

*Marital Power and Decision-Making Processes Regarding Voluntary Counseling and Testing for HIV in Rural Malawi*

Lauren Gaydosh  
University of Pennsylvania  
September 30, 2007

## **Introduction**

In response to the staggering AIDS pandemic in sub-Saharan Africa, many governments, policy organizations and non-governmental organizations recommend the scaling-up of voluntary counseling and testing (VCT). The motivation for the provision of VCT is the assumption that knowledge of HIV infection will lead to behavioral changes in both HIV-positive and HIV-negative individuals, which in turn will benefit overall health as well as preventing further transmission or infection (AVERT 2006). But why do some people agree to a test while others refuse? And how do they tell their sexual partners, if at all? Disclosure is particularly relevant in sub-Saharan Africa, where heterosexual intercourse is the most common mode of transmission. This paper examines the communication and role of the spouse in the VCT decision-making processes of married couples in rural Malawi. The data come from an unusual source. Unlike previous examinations of couples selected from VCT clinics, the data here are interviews with married couples who had been offered VCT in their homes in the course of their participation in a population-based survey that offered VCT. Using these data, this paper explores how husbands and wives decide to accept or refuse HIV testing and the extent to which spouses influence each other's decisions to be tested.

This paper is rooted in theories of marital power, patriarchy, and bargaining, but with attention to the specificities of marital relationships in sub-Saharan Africa, and, more specifically, in Malawi. Guided by the key conceptual framework of marital power, it is then possible to examine the decision-making processes of married men and women in the context of the HIV epidemic, and infer how the AIDS epidemic has influenced traditional marital power and decision making. I draw from interviews with both men and women address gender differences in motivations and decision making and to determine the role of the spouse in influencing this decision-making process. Finally, I consider the implications of my findings for the likelihood that couple VCT will come to be acceptable in rural Malawi. I begin by providing a brief account of the AIDS epidemic in sub-Saharan Africa and Malawi, in order to make the point that the severity of the epidemic points to the need for a better understanding of VCT and its potential for HIV prevention. I then summarize the literature on marital power and decision making as background for my analysis of the processes underlying the decisions to accept or refuse HIV testing. Following a discussion of interview methods and the data used for this paper, I present my key findings on the sources of women's marital power, married men's and women's decision-making processes, and gender differences in decision making, all in the context of HIV testing in rural Malawi. Finally, I present the implications of these results for couple VCT, and suggest that couple VCT permits a different decision-making process and a different way of sharing information between spouses. I then discuss the empirical findings in terms of HIV prevention and AIDS treatment, and in terms of the marital power and decision making literature. Thus, this examination of how couples negotiate whether to participate in HIV testing contributes to both policy and scholarship.

## **The AIDS Pandemic**

### *HIV/AIDS in sub-Saharan Africa*

With an estimated 25 million adults and children living with HIV/AIDS in 2005, sub-Saharan Africa is the region most severely affected by the AIDS epidemic (UNAIDS 2006). Approximately twenty years since the first case of HIV, the epidemic has contributed to a decrease in the average regional life-expectancy from 50 years in 1980 to 45.6 years today (The World Bank Group 2006). Not only does this decline decrease the available labor force, furthering the economic pressures in these developing countries, but it also increases the burden on households and communities caring for orphans and the elderly. As AIDS strikes adults in their most productive years, households lose income earners, further impoverishing the poor. Oftentimes husbands die first, leaving widows to provide for the family with severely limited resources available to them. Considering the debilitating effects of the disease on the populations and societies of the most affected nations, the UN Security Council declared AIDS a global security concern in 2000 (Security Council 2000).

The dynamics of the AIDS epidemic in sub-Saharan Africa also differ vastly from the Western understanding of AIDS as a disease of high-risk populations, such as men who have sex with men (MSM) and injectable drug users. In contrast, the main mode of transmission in sub-Saharan Africa is heterosexual intercourse. While initially this was seen to be primarily sexual relationships outside of marriage, and especially those of “core” or “high risk” groups such as commercial sex workers and truck drivers, more recent studies have emphasized transmission in marriage.

### *HIV/AIDS in Malawi*

Malawi is a small country in the southeast region of Africa neighboring Mozambique, Zambia and Tanzania. Following independence from British colonial rule, Malawi experienced nearly thirty years of one-party rule until multi-party democracy was declared in 1993. Presently the nation of Malawi is ranked the sixth poorest nation in the world, according to the World Bank (The World Bank Group 2006). Of a population of about 10 million, approximately 86% live in rural areas, dependent primarily on subsistence farming supplemented by cash crops and wage labor (NSO 2005). Malawi ranks among the nations with the highest HIV prevalence in the world. Currently approximately 14-15% of the Malawian population aged 15-49 is living with HIV/AIDS (NSO 2005). Since Malawi's first recorded AIDS diagnosis in 1985, AIDS has become the leading cause of death among adults aged 15-49, with more than 500,000 Malawians dying of AIDS since the beginning of the epidemic (Yoder and Matinga 2004). 13% of women aged 15-49 are infected, compared with 10% of men (NSO 2005). In Malawi, as elsewhere in SSA, the ratio of male to female infections is particularly striking and has often been noted. In Malawi, young women aged 15-24 are four times more likely to be infected than their male counterparts – 9% for women versus 2% for men (NSO 2005). Nationally 83% of married couples are concordant HIV-negative, 7% are concordant HIV-positive, and 10% are HIV discordant (one partner is HIV-positive while the other is HIV-negative) (NSO 2005).

### *Response to the Epidemic*

Prevention has been considered to be the most realistic approach to combating the epidemic in SSA, with programs focused on disseminating advice to abstain or to be faithful, or, failing that, to consistently use condoms. Recently, however, voluntary counseling and testing (VCT) has come to be seen as a critical part of any national prevention program, and in the last five years VCT programs rapidly expanded throughout sub-Saharan Africa.

The explicit purpose of VCT is to provide individuals with HIV testing and health counseling at little or no charge. The motivation behind the provision of VCT is that knowledge of HIV status is expected to cause behavioral changes in both positive and negative individuals by increasing individual knowledge of the virus, available treatment and health care options. This knowledge should in turn prevent further transmission or infection (AVERT 2006). Advocacy for provision of VCT and expansion of existing VCT programs rests on several assumptions; VCT efficacy depends on the assumption that people want to be tested for HIV, and that those who want to be tested will go to the VCT center. Also, once people learn their results, advocates assume that those who are HIV-negative will work towards reducing risk behavior in order to remain HIV-negative, and that those who are HIV-positive will avoid infecting others. The counseling segment of VCT informs attendees of ways to avoid infection, prevent transmission, and stay healthy while living with HIV, which many believe will quell the rising rate of new infections (Coates et al. 1998; Painter 2001). VCT is most often administered on an individual level, particularly in prenatal care clinics, with few opportunities for married couples to be tested and counseled together.

In Malawi, the efforts at HIV prevention and treatment began in 1988 with the founding of the National AIDS Control Programme (NACP) - later to be replaced by the National AIDS Commission (NAC) – as a governmental effort to promote health education and HIV prevention (Yoder and Matinga 2004). In 1990, NACP began monitoring AIDS infection through the testing of women at urban antenatal clinics; in 1994 the monitoring was extended to rural antenatal clinics. There are now 19 antenatal clinics with HIV testing throughout the country. However, this service obviously only attends to women and children. Other testing options available include government sponsored clinics, private clinics, and three Malawi AIDS Counseling and Resource Organization (MACRO) testing facilities. Since the 2000 Ministry of Health and Population approval of rapid blood testing kits, MACRO, a non-governmental organization sponsored by the Center for Disease Control, has experienced a dramatic increase in its number of clients. However, rapid testing is only permitted on a limited scale and the Ministry of Health and Population has been reluctant to approve expanded use.

In late 2005, the Ministry of Health in Malawi, funded by the Global Fund for HIV, Malaria and Tuberculosis, began scaling up both VCT clinics and anti-retroviral treatment (ART) centers. The District of Mchinji, which is the site of this study, has nine VCT clinics for a population of with a population of 380,000 people in an area of 3,400km<sup>2</sup>. While testing is free, oftentimes clinics are far from villages, requiring a bus ride, a day away from work, and money for transportation and food. There is also the possibility that the clinic will be closed, or have such a long line that those at the end of the line seeking testing are told to return another day. For these reasons many respondent

in my studies said it was impossible to get tested. Moreover, ART is only available at the District Hospital, necessitating another, and usually longer, trip. Distance, while an important barrier to testing, is not the only barrier: many do not even seek testing--even when a research project in rural Malawi offered VCT in respondents' homes, some refused. Thus, a central question addressed in this paper is why some are motivated to travel to health facilities to be tested and why some are not, and what seems to be responsible for the gender differences. Given that the vast majority of those infected are married, I focus on the decision-making processes within marital couples.

### *Couples*

In the context of societies such as Malawi where virtually everyone marries and a high proportion are currently married, and where the epidemic is heterosexual, it seems likely that couple VCT would have a greater effect than individual VCT. It is known that married (and previously married individuals) are more likely to enroll in VCT than never-married people, and that both members of a marital unit rarely come at the same time. Yet we know virtually nothing about why one spouse comes and the other doesn't, or whether the spouse who is tested shares his/her testing results with the other spouse. VCT advocates rely on attendees sharing their results with intimate partners in order to reduce transmission, but virtually no evidence exists to support this assumption (Glick 2005).

In an attempt to address these issues, an emerging trend in VCT services is the provision of couple counseling. It is suspected, however, that couple counseling is particularly difficult because of stigma surrounding the open discussion of intimate details about the relationship between man and woman, especially within marriage (UNAIDS 1999). Although the research on couple VCT is limited, there is some that suggests the importance of partner input in decision making concerning testing, treatment, fertility, mother to child transmission prevention, and how to manage the results (Allen et al. 2003; Baiden et al. 2005; Bunnell et al. 2005; Painter 2001). In particular, husbands strongly influence women's view of the acceptability of VCT, and women with involved husbands are more willing to get tested, and more frequently express the intention of sharing results with their partners (Baiden et al. 2005). The overwhelming majority of those tested express the desire to learn their results in the presence of their partners (deGraft-Johnson 2005).

