disadvantage deters individuals from disclosing test results (division of labor)</td>
<td>Some support for men. Men in dual-income earner relationships were more likely to disclose.</td>
</tr>
<tr>
<td>2B</td>
<td>Male dominance prevents individuals from disclosing (division of power)</td>
<td>No support found for men or women.</td>
</tr>
</tbody>
</table>
Table 7.1, continued

<table>
<thead>
<tr>
<th>Number</th>
<th>Prediction and TGP construct</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2C</td>
<td>Physical and sexual violence prevents individuals from disclosing out of fear of the consequences (division of power)</td>
<td>Physical abuse: Barrier to disclosure among men and women. Sexual abuse: Men who were sexually coerced were less likely to disclose.</td>
</tr>
<tr>
<td>2D</td>
<td>Relationship unity creates a supportive environment for disclosure (cathexis)</td>
<td>Support found for both men and women; more unity, more disclosure.</td>
</tr>
<tr>
<td>2E</td>
<td>Positive individuals will be less likely to disclose if they perceive their partners to be HIV negative</td>
<td>Support found for men and women.</td>
</tr>
</tbody>
</table>
While HIV testing during marriage was deemed problematic, testing during the courtship phase of the relationship was mentioned as an important relationship ideal. On one hand, this finding opens up possibilities for new HIV testing and counseling programs. Youth and couple-friendly services should continue to target young people before they get married as they are negotiating the terms of their relationships. While at the same time, it is important to cautiously emphasize to young people in premarital partnerships that a one-time test is not enough to prevent HIV.

**Future Directions**

The findings of this dissertation provide a solid foundation for future studies that seek to understand how the relationship context shapes HIV testing behavior. The next phase would be to build and test a more inclusive theoretical model using the unity construct as the foundation. Given that relationship unity was somewhat of an unexpected finding from both the quantitative and qualitative data analysis, a logical next step would be to develop and collect new data related to unity, particularly, trust, intimacy, love, couple collaboration and reciprocity, sexual pleasure, respect—and other constructs that emerged as salient sources of power in the qualitative sources. Taking a strong gender-centered approach would help to ensure that the model held for both men and women. Similarly, there are likely to be better ways to capture the idea of marital discord and its connection to infidelity, punishment, and violence using multi-item scales instead of single-item measures. Validated scales exist for many of these constructs and their use would first require adaptation to the African context. A small pilot study among young couples using these existing scales for unity and discord
could yield a fully tested and validated model that could later be applied to larger study populations. This model could then be used to develop a couple-based intervention that harnesses the unity in primary partnerships in order to increase rates of individual or couples testing for HIV.

Several other areas of research could arise from this dissertation. First, more exploration is needed of repeat testers and how the relationship context influences regular use of HIV testing services. Second, it would be useful to examine how changing relationship patterns or characteristics over the course of the relationship motivates or constrains decisions to test for HIV. Individuals change over time, but so do their relationships. In this study, I used relationship factors mostly at one point in time to predict future testing, however, many of these factors are likely to shift over time as well. Second, this study did not explore the depth of people’s HIV testing history. For example, in the semi-structured couple interviews, respondents were mostly asked about testing in their current relationship. Qualitative research using life history methodologies could yield additional individual, relationship, and structural patterns of influence on HIV testing behavior as they evolve over the life cycle. Third, it would be novel to examine how relationship factors in secondary relationships, e.g., with an extramarital partner, influence decisions to test. Multiple concurrent partnerships was a topic of great concern, however, respondents were not asked to provide details on these relationships—despite the fact that they are likely to influence HIV testing behavior within the primary relationship.
Conclusions

In western settings such as in the United States, the public health approach to HIV/AIDS emphasizes prevention and early detection of disease. Health promoting and health-seeking behaviors only occur if individuals are motivated to do so. As such, public health interventions for HIV/AIDS rely heavily on individual responsibility and community engagement in order for them to be effective. With client-initiated HIV testing in Malawi, the underlying assumptions are largely similar. But what if Malawians simply do not see the value in HIV prevention and treatment services? In a recent study in rural Malawi, Dionne and colleagues (2013) note that although AIDS has been treated as “exceptional” and a priority issue over other development problems, Malawians perceived other problems in their communities as being more pressing matters. Even people who were HIV positive prioritized resource allocation to clean water, agricultural development, and general health services over HIV/AIDS services. As part of the same study, the authors also used a set of ethnographic journals that captured people’s everyday conversations and found that economic survival was the most frequently discussed topic. Conversations about “domestic matters” such as marriage, family, and children also surpassed the number of conversations about HIV/AIDS.

These data combined with the findings of this dissertation suggest that people are forced to make decisions about HIV testing in light of other competing priorities related to marriage, childbearing, and basic economic survival. HIV testing policy and programs cannot divorce individuals from their broader social context simply for the sake of increasing the
numbers of testers and decreasing the rates of transmission. Pushes towards the human “right” to know one’s status will only be meaningful if the social environment supports it. Otherwise, it exists only in the imaginations of western policy makers with grandiose visions of how HIV/AIDS services *should* function in sub-Saharan Africa. Approaches that emphasize unity over rights may elicit a better response at the local level given the importance of this relationship ideal and source of power for Malawians themselves.
REFERENCES

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UNAIDS. 2006. HIV testing and counseling. Geneva: UNAIDS.


APPENDIX A

Relationship Power Scale Items

Preliminary Relationship Power Scale

Autonomy Subscale:
1. Under no circumstances would I ever leave my partner.
2. If my partner were to leave me, I would be in serious trouble.
3. If things were really bad with my partner, I would leave the relationship.
4. If my partner failed to meet my needs, I could easily find another partner.

Communication Subscale:
5. My partner and I sit down and discuss important matters together.
6. My partner shows that they care about me.
7. If I suspect my partner is having an affair, I would talk with my partner.
8. I would consult with my advisors (or friends) if my partner was behaving badly.

Love and Trust Subscale:
9. When I need my partner's assistance, he/she is always there to help me.
10. I initiate sex with my partner when I want to have sex.
11. I am able to buy expensive items without my partner's approval.
12. I have my own money to buy things I want.

Relationship Dominance Subscale:
13. My partner punishes me when he/she is really angry with me.
14. When I disagree with my partner's relatives, my partner chooses their side over mine.
15. My partner is probably having sex with someone else.
16. If my partner was really angry with me, he/she might beat me.
Final Relationship Power Scale

Unity Subscale:
1. My partner and I sit down and discuss important matters together.
2. My partner shows that they care about me.
3. When I need my partner's assistance, he/she is always there to help me.

Discordance Subscale:
1. My partner punishes me when he/she is really angry with me.
2. When I disagree with my partner's relatives, my partner chooses their side over mine.
3. My partner is probably having sex with someone else.
4. If my partner was really angry with me, he/she might beat me.
APPENDIX B

Semi-Structured Interview Guide

Relationship Power and HIV Testing in Rural Malawi

Participant must have a primary partner to be eligible for this interview.

Introduction: Introduce yourself, and state your name and affiliation (University of Colorado)

Purpose of interview: We are trying to learn more about decision-making, power, and sexual behavior within romantic relationships in Malawi. Relationship dynamics can affect the health of both men and women and so this new information will help us to understand what relationship factors affect health.

Consent: Would you be willing to participate in our study? Also, would it be ok if we tape record our conversation? If at any point during this interview you wish to stop the tape recorder, we can do so. (Obtain written consent and provide a copy of consent form to participant).

1. INTRODUCTION
Thank you for taking the time to participate in our research on relationships and HIV/AIDS in Malawi.

➢ Are you from this village?
➢ How long have you lived here?
➢ Are these your children?
➢ How many children you do you have?

2. RELATIONSHIP CHARACTERISTICS
Now, I would like to talk with you about your romantic relationship.

➢ How long have you been with your spouse or partner?
➢ How did you and your spouse or partner meet?
➢ What attracted you to him or her?
➢ For non-marital relationships:
  ▪ How serious would you say your relationship is?
  ▪ Do you think this partner could be your husband/wife one day?
  ▪ Are you dating anyone else?

3. DEPENDENCE
➢ Before we talk specifically about your partner, can you tell me what an ideal partner or spouse would be?
Does your partner meet these ideals? Why or why not?
What does your partner do that makes you happy? What frustrates you? Can you give me examples?
Probes:
- Tell me about the things your partner gives you. When does your partner give you these things? The last time you saw your partner, did he/she give you anything?
- What do you do when your partner does not give you what you want?
- Do you feel like you have to stay in this marriage or relationship?
- If your partner were seeing someone else, what would you do?

4. RELATIONSHIP CONTROL
I would like to talk with you more about your partnership or marriage.

- Do you feel “free” in your relationship? Why or why not?
Probes:
- Are you able to do the things you enjoy? What do you enjoy? Can you give me examples?
- Does your partner ever tell you where you can go, who you can be friends with, or what you should wear? Are there certain things your partner tells you to do or not do?
- Do you feel that you can talk with your partner about anything?
- When you do something your partner does not like, how does he typically respond?
- When your partner does something that you do not like, how do you typically respond?

5. DECISION-MAKING
- How do you and your partner decide on important things in your relationship?
Probes:
- Are decisions made as couple or does one partner make most of the decisions?
- What types of decisions do you have more say in, what types of things does your partner have more say in? (finances, childbearing)
- Do you need to consult with your partner on certain types of decisions?
- Do you and your partner/spouse talk about sex?
Probes:
- Who decides when you have sex, use condoms, or the types of sex positions?
  How do you feel about this?

6. CONDOMS
- Tell me about a conversation you and your partner had about condoms.
Probes:
- Do you and your partner like condoms? Do you use them?
- Do your friends and neighbors use condoms?
- What do you know about condoms and HIV/AIDS?

7. ALCOHOL USE
   - Do you and your partner drink alcohol?
   - How does alcohol affect your relationship?
   Probes:
   - What usually happens after one of you (or both of you) has been drinking?

8. RELIGION
   - What religion are you? What church do you belong to?
   - Is your husband religious? What religion/church does he practice?
   - What does your church tell you about sex, HIV/AIDS, and condoms? Do you agree with this?