Couple VCT attendance presents one of the most interesting and unexplored aspects of HIV treatment and prevention. From the perspective of efforts to prevent HIV transmission, discordant couples are thought to face particularly difficult challenges. A basic one in Malawi, and probably elsewhere, is that the understandings of the epidemiology of HIV are such that it is considered almost impossible that one spouse is infected but the other is not (Watkins et al. 2007). When this happens, it is expected that there will be accusations of infidelity. And, of course, serodiscordant couples have to manage their sexual relations with each other, which may increase tensions in the relationship. There is also some evidence that gender matters in the resolution of tensions over discordant results. One resolution is divorce (Watkins 2004; Reniers 2003, 2005). Another resolution is condom use. In a study of HIV-discordant couples in Zambia, couple VCT prompted "sustained but imperfect condom use in the year following enrollment". Interestingly, HIV-positive husbands were more willing to

comply with condom use than HIV-negative husbands, suggesting that men have more control over sexual behavior within marriage (Allen et al. 2003; see also Allen et al. 1992a, 1992b; Baggaley et al. 1997).

### **Marital power and decision-making**

While a comprehensive examination of the literature on marital power and decision making is well beyond the scope of this paper, it is important to outline the theories advanced by the field in order to frame the current study.

#### *Marital Power*

Power, as described by Weber, is the ability to exercise one's will even in the face of resistance by others (1946). Marital power is a term popularized by Robert O. Blood Jr. and Donald M. Wolfe in their book *Husbands and Wives: dynamics of married living* (1960). In their examination of Detroit wives, Blood and Wolfe establish resource theory, stating that the partner who possesses a greater share of the resources within the marriage will have greater power in spousal decision making (1960). The authors outline eight areas of decision making patterns – husband's choice of job, car, life insurance, vacation, housing, wife's working, physician, and food budget – and from these indicators generate a decision making score (Blood and Wolfe 1960). While their work laid the foundation for marital power and decision making literature, Blood and Wolfe concentrate only on American couples and focus on economics.

Following the work of Blood and Wolfe in 1960, marital power scholarship gained popularity in the 1960s and 1970s. Particularly notable, Hyman Rodman's theory of resources builds on Blood and Wolfe, claiming both resources and norms operate within a cultural context which influences the relative power of spouses (1972). Resources alone do not guarantee marital power. With the introduction of the cultural and social influences on marital power and the movement away from exclusive focus on resource theory, many studies emerged testing the hypotheses set forth by both resource theory and Rodman's theory (Burr, Ahern, and Knowles 1977; Denton 2004; Godwin and Scanzoni 1989a; Godwin and Scanzoni 1989b).

The biggest weakness of the marital power and decision making literature is its almost exclusive reliance on quantitative data. Most often researchers directly ask spouses in a survey setting how they view their ability to get their way in marital decisions, who makes the decisions in the household, and if they feel the decisions are made by consensus (Denton 2004; Godwin and Scanzoni 1989a; Godwin and Scanzoni 1989b; Hindin 2002). There is virtually no information on the conversations spouses have concerning important decisions, such as HIV testing, or how spouses influence each others decisions. The scholarship also remains firmly in the realm of theory, and there are few examples of applied theory or real life examples (Monroe et al. 1985; Rollins and Bahr 1976). The lack of detailed information leaves much to be desired in examining the decision-making processes of married couples.

In addition to the methodological shortcomings of the marital power literature, the present body of knowledge mostly concerns American married couples, and largely ignores the institution and social interactions of marriage in other nations, particularly developing nations. The few studies that apply marital power and resource theory frameworks in a developing country context rely again on broad quantitative data without

much detail of processes at work (Hindin 2002; Warner, Lee, and Lee 1986). The qualitative interviews for this paper provide detailed insight into the individual and joint decision-making processes of married couples in rural Malawi, a perspective rarely offered in the resource theory literature.

### *Patriarchy and Bargaining*

Before examining husbands' and wives' decision-making processes and relative marital power it is first necessary to explore the patriarchy inherent in the institution of marriage. In a general sense, patriarchy refers to the asymmetrical distribution of power in favor of the male. For the purpose of my discussion I rely on Therborn's definition patriarchy as consisting of two dimensions: the rule of the father and the rule of the husband (Therborn 2004). The data for this paper consist of interviews with married couples; therefore I will consider only the rule of the husband in my analysis.

The rule of the husband is manifested in three components: the presence or absence of institutionalized sexual asymmetry, which is evident in polygyny or different adultery laws; marital power hierarchy; and heteronomy or a woman's lack of autonomy under her husband (Therborn 2004). The analysis set forth in this paper focuses on the patriarchy evident in marriage and does not consider instances of patriarchy institutionalized through state structures or aid institutions. Instead it pays particular attention to marital power and reported heteronomy.

In her trailblazing article "Bargaining with Patriarchy", Deniz Kandiyoti explores the ways in which women strategize under the constraints of patriarchy in order to maximize their autonomy (Kandiyoti 1988). Kandiyoti argues that different forms of patriarchy can be identified "through an analysis of women's strategies in dealing with them" (Kandiyoti 1988: 275). This identification works conversely as well, because different systems of patriarchy dictate various strategies women employ in bargaining. Women "strategize within a set of concrete constraints that reveal and define the blueprint" of what Kandiyoti terms, "the patriarchal bargain" (Kandiyoti 1988). According to Kandiyoti, all women operate within this system of bargaining and, depending on the severity of the system of patriarchy, their strategies differ. This framework is helpful in conceptualizing the complicated decision-making processes of married couples and the ways in which spouses attempt to influence each other's decisions.

Following the publication of Kandiyoti's article various authors examined the bargaining strategies within different patriarchal contexts. Kandiyoti herself compared the sub-Saharan African form of patriarchy to the "classical patriarchy" of the Middle East and Asia, also known as the "patriarchal belt". In Kandiyoti's analysis, women in sub-Saharan Africa have more bargaining power and relative autonomy than women in the "patriarchal belt", despite the institutionalized forms of patriarchy such as polygyny present in sub-Saharan Africa (Kandiyoti 1988). However, most articles utilizing the framework of Kandiyoti's patriarchal bargain focus on the "patriarchal belt" and women's strategies under fundamentalism (Gerami and Lehnerer 2001; Haj 1992; Moghadam 2004). In Iran, Gerami outlines four strategies women use in bargaining with patriarchal state policies: subversion, or undermining these policies; co-optation, or manipulating these policies; acquiescence, or submission to these policies; and collaboration, or active support of state policies (Gerami and Lehnerer 2001). The

strategies of acquiescence and collaboration become particularly important under severely limiting constraints when cooperation is essential for survival.

The trail following Kandiyoti's framework has not been restricted to the "patriarchal belt", but is echoed in the work of Arlie Hochschild and Nancy Folbre in their discussions of women's labor in the United States (Folbre 2001; Hochschild 1989, 1997). Perhaps because bargaining theory draws its roots from economics, much of the work generated around Kandiyoti's patriarchal bargaining has focused on the strategies women employ to maintain or maximize their economic power. This is not only true for research in the United States, but is also apparent in analyses of women around the world, including the nations of the "patriarchal belt" and sub-Saharan Africa. With the expansion of the global economy, women in Southeast Asia have been pushed outside the household; the economic pressure forces women and men to negotiate with patriarchy in a way that permits women to engage in wage labor and yet maintain some resemblance to the traditional, familiar system of gender hierarchy (Feldman 2001; Haj 1992; Moghadam 2004). Conversely, with the interference of outside donors and companies, the women of sub-Saharan African have been challenged to defend their existing economic power and prevent the seeping in of patriarchy (Burgess and Beilstein 1996; Guy-Sheftall 2003; Kandiyoti 1988; Omorodion 2004)

#### *Marital Power and Decision Making in SSA*

The existing research on marital power and decision making in the sub-Saharan context revolves around two main topics: women's autonomy and fertility decision making. Most of the research conducted on women's autonomy concentrates on women's economic power and bargaining in agricultural work (Burgess and Beilstein 1996; Kandiyoti 1988; Wooten 2003). With the forces of globalization influencing the continent, much work has examined how the infringement of development impacts women's lives and work (Burgess and Beilstein 1996; Omorodion 2004; Wooten 2003). Burgess details the obstacles women must face in successfully breaking into the marketplace, and categorizes their strategies as "collective action, participation, skills development, interventions by change agents, and influence by women's movements over states" (Burgess and Beilstein 1996). Omorodion explains the interaction of development and patriarchy; "Development makes patriarchy a local and international tool for advancing male economic interests and power at the expense of that of the female population" (Omorodion 2004: 11-12). Undoubtedly women in sub-Saharan Africa face patriarchal constraints in the formal and informal economic sector; however, there is little knowledge about women's bargaining strategies outside their economic productivity, especially in the context of marriage.

There has been great activity in the context of marriage surrounding fertility and marital decision making in sub-Saharan Africa. Nancy Folbre draws a connection between women's fertility and economics, arguing that, "The social relations which govern human reproduction often reinforce the domination of women and the exploitation of women's labor" (Folbre 1983). Agadjanian extends this connection, uncovering the influence of women's work environments in Mozambique to their fertility decisions (2000). He finds that women in isolated work environments are less likely to use contraception than women in interactive work environments, emphasizing the importance of women's social networks on their bargaining strategies (Agadjanian 2000).

Within marriage fertility decisions must be negotiated, and they provide a unique opportunity to examine the decision-making processes and bargaining of husbands and wives. Recent research has gravitated towards an examination of men's role in fertility decision making (Agadjanian 2002; Bankole and Singh 1998; DeRose and Ezeh 2005; Hollos and Larsen 2004; Kaida et al. 2005). Most studies conclude that men's desires override the desires of their wives, and men maintain almost complete power in fertility decision making (DeRose, Dodoo, and Patil 2002; Dodoo and Tempenis 2002; Ezeh 1993; Hollos and Larsen 2004).

More recently there has been an attempt to examine the complex interaction between men and women in deciding how many children to have, when to have another child, and when to use contraceptives (Blanc and Wolff 2001; DeRose, Dodoo, and Patil 2002; Dodoo and Tempenis 2002; Maharaj and Cleland 2005; Salway 1994). There are limited findings that women indeed influence men's decision making (Bankole and Singh 1998; Feyisetan 2000; Thomson 1997) Most frequently reported marital communication increased likelihood of joint decision making and contraceptive use (Bankole and Singh 1998; Feyisetan 2000). However, even under optimal circumstances such as increased spousal communication, greater education, higher income, there is no evidence that women have *greater* autonomy over their reproductive decisions than their husbands (Feyisetan 2000; Hollos and Larsen 2004).

Despite the growing body of knowledge on couples' fertility decision making in sub-Saharan Africa, the research which focuses on both men and women is overwhelmingly quantitative and does not reveal whether a complex process of bargaining and negotiation within marriage even exists. When both information on both the husbands and wives is available, the data offer a surface view of men and women's approval and use of contraceptives (DeRose and Ezeh 2005; Maharaj and Cleland 2005; Renne 1993). The research determines decision making through correlations between expressed fertility desires and actual rates, which leaves the question of how couples reach their decisions (Bankole and Singh 1998; DeRose, Dodoo, and Patil 2002; Dodoo and Tempenis 2002; Salway 1994). We cannot tell from the existing research what conversations occur between spouses and if and how these conversations influence their decisions. In addition, the existing research fails to examine the effect of HIV/AIDS on the decision-making processes of individuals or couples, and instead uses contraceptive use as an indicator of risk-reduction (Blanc and Wolff 2001; Grieser et al. 2001). The dearth of knowledge of marital power and bargaining extends beyond fertility, and reveals a gap in the knowledge of marital relations in less-developed nations.

### *Strategies and Decision Making in the Context of HIV/AIDS in Malawi*

The AIDS epidemic in Malawi has acted as a catalyst in motivating Malawians to adopt new strategies and decision-making processes in their everyday lives (Watkins 2004). Ann Swidler describes this type of catalyst in her book *Talk of Love*: under the stress of intense social disruption, "people use culture to organize new strategies of action and to model new ways of thinking and feeling" (2001: 94). This concept is widely understood and explored in contemporary research on the repercussions of the AIDS epidemic. Most work focuses on new strategies adopted in an effort to minimize risk (Reniers 2003, 2005; Schatz 2005; Smith and Watkins 2005; Watkins 2004; Zulu and Chepngeno 2003). Reniers considers the motivation for the adoption of marital strategies

such as spousal communication, selection of low-risk partners, and divorce amongst Malawians, proclaiming: “The life threatening character of AIDS and the absence of a cure are plain and unmistakable incentives” (2005:1). Watkins uncovers a similar pattern, revealing that Malawians modify external prevention prescriptions concerning sexual behavior to fit their own culture, consequently developing new prevention strategies (Watkins 2004). While it is evident from the existing scholarship that Malawians indeed modify their culture in response to the AIDS epidemic and create new strategies, there has been little attention to the strategies and decision-making processes of married men and women.

Straddling the literatures on marital power, decision making, bargaining with patriarchy, and VCT efficacy, this paper examines the marital power and decision-making processes of married couples in rural Malawi in the context of HIV testing. In a departure from the existing information of women’s marital power, the specific context of the AIDS epidemic transforms the usual sources of women’s marital power in Malawi. While drawing from the relevant decision making literature, the decision to accept or refuse HIV testing and counseling sets itself apart from other decisions married couples must make due to the severity of the epidemic in Malawi. This paper examines why married men and women accept or refuse HIV testing and counseling, and how they influence each other’s decisions, as well as gender differences in decision making. Using qualitative interviews combined with quantitative information, this paper offers new and more detailed insights on the ways spouses negotiate their decisions under the added stressor of the HIV/AIDS epidemic.

## **Methods and Data**

Data for this paper come from qualitative interviews conducted in the Summer, 2006 alongside an ongoing longitudinal project, the Malawi Diffusion and Ideational Change Project (MDICP). MDICP examines the role of social networks in changing demographic attitudes and behavior, particularly HIV and sexual behaviors. MDICP began in 1998, focusing on two original questions: the roles of social interactions in the acceptance (or rejection) of modern contraceptive methods and of smaller ideal family size, and the diffusion of knowledge of AIDS symptoms and transmission mechanisms and the evaluation of acceptable strategies of protection against AIDS. At the start of MDICP in 1998, one district was randomly selected from each region of Malawi – Rumphu in the North, Mchinji in the Central, and Balaka in the South. The original MDICP sample consisted of ever-married women and, if they were currently married, their husband. In subsequent rounds new spouses were added, and an additional adolescent sample was drawn in 2004. The central district where the qualitative interviews were conducted, Mchinji, has approximately 1,400 respondents.

In 2004, MDICP added the collection of biomarkers to the project, and respondents who consented were tested for HIV and three other STI’s in their homes, with post-test counseling subsequently offered in mobile clinics (tents). In 2006, HIV testing was again offered at respondents’ homes; respondents were given a choice of receiving post-test counseling and results at their home or at a mobile clinic. More than 3,500 individuals were tested, and virtually all of those who chose to receive their results did so at their homes. The biomarker collection in 2004 included the administration of delayed-results HIV test. With advances in technology, in 2006 MDICP offered in-home

rapid-blood testing for HIV in a procedure known as home testing and counseling (HTC), a modification of the voluntary counseling and testing model (VCT). Upon completion of the main survey component of the study, respondents were offered VCT, and a random sub-sample was offered couple VCT. In Mchinji, 1,041 respondents participated in the VCT provided by MDICP, an acceptance rate of 91.9%.

It is important to consider whether people indicated they were pressured by the MDICP to agree to testing. In the interviews, one of the most unexpected motivations that both men and women cited for accepting VCT is desire to please the research team or an obligation of their participation in the project. This was never the only reason cited for acceptance, but nevertheless it was an important influence. A woman who refused because of her husband's reluctance describes her desires to participate: "Yes. I do not want to get out of a group that I was already included...But the program that is there is that those doing the testing when they come, then they should test us. We should be included in the research" (48008~24~07~06). Another woman describes her desire to comply with the research, "Because for us to refuse no, we thought that it would be bad for us to refuse, but accept it because we got involved in the research a long time ago. And so let us just follow this. Yes. If they will find it with us or they will not find it with us no problem, but let us just accept it. Indeed" (45011~17~07~06). The respondents obviously feel an obligation to the research project and were willing to comply; it is unclear whether or not respondents felt their future inclusion in the project was predicated on their VCT participation. It is also unclear whether or not participants believed in the goals of the project and respected the team and therefore felt compelled to participate. One woman likens her feelings for the efforts of the project to her religious sentiments:

It is you right to get your blood tested because if the government is bothering about this disease of Aids then it is your right to get your blood tested so that you know how you are. It is also the same that these people are giving you some encouragement that may be if you are fine in your body then you should stay well. Now by refusing you trying to show that you are just like the one refusing God's commands because if God says please no sins us people say no. Yes we more like indeed listen when we are at the church but after church we go and to sinful things. And so it is the same with you. If you are refusing these people then it is like you are refusing God too (45511~17~07~06).

Regardless there was no case where the respondent expressed personal reluctance or unwillingness to participate but pressure from the project to comply.

With the provision of in-home rapid testing, MDICP provides the opportunity to compare opinions on both methods of testing. The interviewers were subsequently able to ask the concrete situation of VCT rather than abstractions about traveling to the local clinic; respondents explained why they accepted or refused testing, not why they had or had not traveled to the clinic, which provides much better information on decision making surrounding HIV testing. The provision of VCT in 2006 afforded me the unique opportunity to study married couples within the context of HIV testing. The data for this paper are drawn from 45 in-depth interviews conducted in Mchinji with married couples

who had been approached for VCT. Ideally I would I have liked to include equal numbers of different types of couples, such as couples who refused VCT, those who were couple counseled, concordant positive and concordant negative couples, and discordant couples. However, the lower prevalence in this region resulted in a limited pool of HIV-positive individuals and this over-sampling of HIV-positive individuals was not possible. When the sample was drawn, 422 individuals had been approached for VCT, and only 1 couple was found to be concordant positive and only 7 couples were found to be discordant.

The qualitative sample included 25 couples selected from those first 422 individuals. Of these 25 couples, 21 complete couple interviews were conducted, where both the husband and wife were interviewed; 3 individual interviews were conducted when the other spouse could not be located after several visits; and 1 couple was away at the hospital for several weeks. No one refused to be interviewed. Of the 21 complete couples, 5 had at least one partner who had refused VCT. Of the remaining 16 that were tested, 1 couple was concordant positive, 10 were concordant negative, and 5 were discordant. In an effort to examine the differences or similarities between couple VCT and individual VCT, of the 16 couples who participated in VCT, 9 were individually tested and counseled, and 7 were couple tested and counseled.

The semi-structured interviews were conducted in Chichewa, the native language of Mchinji, by trained local interviewers. The interviews were conducted in Chichewa and tape recorded; subsequently, a few days following the interview the interviewer simultaneously translated and transcribed the interviews into English. There were 2 interviewers, 1 female and 1 male, who individually interviewed the wife and husband, respectively. Between two and four weeks following the VCT component of the study, the respondents in the qualitative sample were approached at their homes for participation in the qualitative study. Interviews ranged between thirty and seventy-five minutes, most running around forty-five minutes. Interviewers loosely followed an interview guide which covered five major themes: social networks, response to in-home rapid-testing, reasons for consent/refusal, projected behavioral change, and partner roles. In addressing social networks, interviewers attempted to learn what respondents talk about with their friends, neighbors and families concerning HIV testing. The response to in-home rapid-testing component elicited personal and community reactions to the introduction of in-home VCT as opposed to clinic VCT. The most fruitful theme was reasons for consent/refusal, and these responses provide the foundation for the analysis in this paper. While the behavior change component was meant to capture projected changes in sexual behavior, the interviews instead illuminated past and current behavior of both the respondent and his/her spouse as a key factor in VCT decision making. Finally, through the discussion of reasons for consent or refusal of VCT, the influence and role of the spouse became apparent. The translated and transcribed interviews were coded along these five themes using NVivo Qualitative Research Software.

In this paper I focus on the major themes of reasons for VCT consent/refusal, behavior as it relates to marital decision making and spousal influence. These themes are illustrated using transcript excerpts. All names have been removed from the transcripts and, on occasion, replaced with aliases to preserve confidentiality. Where present, the letter I: refers to dialogue spoken by the interviewer, where the letter R: refers to dialogue spoken by the respondent. I added words in brackets to clarify the meaning of the

passage, make it easier to read, or retain Chichewa words and provide approximate translations. The word *kachilombo* is never translated; the word means the virus that causes AIDS, or literally translated, “fearsome beast”. When translating, interviewers were instructed to stick as closely as possible to the literal English translation, not to embellish the words of the respondent, or to correct for incorrect grammar. Pauses, laughter, and external noises were reported as well, helping to retain a conversational flow in transcribed text.

## **Results**

In the conceptual framework that guides this paper, marital power dictates how decision making operates, why couples decide for or against testing, and the role of the spouse in this process. Finally, these factors have implications for couple-VCT. The following section therefore outlines the sources of women’s marital power in Malawi regarding VCT, moves to a detailed exploration of reasons for VCT acceptance and refusal, and finally, an account of gender differences in motivations for VCT decision making.