9. HIV TESTING
   We are now going to talk about your thoughts and experiences with HIV testing. This information will help us to understand how relationships affect HIV testing and will remain completely confidential.
   - Have you and your partner discussed getting tested for AIDS? Tell me about what you talked about.

   If YES, ask:
   - Why did you decide to get tested?
   - How did you feel about getting tested? Afraid?
   - What did you think your test result would be before testing?

   If NO, ask:
   - Have you ever considered being tested for HIV? Why or why not?
   - Would you talk with your partner before being tested? Why or why not?
   Probes:
   - If your partner did not want you to be tested, would you get tested anyways?
   - How would your partner react if he found out you were tested?

   ***CONTINUE with interview if respondent was previously tested for HIV***

10. KNOWLEDGE OF HIV STATUS
    - Did you inform your partner of the test result? Why or why not?

    If informed partner of HIV test result, ask:
    - How did your partner respond to the HIV test result?
If did **not** inform partner of HIV test result, ask:

- Why did you **not** inform your partner of your HIV test result?

If tested together:

- What did you and your partner talk about after getting your test results?

In either scenario, ask:

- Has anything changed in your life since you learned your HIV status?

Probes:

- Have your beliefs or behaviors changed since testing? If yes, what has changed?
  - What caused these changes?
- How did you feel after receiving your test result? Surprised? Happy? Sad?

**11. CONCLUSION OF INTERVIEW**

- Is there anything else you would like to tell me? Are there any other questions that you have for me?
- Thank the respondent for their time.
- After turning off the recorder, ask the respondent about their impressions of the interview. What was it like to do this interview? Was it difficult or easy to talk about these things?
APPENDIX C

Focus Group Discussion Guide

Gender, Relationship Power, and HIV Testing in Rural Malawi

Principal Investigator: Amy Conroy
University of Colorado Denver
HSRC No: 10-0861
Rev: 3.0, Rev Date: July 25, 2011

PART A: Questions on power within couples

First, I will ask you some thought-provoking questions on relationships.

1. Can you describe the perfect relationship? Probes: What makes a good wife (girlfriend)? What makes a good husband (boyfriend)? What are the most important things that men/women get out of their relationships? What is most important when choosing a marriage partner (or a chibwenzi)? Note: if “love” comes up, ask: what does it mean to love your partner?

2. What happens when couples disagree on an issue? Are men/women free to bring up their issues with their partners? What about if the issue is serious, for example, if a man/woman is having sex with another person?

3. What does it mean to be “the head of the household”? Probes: Do women expect men to be the head of the household? Can women ever be the head of the household? Under what circumstances?

4. What makes a man/woman feel powerful in their relationships? Probes: How does a person know if they have power in the relationship? How much power do you think men and women should have in their relationships?

5. In Malawi, gender empowerment programs help to make women and men equal. For example, women now work in jobs that were once only for men (give examples). Because of working and education, women are becoming more independent/gaining freedom. Probes: Has women’s power changed because of gender empowerment? How does it affect relationships? How do men feel about this?

6. Does men’s/women’s power in the relationship change after marriage? How so? Probes: Do men take on a different role once they are the head of the household?
What is now expected of a wife/husband once they are married? Does sex change after marriage? How so?

PART B: Vignettes on HIV testing

Thank you very much for your responses. Now, I will present a series of scenarios on HIV testing will be presented for discussion. These are completely hypothetical situations, but we want to know what you think the individual should do in the given situation. Also, please let us know if you think this scenario would never happen in the first place so we can revise the scenarios to better capture Malawian life. Again, please do not discuss your own personal experiences with HTC, just what you think the outcome of the situation will be and why.

Scenario #1:

Lucy is a 20-year-old married girl from the Balaka area. She wants to know her HIV status and goes to a VCT center to get tested. She hears rumors that her husband might be cheating on her. Does she need to get her husband’s permission before going? Why or why not? Could he prevent her from going to get tested? Suppose that Lucy never told her husband she was going for VCT and she ended up testing positive for HIV. Should she tell her husband? How do you think he will react? What if Lucy tested negative, should she still tell him? What will he think?

What if Lucy is not married, should she obtain her boyfriend’s permission before she goes? Should she tell him she is going for testing?

Scenario #2:

Promise is a young man from Balaka. He is worried about his HIV status. His uncle just died of HIV and Promise has not been feeling well himself for the past 6 months. He has been married for 3 years now and loves his wife. Should Promise tell his wife he is thinking of going for testing?

Scenario #3:

Suppose that Lucy and Promise are engaged to be married. Before they get married, they decide to go to HTC so that they can find out their HIV status. Lucy tests positive and Promise tests negative – they are told their results together in the same room. What could happen to their relationship after learning their status? Would it change, if so how? What if Lucy tests negative and Promise tests positive. Does this change their future together?

What if Lucy and Promise were married, not dating. Suppose Lucy is positive, Promise is negative. Would they stay together?
PART C: General reasons for getting tested

Do people go for VCT/HTC here in the Balaka district? What factors make people decide to get tested? What prevents people from getting tested?