### *Conversations about VCT and Women’s Marital Power*

Conversations about the AIDS epidemic, worries and fears, strategies and HIV testing are frequent amongst most married couples, and women even initiate discussion, despite the popular conception of women’s limited autonomy. The interviews also provide rich information on the power dynamics of Malawian marriages. This section examines the conversations of husbands and wives concerning VCT and HIV/AIDS as well as the sources of women’s marital power within the patriarchal society of Malawi.

Overwhelmingly men and women report discussing HIV testing and the AIDS epidemic with their spouses, family, friends and neighbors. Oftentimes the conversations revolve around husband and wives’ shared vulnerability to infection and strategies they can employ within marriage to avoid contracting the virus. Women frequently remind their husbands of the necessity of fidelity. One woman describes her conversations with her husband:

Myself and my husband do talk indeed mainly as to how we can stay here in our home that you see the way things are. We were both tested the blood and found us that we do not have the *Kachilombo*, then it is important mainly on your part my husband let's try to change the behavior of being movious or maybe marrying other wives now, please change. These days are different days...Since you have two wives please let's stay like that just two. Don't start keeping your eyes above again that you should take another wife, no, or maybe you should be going out again with other women, no; because these days are not good days (40001~19~07~06).

In this example it is obvious how this woman understands her own serostatus as contingent on her husband. Married men and women frequently describe this shared fate and vulnerability. This conversation also reveals this woman’s relative marital power; she is able to confront her husband and talk openly about his sexual behavior, their HIV

status, and the need for change. Sometimes the women are more indirect—although their motive may be clear to their husband, as in the example: “Sometimes my wife could start the stories [discussion] of VCT, the thing is: she could start it as a way of rebuking me in case where I stay in town I go around with other women. She could stress that even if I don’t go around with other women, I should not even be having that desire to do so.” In bringing up the issue of testing and counseling, John’s wife Memory signals that she is dissatisfied and does not trust him. He knows that her conversation is about more than getting tested for HIV; in asking him to get tested, John’s wife implies that she doubts his behavior and is reminding him to remain faithful to their marriage. This reprimand is Memory’s way of wielding power and control within their marriage when she feels vulnerable and helpless to the behavior of her husband.

Memory’s initiation of discussion with her husband is not unusual; in fact, amongst the women in the sample, most report initiating conversations about VCT, HIV or sexual behavior with their husbands. Ruth, a woman in a monogamous marriage, describes her conversation with her husband following VCT:

In our discussion he said that, have you been told how you have been found in your blood? I said yes, then he said remember that you do suspect me. Then I said yes I suspect you because of how your movements are. That then makes me to be suspicious of you. Then he said no, you can just be suspecting somebody of some movements whilst may be one moves well. I cannot do something childish because I do not have a mother or a father. And so if I become childish, these kids will have no one to look after. That’s what we discussed and then I said well if you are saying the truth then may be you just indeed move without any problem. But if you are just saying this to cheat me then you will still get the disease. You will forget it that you do not have your mother, you will still get the disease. But if you do remember that you do not have your mother and father and so there is no one to keep your kids then if you do remember that may be you can avoid this disease.

Ruth is forward in her discussion with her husband because she realizes the serious risks he poses to her health. Ruth reminds her husband not only of her doubt but also of his promise to remain faithful. She cautions that if he is deceiving her and lying about his HIV status, he will infect her and leave their children without parents. In this example Ruth addresses the issues of HIV, fidelity, and testing, and reminds her husband of the risks of his deception. While Ruth does not see it as an immediate possibility to leave her husband if she believes he is unfaithful, she bargains within the constraints of her marriage and through conversation she optimizes her marital power, persuading her husband to abstain from sleeping with many women.

The conversations between husbands and wives are not always so confrontational or indirect; oftentimes the spouses express trust in each other and talk together about the steps they must take as a couple to protect themselves. There is an evident mutuality, reciprocity, and understanding of the necessity of marital cooperation in complying with

the advice of VCT counselors. One woman relays her and her husband's plans for the future:

Our plans are that we give each other some counseling in our house just as the people told us. We also give each other some counseling that now that they have found us like this, mh, we need to look after ourselves very much because this is something valuable that we were found like this without anything due to the way things are these days. Therefore we need to keep ourselves very much we give each other some counseling in the house. Yes. When you talk frequently, you find that the in the counseling you agree on what to do in the house. Mm.

I interpret this as suggesting that for this woman, her marriage and her communication with her husband is a source of strength and solidarity. In her frequent discussions with her husband she can reassure herself of his faithfulness, and they can strengthen their marriage by reminding each other of the value of their HIV-negative status. This status is something they see as needing protection, and through their communication as partners they can save themselves from the epidemic.

Within marriage both men and women must negotiate under the constraints of patriarchy. Unlike previous research on married couples, this study has the unique context of universal free voluntary counseling and testing. With the accessibility of HIV testing, women had the ability to maximize their marital power through different strategies unique to this moment. Women's strategies aim to eke out power from the existing system; some strategies emphasize women's control over their own lives and bodies, while others attempt to influence the behavior of husbands. Regardless of the type of strategy employed, women engaged with the system of patriarchy in their marriages and in their communities, and discovered new and creative ways to maximize their autonomy and marital power.

One of the most important sources of women's marital power is getting tested for HIV and knowledge of HIV results (recall that almost everyone who was tested received his/her results). One woman here referred to as Mercy, in a polygamous marriage with one co-wife, acknowledges her vulnerability due to her husband's reckless behavior and unwillingness to get tested:

I really talk to my husband that these days are different, we are in danger days, you will contract the virus. He then responds saying: "How can I keep goats when I have no strings, it better to leave the goats go". What does the irony mean? It means why should someone who is already spoiled care about dying: I am already dead looking at the way I have been going around with other women.

Mercy reveals her husband's fatalism, and believes he is dead already. He will not change his behavior, and he will not even confirm his doubts by getting an HIV test. Mercy is vulnerable to the behavior of her husband and her co-wife, and has no control over her own health. Frustrated with her husband's behavior and pessimism, Mercy decides to take her health into her own hands and get tested. In testing for HIV, Mercy is empowered by the knowledge of her status. She discovers that, despite her husband's

promiscuity, she is HIV-negative, and she has taken the initiative to settle her own mind and control her health. Mercy uses this knowledge to empower herself in her marriage, and continues to test herself every few years because, even though she cannot control her husband's sexual behavior, and she may not have the control to refuse sex, she can control her knowledge, and she stays in control by repeatedly testing herself.

Another source of marital power is evident in women's attempts to convince husbands to get tested for HIV. In the previous example, Mercy gets tested because she cannot control her husband's actions and must rely on herself. However, this bargaining strategy is limited because it does not protect the wife from infection. Some women extend their own decision to test and try to persuade their husbands as well. Mercy gets tested four times alone before her persistent reminders finally penetrate her husband and he accepts VCT. Reflecting on their recent testing, Mercy recounts her husband's sentiments:

But now when he met the VCT people and especially upon being tested negative he confessed that, "My wife you will never see me again going around with other women." He continued to confront me that, "I had a lot of worries before I got tested but now am happy because I know my status that am without kachilombo...But now that the VCT have tested me and [I] am alright you my wives, you shall never hear me again going around with other ladies. Now that am ok am walking as a proud man. And if I get the virus from now on, it means it's you my wives.

In convincing her husband to test, Mercy has increased her marital power because she no longer has to rely solely on her own HIV status, but can ease her worries on the negative status of her husband and co-wife. He also pledges his fidelity, but Mercy confides in the interviewer, "I don't know whether he really means it or not. I know not." Mercy's honesty reminds us of the limitations of her bargaining strategy and the persistent constraints of patriarchy.

Women's bargaining strategies are diverse, and not all lead to reduction of risk in terms of HIV transmission. Within the patriarchal society of Malawi, many women have limited control over the economic resources of their families. Under rigid patriarchy women must procure money from their husbands; if he refuses, the woman must look for alternative sources of income. Many turn to agrarian options such as raising livestock, selling eggs, growing and selling crops such as peanuts. Others turn to the more risky option, prostitution. Joyce describes these contrasting strategies:

Some say especially women that my husband is not giving me money then in order for me to have some I should do prostitution. But some say no I do not want to be promiscuous, I will be doing business I will be working hard in order to earn money like what I myself here do. I run some business like alcohol brewing. And sometimes when I do not have money I kill some livestock that I keep here or I sell some crops that I grow like groundnut. I grow and sell and so on and so forth. Now like that it is hard for one to think of prostitution because most people are doing

it for money. My husband has not given me money and so I will do prostitution and have my own money in my pocket. That is what is leading people into the grave. Umh. Yes indeed.

Joyce recognizes the economic limitations put on women and the creative strategies women employ in dealing with these constraints. While Joyce does not approve of the alternative of prostitution, she recognizes it as a common way of negotiating patriarchy within marriage. However, Joyce also recognizes the other valid, safe strategies of bargaining that she employs in order to make money, and deems prostitution unsafe and foolish.

### *Decision Making – Accepting VCT*

I now turn to examine how married individuals decide to accept VCT. The interviews conducted with married people following a visit by the voluntary counseling and testing team provide a unique insight into the decision-making processes of married men and women. From the interviews it is possible to better understand what motivates married individuals to accept or refuse HIV testing, and what influences their decision-making processes. Due to the fact that the interviews were conducted separately, a gender analysis of influences on decision making is also possible. This section details how married individuals make the decision to accept VCT, describing influences on both men and women.

Many men and women cite the necessity to look after their children as a reason for accepting VCT. Describing sleeping around with multiple partners as being “childish”, the diction men and women use represents a responsibility to act like an adult for the sake of their own children. One woman describes this sensibility, “I cannot do something childish because I do not have a mother or a father. And so if I become childish these kids will have no one to look after them” (45001~17~07~06). Her husband echoes, “Well it is now important, now that it is like this if you had any childish mind then you better change, because well look at here we have these children, and all these kids are looking upon us. And these kids need somebody to assist them. Now who is to assist them? It is us” (45501~17~07~06). Many parents find inspiration and courage in their role as caregiver, recognizing that protecting their own health in turn protects the future of their children. One HIV-positive woman describes the plans she and her HIV-positive husband make for her children:

And so it is important that we make a future for the kids may be yes death can come anytime and so kids who are orphans usually do suffer. We see them all around here, they are so may. And so if one can make a future for the kids that at the time you will be dying the kids should at least have somewhere to comfort them. That’s the plan that we have in our home now. That we should work very hard so that these kids should find a comfort (when we die). Yes (45011~17~07~06).

Getting tested and learning HIV status enables couples to protect their children by preparing for the future and ensuring the well-being of their offspring. Reluctant to leave their children as orphans, parents express the desire to be prepared for their own death if

they are HIV-positive; the best preparation is knowledge of “how I am in my body”, or health concerning HIV status.

Planning for the future in all aspects is a powerful motivation for getting tested. Many respondents said that knowledge of HIV status enables an individual to plan work for the coming seasons, motivates a family to save money for a new project, or allows parents to make provisions for the children’s future. This includes those who are HIV positive: A man describes a conversation with a fellow man, “And so he said, ‘The good thing is that when you know after testing that you do not have the Kachilombo, then you know how your body is and about the future that well, now I can do this if I can find some money and maybe make such such a plan so that it should help me in the future’” (45501~17~07~06). Not only do men and women think about these plans themselves, but they share these thoughts in conversations with others, helping to motivate and convince the people in their networks to get tested. The individuals who express this motivation describe knowledge of HIV status as essential; without knowing if one is HIV-positive or HIV-negative, a person cannot make plans for the future because uncertainty makes him/her feel such hard work will go to waste.

Interestingly, many men and women express the decision to accept VCT as made together as a “family”. One man explains when the counselors visited his house his wife was temporarily away, “So we [counselors and respondent] sat there and later they asked me whether it was possible for them to test both of us me and my wife. I told them its ok with me but I don’t know of my wife...Then I called my wife and we decided that we should be tested” (38708~21~07~06). Another man who initially refused testing explains his need to discuss the issue with his wife before making a decision:

This was for me and my wife to decide and ask ourselves whether its proper for us to undergo blood testing...That’s what I told you in the beginning that we have not been tested this time around (2006) because when they counseled us as a couple I told them that I need to sit down with my wife to discuss this issue whether to get tested or not (48507~24~07~06).

After discussing the issue with his wife they both decide to accept testing; a week following the qualitative interview they receive VCT. While this joint decision-making process might be a manifestation of shared marital power, it is necessary to consider the power of persuasion when one partner accepts. Both men and women explain the pressure to accept if their spouse accepts. When asked what she would have done if her husband refused testing, one woman explains:

R: I would have suspected and asked him why he has refused yes...

I: Okay. What if you refused and he accepted it. Would you have been able to say it that you do not want it?

R: Like myself I wouldn’t have been able at all. Yes.

I: Why wouldn’t you have been able to say it?

R: Because, I would have been the one to be wrong. Since he has already accepted it then me too cannot refuse it but also accept it. Yes... Because if I refuse then he will

suspect me and say how is she or may be what is she thinking about, why has he refused (45011~17~07~06).

While some couples may make the decision together, it is likely that most couples experience this pressure to agree if their spouse agrees. Respondents then are motivated by partners' acceptance; if the partner has nothing to hide or be afraid of, then the individual must also prove him/herself by accepting testing. A man asked the same question responds almost identically:

I: Let me say you agreed that I am ready, I will get tested. What if your wife had refused that she did not want, what would you have done?

R: I would have suspected her.

I: Can you explain further on that point.

R: Yes, I would have suspected her. Why has she refused whilst I have accepted it? What is it that she has in mind? Or maybe she is thinking that her relationship died because of this disease. There are so many things that I would have suspected her of. Indeed.

I: Okay. What if you refused but she accepted. What would have happened?

R: [She] too would have suspected me [Rooster crows] (45511~17~07~06).

Therefore spouses certainly influence each other in the decision to test. Not necessarily through force, but both men and women understand that accepting VCT signals fidelity and trust, and without reciprocation marital problems and distrust may result. Couples who refuse testing cite this marital discord as a reason for not getting tested.

#### *Decision Making – Refusing VCT*

The refusal rate for in-home VCT offered by MDICP was very low; of the total MDICP sample in 2006, only 9% refused VCT when offered. Therefore, while it was important to include refusals in the qualitative sample, there were only a few couples interviewed. Five couples were classified as refusals, meaning at least one partner refused VCT, were interviewed. In one of the five couples the wife refused VCT while the husband accepted. Overall, with the exception of one couple, interviews with refusal respondents were less interesting because of the respondents' unwillingness to talk candidly about HIV testing and their experience with VCT. For example, one woman even denies knowledge of the HIV virus and the AIDS epidemic, contesting:

I: But do you know that there is a Kachilombo of AIDS?

R: Mmm, I do not know it.

I: Ooh.

R: Mm.

I: You do not know that there is a disease of the Kachilombo of AIDS?

R: Mmm.

I: Really?

R: (Laughs) (63008~25~07~06)

It seems as if the interviewer doesn't believe the woman, and indeed it is unlikely that anyone in rural Malawi does not know about AIDS. In this case as in others, the reason for refusal is oftentimes superficial and unrevealing. Nevertheless, this section describes the reasons for refusal of VCT, particularly the role of the husband in influencing women's decisions.

One of the most frequently cited reasons for refusing VCT was the previous knowledge of serostatus. Respondents reasoned that because they had been tested in the past, and their behavior had not changed there was no reason to be tested again. A woman who refused together with her husband explains her participation in MDICP in 2004, her sero-negative status, and her refusal of VCT in 2006:

We were part of the group who went there, got tested and the results were explained to us there [in 2004]. They found out that I am fine together with my husband. However, this time I have not been tested...I refused to be tested because I saw that last time I was tested and I was found negative. Apart from that the counseling that I received there was enough and I took it all clearly. That's what I said to them [counselors] (70002~05~07~06).

Men and women alike express this rationale. Almost all who refused testing in 2006 had been tested previously, either with the project in 2004, or independently. Reasoning that because their behavior had not changed their status had remained the same as well, many refused what they saw as a superfluous HIV test. Most importantly, clearly implicit in these responses is the respondents' assumption that either their partners' behavior was always good and had not change, or that the partner changed behavior following testing which is not necessarily the case.

Despite the evidence presented earlier that women exert power in trying to influence their spouse to change his behavior or to agree to be tested, women who refused to be tested often cited their husbands' refusal as a reason for their own refusal. One woman describes this impulse, "The reason why I refused was that, you know I at first signed and accepted to be tested, but then my husband refused and said I do not see any meaning of this, whether I am tested, there is nothing that is going to help me whether they find it with me there is nothing I am to gain. Indeed" (74002~11~07~06). Her husband understands this, and explains, "In the first place she accepted, but she later said no because me as the head refused" (74502~11~07~06). This change of heart was frequent amongst refusals, where the wife initially accepted, but upon her husband's refusal also refused. In another couple a wife here referred to as Elisabeth, accepted the VCT, but when her husband refused she reluctantly changed her response:

I wish I could be tested but then if one's husband has refused then it is hard for me the wife, isn't it. I cannot just decide on my own that I will do this and that, no it is difficult. That is why we sat down and discussed that we should still get tested because there is no reason for us to refuse, no. But I really still wanted to be tested. Mm (48008~24~07~06).

Interestingly in this case the woman submits to the decision of her husband despite her strong desire to be tested. She explains that there is no option but to go along with her husband; many other women expressed this as well, stating that they would cause trouble in their families if they got tested and their husband did not. This was sometimes due to conviction that it is only helpful to know HIV status if it is known by both the husband and the wife; other times it was seen as impossible to go against the decision of the husband. However, as explained in the next section, Elizabeth may give in to her husband initially, but she persuades her husband over the period of several weeks and is finally tested. Elizabeth's example demonstrates how women negotiate within their marriage in order to satisfy both their husbands and themselves.

### *Gender Differences in Accepting and Refusing VCT*

As described in the section on accepting VCT, suspicion plays a powerful role in motivating individuals within marriage. Suspicion also manifests itself in another motivation for accepting VCT. While both men and women cite suspicion of their spouse's fidelity as a reason for getting tested, it is much more common for women to distrust their husbands. Both husbands and wives understand the shared fate of the couple; despite their personal actions, they are aware to the cruel reality that their HIV status relies on the actions of their spouses. One woman explains, "Of course a person knows what he/she does, like in my case I had no worries because I don't do bad thing, I don't do crooked ways. I just stay here at home. If anything since am married maybe my husband is the one who can give me Kachilombo" (49003~24~07~06). A man echoes this reality, "The main reason why going for test is how I see myself, the way I move I know myself that I don't like proposing women, but I have seen that I have a family, I don't know how my wife moves, but for my own sake and the way I move, I want to know how is my body" (45512~14~07~06).

Only a few men mention suspicion of their wife as a reason for getting tested, while most women cite their husbands' behavior as a reason for accepting VCT. Polygamy perhaps plays a great role in this because it is acceptable for a man to sleep with many women, but the reverse is not true. A man describes this double standard, "It's the man who is more free to move [sleep around]. And even if the woman is found committing adultery the marriage breaks, while if the husband similar things happen nothing is done" (48507~24~07~06). In addition, men oftentimes work outside of the home village or travel for jobs, leading wives to doubt what they do when working in the towns. One woman describes her husband's fidelity:

You know some men pretend to be good in terms of behavior at home while some start behaving badly from their home to wherever they go. I do not know this is done secretly maybe, I do not hear, yes. But at home his behavior is good and we stay well... But since he is a man and he goes for drinking as well and with his job as a carpenter such that sometimes he goes somewhere else to work, for example he has just spent a month at Chimwamkango. Then can I know how he was there?  
(38011202705~21~07~06)

Most women cite suspicion of their husband's infidelity as a motivation for accepting VCT. A woman in a polygamous marriage describes her husband's behaviors and her desire to get tested:

There was something which made me persist to go for VCT. I doubted of my husband. He runs too much. He got married to three wives. He has also been bringing his girlfriends... Sometimes when I am in, but sometimes when I am out he usually starts going for such other women and later on marries them. Even this co-wife he has now it started as a mere relationship, but later on here she is as a co-wife. In addition, he has another woman right in the village. Now because of his sleeping with many women, I had worries that I may contract the virus through him. There was something which made me persist to go for VCT. I doubted of my husband. He runs too much. He got married to three wives. He has also been bringing his girlfriends... I really see my husband as someone who likes marrying (86008~25~07~06).

This woman's story represents an extreme case of a typical wife's suspicions. Whether it is knowledge of other lovers and wives, or suspicion of infidelity, women recognize their own health depends on the actions of their husbands; because they cannot rely on the knowledge of their personal behavior as a predictor of HIV status, they must rely on testing. Therefore, VCT becomes not only an indicator of personal health but also of the fidelity of their husbands.

Women also frequently cite the support of their social networks as an influence on their decision to test. Conversations with other women strengthen their resolve and help give them the courage to learn their serostatus. The networks women cite include close friends and neighbors, as well as elder family members such as aunts, mothers, and grandmothers. One woman explains the support she receives from her aunt:

For example my mum over there, my elder mum (meaning her elder aunt in English) is the one who usually encourages me and says that even if you are frequently sick, if they test you and find that you have it please do not be very worried at all because this is now your second life. Because when you are told you now know how you are to live your life as to how you are going to take care of it. Yes, that's what she tells me indeed (38011202705~21~07~06).

Women influence each other to accept testing by their reassuring advice in open conversations about HIV/AIDS and testing. Women encourage each other to have courage and remain optimistic; even in the face of seropositivity, women remind each other of the benefits of knowing HIV status and learning how to live healthily. By sharing experiences, difficulties, and triumphs, the women create a strong network of support. Within the social network women are both recipients and providers of information and advice. Consequently, another motivating force behind accepting VCT is their ability to subsequently encourage other women. One woman explains, "For us

here in the village, we have women organizations where we stay together as women like the organization called 'women voice'...Advising each other that let us be faithful to our spouses in our families, let every wife have her husband alone when it comes to sex" (84005~25~07~06). This demonstrates the way women rely on each other and pride themselves on giving advice and strengthening their will, as well as protecting their own families and husbands.

While men rarely mention the infidelity of a wife, men often cite their wives' suspicion as a reason for accepting VCT. This is frequently paired with the admission of their own infidelity. Therefore, in an effort either to convince their wives of their fidelity or to assuage their personal fears of infection resulting from previous behavior, husbands agree to HIV testing. One man explains his initial hesitation and ultimate acceptance of VCT: "In 2004 I was not monogamous, not even my wife. But in the 2 years which has passed between 2004 till today 2006, as a man you can't deny to have slept with other ladies around, so this is what make me to be worried to accept [on the] spot. I asked myself in my heart to say: Will I be found ok?" (48507~24~07~06). Due to his infidelity this man is first hesitant and afraid to learn his serostatus, but later finds courage and decides he must know the effects of his transgressions. One man who was initially hesitant to accept testing because of his many girlfriends describes his change in perspective following his HIV-negative result:

I have learned something from this VCT experience. I even thought immediately to say, if it was possible to chase one wife away I would have chased my second wife to remain with only one wife, but the drawback is that can you chase someone who has not wronged you in any way? Because if I only remain with one wife, I may live long (86508~25~07~06).

While it is unclear, and perhaps even unlikely that this man will truly reform his sexual behavior after the initial elation of his results has worn off, it is clear that his infidelity was a powerful motivation which almost convinced him not to test, but ultimately inspired him to learn his results.

Recognizing their own infidelity as a source of their wives' vulnerability to infection, many men articulate their acceptance of VCT as an attempt to protect their families. Implicit in this motivation is husbands' sense of responsibility and authority as the head of the household. Conceptualizing their role as husband and father as the protector of the family, many men describe their acceptance as guarding the health and well-being of their family. One man explains the role:

Yes, many [women] have AIDS because of the unfaithfulness of their partners. Let me tell you that in a family, father is the head and mother and children are to listen from the father. Most of the time you will find that fathers are problems because if the father learns to be faithful, then too the whole family because father is the head, but if he is not faithful then the whole family will be affected...So fathers, we should take the role of being counselors in our families so that our families should not be

infected. A word that a father speaks in a house carries more weight (55506~11~07~06).

This example illuminates the role of the husband/father that is often implicit in men's explanation of decision making. In this instance the man expects husbands to take responsibility for their own actions and the health of their families. The strong patriarchy and norms regulating appropriate male behavior enforce VCT as an inflexible responsibility of the leader of the family. Ironically on one hand patriarchy endorses the infidelity of husbands while on the other it requires safeguarding the family through fidelity and HIV testing. Alluding to his own infidelity and subsequent desire to protect his wife, another man explains, "I did so [accepted testing] because most of us men we are victimizing women. Most of them have contracted the virus because of the unfaithfulness of the husband. That I strongly believe and I don't want that to happen to my family" (55506~11~07~06). In his last sentence this man exhibits his sense of responsibility to his family and understands his actions as protecting their health.

There are not only gender differences in reasons for accepting and refusing VCT, but there are also differences in how men and women persuade and influence each other's decisions. Women have particular expertise in persuading their husbands, especially in convincing them to accept testing. Many women describe the persuasive techniques they employed, either continually talking about VCT, stressing the importance of protecting themselves as a family, or reminding husbands of their duty as the head of the family. After describing her initial disappointment and refusal of VCT, Elizabeth recounts her conversations with her husband, convincing him to test:

And then I said if you are not going to be tested your blood then it is going to be difficult. And then we encouraged each other and then the doctor came for the second time and after encouraging him the doctor said please sister plead with him...I then encouraged him and said when I was pregnant I got tested and I was not found with the Kachilombo and this time too I have been tested and I have not been found with it. And so is it possible that I can be tested twice and found with no Kachilombo, there trying to convince him... And after I encouraged him even more, eventually I saw that he gave up. Indeed (48008~24~07~06)

Here Elizabeth reveals her previous experience with testing and HIV-negative results, attempting to galvanize her husband and strengthen his will. Many women cite their own previous sero-negativity in their attempts to convince husbands. Particularly interesting is Elizabeth's choice of words, stating her encouragement as a technique to convince her husband. Women recognize their inability to tell husbands what to do, but instead persuade husbands by encouraging them to be brave. Women oftentimes present as more courageous and capable of receiving their results, whereas men more often cite their fear of sero-positivity as a reason to refuse testing. Elizabeth's husband recognizes her role in convincing him to test and her use of fertility as a technique:

My wife explained to me that: "At times things change and we may decide to have children. We may agree let us have

a chap and we may have him and only find that our blood is not okay. That only means you have just created problems because your bodies become weak and the child will not live. So you need to think of a child if you see that your body is okay.” With this my wife had convinced me that indeed before we think of having another child in future it’s important that we know our blood (48507~24~07~06).

While it is unclear and unlikely that Elizabeth threatened to withhold her child bearing, it is evident from this example that she appeals to his responsibility as father in her plea to think of the children. This rationale convinces the husband to accept testing in order to protect his future offspring; Elizabeth’s reminder of his obligation to protect his family inspires courage and convinces him, despite his fear of sero-positivity, of the goodness of testing.

Evident from these interviews is women’s ability to persuade their husbands. Despite the apparent monopoly of marital power by the husband, women utilize creative strategies to maximize their own power and get their way even when the husband may initially disagree. Understanding this ability to convince and encourage their husbands, one woman reveals, “When they [the counselors] came back they told me that your husband is refusing and then I said, he is refusing? Well just wait. I will persuade him. Then that’s when I called him and explained it him how it went on as well as the results” (40001~19~07~06). While men may intimidate women into refusal through their own decision to refuse, it is obvious that women find ways to circumvent this decision and convince their husbands to accept testing so that they too can be tested.

These interviews demonstrate the ways in which VCT influences the relative power of spouses in decision making. VCT provides a unique equalizing opportunity in terms of marital power, particularly for women, most likely due to the severity of the AIDS epidemic in Malawi. As described in the reasons for accepting VCT, counseling and ART are essential accompaniments to VCT because they provide a sense of hope and a real benefit of undergoing VCT. Generally, men and women have similar motivations for accepting and refusing VCT. The interviews suggest that decision-making processes differ by gender where there are imbalances in marital power. Consequently, the information and insight gathered from these interviews provide a strong case for advocating couple VCT as a way to minimize such imbalances and promote a more equalized power dynamic and decision-making process.

### **Analysis - The Case for Couple VCT**

With an almost even combination of individual and couple counseled and tested respondents, the interviews provide valuable insight into the provision of couple VCT. From the interviews it is apparent that the sharing of information between spouses differs when couples are tested and counseled together, as compared to when they are tested and counseled individually. This section makes a case for couple VCT.

Most respondents expressed overwhelming support for couple VCT, emphasizing the importance of sharing results with spouses, having conversations about VCT and how to avoid infection within the marriage. Expressed in terms of family and cooperation, couple VCT was described as imperative for a healthy and trusting marriage. One

woman explains the general importance of sharing results and counseling with the spouse:

If indeed they love each other in their family then they can tell each other like since they have found us all fine then we need to counsel each other clearly, on should advise the other and one the other. In that way then things become fine. But if you just look at each other then you start suspecting each other in the heart saying, aah, the way it is did those people find us well? No, maybe not. But then it seems that you do not stay well with each other in your family, but if you stay well and discuss whatever is important then things become fine (55006~11~07~06).

This woman exemplifies the responses of many other men and women responding to whether spouses can or should share their results with each other. In particular, the word family was used often to explain why it is important, and the woman here states that in order to “stay well”, to maintain a good family, it is necessary for husband and wife to talk with each other about both the results and the counseling, “whatever is important”.

One of the reasons for approving of and even preferring couple counseling was its equalizing force; giving counseling and testing to the couple while together leveled the playing field and gave both partners equal information. A woman describes her opinion on couple counseling in particular:

That too is good, giving some counseling whilst you are together because you know each other and you also tell each other that the counseling that they gave us is good let's follow it. Yes. But now one is given the counseling alone and the other one too given individually one cannot know what the other one has been told according to how the counseling has been given. However, if you have been given counseling together, then you tell each other what to do like, well my husband if they have found you with the Kachilombo then let us follow what the doctor has told us. Yes (40001~19~07~06).

For this woman, it is important that both husband and wife have the same information regarding counseling and appropriate behavior not only because they can remind each other, but also because then one spouse does not have an advantage over the other. Other women and men echo this sentiment of reinforcement and working together as a family to protect themselves against the virus. If they are counseled together, couples can remind each other of what they were told and what they should follow. This gives the woman more legitimacy in bringing up certain practices because she can cite the counseling session to which the husband was also witness. One woman explains not only her own sentiments, but also the views of her neighbors:

Other people are saying the same thing that receiving the counseling together is also good because you all listen to the counseling together. And if you heard the counseling together and something pops up whether you have the disease or you do not have the disease, you can start telling

each other in your family the counseling that you were given saying that my husband if my wife please take that counseling that we received. Let's stay here well with good behavior so that maybe we can live longer. These days things are not quite alright yes (40001~19~07~06).

This woman articulates the predicted benefits to couple counseling. She and her neighbors believe that by hearing the counseling together with the husband gives both men and women equal ability to discuss strategies of prevention or living positively that were addressed in the session. Without couple counseling there would be mistrust and suspicion, as well as less couple solidarity.

Also, transparency is particularly important, because the woman understands that her husband can lie to her about his results and the counseling they should follow, and vice versa. One man admits to this temptation to lie or conceal the truth when tested alone:

This method of receiving counseling together with my wife this is still a good method because the way we got tested last year going there one by one it can be the beginning of...you know even myself can lie to my wife and say they have not found me with it whilst they have found it. And so even if they gave me some counseling there, I will still lie because if I say it then there will not be sex. And so even if they have given me some counseling I cannot use it because it is done individually and also it can be one way one can hide. And so this method of getting tested together with the wife is a good method so that she should know how the body of the husband is and me too as a husband should know how the wife's body is. Thank you very much we have found that you are fine or may be we have found you with it and so look after each other (45511~17~07~06).

This man admits that he is afraid his wife will withhold sex if he is found HIV-positive demonstrating the relative marital power of the wife in this situation. Underneath his resistance to lying is this man's devotion to his role as head of house and protector of the family, particularly in his closing remark about looking after each other. The man recognizes couple counseling as a "good method" because it motivates couples to be honest and care for each other. Women and men alike express this view.

The most compelling case for couple counseling were two moving stories we encountered when interviewing the couples. In one case a husband and wife, here referred to as John and Fannie were tested separately, and the man was found HIV-positive while his wife was HIV-negative. However, the husband did not reveal his results to his wife because he believed she would not be able to handle the news, and feared she might kill herself. He explains: "I am saying this from what my wife says, I am telling you my wife says all this, that once she is tested positive she can take poison and die...I did not share the results with my wife because I know her thoughts as I told you earlier on that she can really do that" (40501~19~07~06). Later in the interview John explains that he frequently shares his status with his community, and is open about being HIV-positive, but because of his candidness no one believes him, including his

wife: “As I have already told you, my wife is in the same group of people who are refusing that I can’t have the virus...Eee, she takes it as kidding, she does not believe or accept. And I tell you once more that there is no one who believes when I share with him/her that I am HIV-positive” (40501~19~07~06). As a result, this couple cannot discuss their sexual behavior, or ways to prevent transmission from husband to wife because Fanny does not believe John when he says he is HIV-positive. Due to individual counseling, Fanny cannot hear for herself John’s serostatus, and they cannot learn ways to protect themselves and live with discordance. Particularly in the case of discordance, couples oftentimes do not understand how it is possible for one partner to have HIV and the other not; the counseling segment is essential for discordant couples, especially in preventing transmission from the HIV-positive spouse to the HIV-negative spouse.

Another example of this type of marital distrust occurred with a discordant couple where the wife was found HIV-positive in 2004 and her husband found HIV-negative. This couple, here referred to as Henry and Samantha, refused testing in 2006. When asked why he refused testing, Henry claimed that HIV testing only makes a person worry and there is no benefit to testing. Henry never mentioned the HIV status of his wife. Samantha, after much probing, revealed that she had been tested in 2004 and found HIV-positive. In 2006 Samantha wanted to accept testing because her husband did not believe her; couple counseling was the only way to convince Henry, but he refused. Samantha explains:

I: Now how did he feel when you explained it to him that you have been found with it and then he said he had not been found with it?

R: He said I was telling a lie.

I: Ooh.

R: Yes. Now that is why I wanted us to be tested together but then now he refused.

I: Aah. Is that so?

R: Yes. That’s why I said well let it be as it is. [Laughs]

I: Okay. And so you did not try to convince him that you remember that time

R: I told him.

I: You were saying it was not true.

R: Yes he said it was not true.

I: What if now we get tested together so that we can see it again.

R: Eyah!

I: Both of us together.

R: Yes. But he refused. He was in fact the first one to refuse and so I said well then I will also not get tested because I will not be able to tell you again [Laughs] (74502~11~07~06).

These two examples demonstrate the occurrence of distrust amongst couples, particularly regarding discordance. Without being able to share her results with her husband and convince him of their validity, Samantha is powerless to protect herself and her husband.

Her last line has a tone of futility and despair. She does not have Henry's support in living positively with HIV. Samantha also distrusts Henry and believes he lied when reporting sero-negativity. We know however from 2004 test results that indeed Henry was HIV-negative and Samantha was HIV-positive. Instead of working together to avoid transmission to Henry, Henry rebukes Samantha's efforts to keep their family safe. Samantha describes her attempt to bring condoms into the marriage:

I: Ooh! Now was there anything you discussed as to what you were going to do as a couple in terms of sex?

R: Yes.

I: What did you agree upon?

R: We talked about using a condom. I suggested it.

I: Did he agree to use a condom?

R: [laughs] He did not.

I: And you the one who stated the issue of using a condom?

R: Mm.

I: That what if we use a condom when having sex?

R: Yes.

I: And so he refused?

R: Yes.

I: Why do you think he refused?

R: I cannot know what he had in mind.

I: Didn't you ask him?

R: No.

I: You just left it like that.

R: Yes.

(74502~11~07~06).

Once again evident from Samantha's responses to the interviewer's questions is a sense of futility and hopelessness. Samantha has resigned herself to the fact that she cannot convince her husband, and she must live in fear of her own HIV. Both John and Fanny and Henry and Samantha demonstrate the importance of couple VCT, particularly in the case of discordance. In couple counseling, Fanny could have learned that HIV is not a death sentence for John, and that there are ways for the couple to protect Fanny from infection. Henry could have seen for himself the positive test result of his wife, and they would be counseled on how discordance is possible in a married couple, and how to live together, protecting each other. The interviews support the advocacy of couple counseling; the couples who participated in couple VCT were extremely satisfied and promoted the method, while couples who were individually tested often remarked about the benefits of being tested together. In addition, these case examples demonstrate the necessity of couple VCT in a marriage where the spouses are unwilling or unable to share their results.

The interviews suggest that couple VCT is not only more conducive to establishing a trusting relationship, but it is also preferred by most respondents. Relying on the results presented in this paper, it seems that couple VCT does not force respondents to engage in equal power sharing and joint decision making, but rather couple VCT capitalizes on these processes which are already present. As demonstrated

earlier, VCT provides a unique opportunity for women to maximize their marital power, and couples express their VCT decision making as a shared process and considerate of the needs and opinions of their spouses. The interviews suggest that couple VCT would reinforce these processes, as well as help to minimize instances of unequal power in VCT decision making. Couple counseling is appealing to both types of couples: trusting and distrusting. If the spouses trust each other, they feel couple counseling is a wonderful opportunity to work together as a family. If they do not trust each other, they find a huge advantage in getting results together so they cannot accuse each other and can use the counseling advice as an authority to persuade their partner not to be movious.

## **Conclusion**

In this paper I used qualitative interview data to examine marital power and decision-making processes in the context of HIV testing in rural Malawi. Unlike existing literature on marital power and bargaining, this paper gives a detailed picture of how married couples negotiate the decision to undergo VCT. While the academic and policy communities recognize the imperativeness of combating the AIDS epidemic, we do not have key information about couples that can inform how best to address the epidemic in sub-Saharan Africa. This paper makes a unique contribution to both research and policy through its investigation of the dynamics of marital power and decision making in the context of HIV testing, providing new insight on this important issue.

The paper presented four main conclusions. First, the interviews suggest that in terms of marital power VCT provides a unique equalizing opportunity. Concerning VCT decision making, the epidemic relaxes traditional constraints, particularly for women. Second, counseling and ART are essential accompaniments to VCT because they provide a sense of hope and a benefit of undergoing HIV testing. Third, men and women have similar motivations for accepting and refusing VCT; regardless of gender, respondents cite the responsibility to future generations, infidelity and suspicion, and fear of being found HIV-positive as motivations in their decision-making processes. Finally, decision-making processes differ by gender where there are imbalances in marital power. Women express different reasons for their decision making than men when women's marital power is limited or overridden.

I propose that couple VCT be promoted and scaled-up for married couples. The interviews suggest that couple VCT is not only more conducive to establishing a trusting and balanced relationship, but it also preferred by most respondents, both male and female. As stated earlier, when couples are counseled together they can remind each other of the counselor's advice and guidelines. Again, this gives the woman more legitimacy in bringing up certain practices, which she may otherwise feel uncomfortable proposing, because she can cite the counseling session in which they both participated. While the findings in this paper support this conclusion, the study is limited due to the small number of HIV-positive respondents in the sample. The implications for marital power, particularly for women, could differ for women who are HIV-positive. However, this study remains highly relevant because, with a prevalence rate of approximately 15%, most people in rural Malawi are learning that they are HIV-negative when they undergo VCT. Another limitation of the study is, like many interview-based studies, the results rely on the honesty of the information provided by respondents when asked about sensitive issues. There is a chance that the few female respondents who were reluctant to

answer questions were involved in a more unequal marriage, and therefore we only got answers from more empowered women in more egalitarian marriages. The reluctant respondents were such a small minority, however, that their silence on such issues was counted as dissent, and these exceptions do not discount the responses of the majority. If this finding were supported by further research, there would be a strong case for providing couple VCT for all married couples in a setting similar to rural Malawi.

With approximately two million AIDS deaths in sub-Saharan Africa annually, the importance of combating the epidemic cannot be overstated (UNAIDS 2006). VCT is increasingly important in the battle against AIDS in sub-Saharan Africa, as it promotes prevention and serves as a gateway for treatment. However, the debate over the efficacy of VCT, the appropriateness of scaling-up VCT, and the benefits of couple VCT ensues. This paper provides an understanding of how couples negotiate the decision to test for HIV, and how this process influences marital power. With a better understanding of the decision-making processes of married couples, it is easier to target VCT to their motivations, needs and desires. While further research on a broader and generalizable scale is necessary, this paper is a step forward in the academic and policy debates, demonstrating the benefits of testing and counseling husband and wife together, and supporting couple VCT as a vital next step in HIV/AIDS prevention in Malawi.

## REFERENCES

- Agadjanian, Victor. 2000. "Women's Work and Fertility in a Sub-Saharan Urban Setting: A Social Environment Approach." *Journal of Biosocial Science* 32:17-35.
- . 2002. "Men's Talk about "Women's Matters": Gender, Communication, and Contraception in Urban Mozambique." *Gender & Society* 16:194-215.
- Allen, S., A. Serufilira, J. Bogaerts, P. Van de Perre, F. Nsengumuremyi, C. Lindan, M. Carael, W. Wolf, T. Coates and S. Hulley. 1992a. "Confidential HIV testing and condom promotion in Africa: Impact on HIV and gonorrhea rates." *Journal of the American Medical Association* 268:3338-3343.
- Allen, S., J. Tice, P. Van de Perre, A. Serufilira, E. Hudes, F. Nsengumuremyi, J. Bogaerts, C. Lindan and S. Hulley. 1992b. "Effect of serotesting with counseling on condom use and seroconversion among HIV discordant couples in Africa." *British Medical Journal* 304:1605-1609.
- Allen, Susan, Jareen Meinzen-Derr, Michele Kautzman, Isaac Zulu, Stanley Trask, Ulgen Fideli, Rosemary Musonda, Francis Kasolo, Feng Gao and Alan Haworth. 2003. "Sexual behavior of HIV discordant couples after HIV counseling and testing." *AIDS* 17:733-40.
- Ashford, Lori. 2001. "New Population Policies: Advancing Women's Health and Rights." *Population Bulletin* 56:17-20.
- AVERT. 2006. "HIV/AIDS in Africa". West Sussex, UK: AVERT. Retrieved April 3, 2006. (<http://www.avert.org/aafrica.htm>).
- Baggaley, R., Philippe Gaillard, Thandiwe Sigxashe, Connie Osborne. 1997. "Men make a difference: involving fathers in the prevention of mother-to-child HIV transmission." Development Gateway Foundation. Retrieved April 3, 2006. (<http://www.developmentgateway.org/node/171389>.)
- Baiden, Frank, P. Remes, R. Baiden, J. Williams, A. Hodgson, M. Boelaert and A. Buve. 2005. "Voluntary counseling and HIV testing for pregnant women in the Kassena-Nankana district of Northern Ghana: Is couple counseling the way forward?" *AIDS Care* 17:648-57.
- Bankole, Akinrinola and Susheela Singh. 1998. "Couples' Fertility and Contraceptive Decision-Making in Developing Countries: Hearing the Man's Voice." *International Family Planning Perspectives* 24:15-24.
- Blanc, Ann K. and Brent Wolff. 2001. "Gender and Decision-Making Over Condom use in Two Districts in Uganda." *African Journal of Reproductive Health* 5:15-28.

- Blood Jr., Robert O. and Donald M. Wolfe. 1960. *Husbands and Wives: dynamics of married living*. New York: Free Press.
- Bunnell, R.E., J. Nassozi, E. Marum, J. Mubangizi, S. Malamba, B. Dillon, J. Kalule, J. Bahizi, N. Muzsoke and J.H. Mermin. 2005. "Living with discordance: knowledge, challenges and prevention strategies of HIV-discordant couples in Uganda". *AIDS Care* 17:999-1012.
- Burgess, Stephen F. and Janet C. Beilstein. 1996. "Women's Voice and Agency in Rural Africa: Small-Scale Communal Farmers in Zimbabwe." *Women & Politics* 16:19.
- Burr, Wesley R., Louise Ahern and Elmer M. Knowles. 1977. "An Empirical Test of Rodman's Theory of Resources in Cultural Context." *Journal of Marriage and the Family* 39:505-14.
- Coates, T., G. Coates, G. Sangiwa, D. Balmer, C. Furlonge, C. Kamenga and S. Gregorich. 1998. "Serodiscordant married couples undergoing couples counseling and testing reduce risk behavior with each other but not with extramarital partners." 12<sup>th</sup> World AIDS conference presentation, Geneva: 28 June-03 July.
- deGraft-Johnson, Joseph, Valerie Paz-Soldan, Antonio Kasote and Amy Tsui. 2005. "HIV Voluntary Counseling and Testing Service Preferences in a Rural Malawi Population." *AIDS and Behavior* 9:475-84.
- Denton, Melinda L. 2004. "Gender and Marital Decision Making: Negotiating Religious Ideology and Practice." *Social Forces* 82:1151-80.
- DeRose, Laurie F., F. N. Doodoo and Vrushali Patil. 2002. "Fertility Desires and Perceptions of Power in Reproductive Conflict in Ghana." *Gender & Society* 16:53-73.
- DeRose, Laurie F. and Alex C. Ezeh. 2005. "Men's Influence on the Onset and Progress of Fertility Decline in Ghana, 1988-98." *Population Studies* 59:197-210.
- De Vincenzi, I. 1994. "A longitudinal study of human immunodeficiency virus transmission by heterosexual partners." *The New England Journal of Medicine* 331: 341-346.
- Doodoo, F. N. and Maria Tempenis. 2002. "Gender, Power, and Reproduction: Rural-Urban Differences in the Relationship between Fertility Goals and Contraceptive use in Kenya." *Rural Sociology* 67:46-70.
- Ezeh, A. C. 1993. "The Influence of Spouses Over each Other's Contraceptive Attitudes in Ghana." *Studies in Family Planning* 24:163-74.
- Feldman, Shelley. 2001. "Exploring Theories of Patriarchy: A Perspective from Contemporary Bangladesh." *Signs* 26:1097-127.

- Feyisetan, Bamikale J. 2000. "Spousal Communication and Contraceptive use among the Yoruba of Nigeria." *Population Research and Policy Review* 19:29-45.
- Folbre, Nancy. 1983. "Of Patriarchy Born: The Political Economy of Fertility Decisions." *Feminist Studies* 9:261-84.
- , 2001. *The Invisible Heart: Economics and family values*. New York: New Press.
- Gerami, Shahin and Melodye Lehnerer. 2001. "Women's Agency and Household Diplomacy: Negotiating Fundamentalism." *Gender and Society* 15:556-73.
- Glick, Peter. 2005. "Scaling Up HIV Voluntary Counseling and Testing in Africa: What can evaluation studies tell us about potential prevention impacts?" *Evaluation Review* 29:331-57.
- Godwin, Deborah D. and John Scanzoni. 1989a. "Couple Consensus during Marital Joint Decision-Making: A Context, Process, Outcome Model." *Journal of Marriage and the Family* 51:943-56.
- , 1989b. "Couple Decision Making: Commonalities and Differences Across Issues and Spouses." *Journal of Family Issues* 10:291-310.
- Grieser, Mira, Joel Gittelsohn, Anita V. Shankar, Todd Koppenhaver, Thomas K. Legrand, Ravai Marindo, Webster M. Mavhu and Kenneth Hill. 2001. "Reproductive Decision Making and the HIV/AIDS Epidemic in Zimbabwe." *Journal of Southern African Studies* 27:225-43.
- Guy-Sheftall, Beverly. 2003. "African Feminist Discourse: A Review Essay." *Agenda* 58:31-6.
- Haj, Samira. 1992. "Palestinian Women and Patriarchal Relations." *Signs* 17:761-78.
- Hindin, Michelle J. 2002. "For Better Or for Worse? Women's Autonomy and Marital Status in Zimbabwe." *Social Science Research* 31:151-72.
- Hochschild, Arlie. 1989. *The Second Shift*. New York: Avon Books.
- , 1997. *The time bind: When work becomes home and home becomes work*. New York: Holt.
- Hollos, Marida and Ulla Larsen. 2004. "Which African Men Promote Smaller Families and Why? Marital Relations and Fertility in a Pare Community in Northern Tanzania." *Social Science & Medicine* 58:1733-49.
- Kaida, Angela, Walter Kipp, Patrick Hessel and Joseph Konde-Lule. 2005. "Male Participation in Family Planning: Results from a Qualitative Study in Mpigi District, Uganda." *Journal of Biosocial Science* 37:269-86.

- Kandiyoti, Deniz. 1988. "Bargaining with Patriarchy." *Gender and Society* 2:274-90.
- Maharaj, Pranitha and John Cleland. 2005. "Women on Top: The Relative Influence of Wives and Husbands on Contraceptive use in KwaZulu-Natal." *Women & Health* 41:31-41.
- Matovu, Joseph K.B., Ronald H. Gray, Fredrick Makumbi, Maria J. Wawer, David Serwadda, Godfrey Kigozi, Nelson K. Sewankambo and Fred Nalugoda. 2005. "Voluntary HIV counseling and testing acceptance, sexual risk behavior and HIV incidence in Rakai, Uganda." *AIDS* 19:503-11.
- Moghadam, Valentine M. 2004. "Patriarchy in Transition: Women and the Changing Family in the Middle East." *Journal of Comparative Family Studies* 35:137-62.
- Monroe, Pamela A., Janet L. Bokemeier, J. M. Kotchen and Harley McKean. 1985. "Spousal Response Consistency in Decision-Making Research." *Journal of Marriage and the Family* 47:733-8.
- Myer, Landon; Miriam Rabkin, Elaine J. Abrams, Allan Rosenfield, and Wadaa M. El-Sadr. 2005. "Focus on Women: Linking HIV Care and Treatment with Reproductive Health Services in the MTCT-Plus Initiative." *Reproductive Health Matters* 13(25): 136-146.
- National Statistical Office (NSO) [Malawi], and ORC Macro. 2005. *Malawi Demographic and Health Survey 2004*. Calverton, Maryland: NSO and ORC Macro.
- Omorodion, Francisca I. 2004. "The Impact of Petroleum Refinery on the Economic Livelihoods of Women in the Niger Delta Region of Nigeria." *Jenda: A Journal of Culture and African Women Studies* 6:1-12.
- Painter, Thomas M. 2001. "Voluntary counseling and testing for couples: a high-leverage intervention for HIV/AIDS prevention in sub-Saharan Africa." *Social Science and Medicine* 53:1397-1411.
- Reniers, Georges. 2003. "Divorce and Remarriage in Rural Malawi." *Demographic Research* S1:175-206.
- . 2005. "Marital Strategies for Managing Exposure to HIV in Rural Malawi." Paper presented to the Annual Meeting of the Population Association of America, Philadelphia: March 31-April 2, 2005.
- Renne, E. P. 1993. "Gender Ideology and Fertility Strategies in an Ekit Yoruba Village." *Studies in Family Planning* 24:343-53.
- Rodman, Hymann. 1972. "Marital Power and Theory of Resources in Cultural Context." *Journal of Comparative Family Studies* 3:50-69.

- Rollins, Boyd C. and Stephen J. Bahr. 1976. "A Theory of Power Relationships in Marriage." *Journal of Marriage and the Family* 38:619-27.
- Salway, Sarah. 1994. "How Attitudes Toward Family Planning and Discussion between Wives and Husbands Affect Contraceptive use in Ghana." *International Family Planning Perspectives* 20:47-74.
- Schatz, Enid. 2005. "'Take Your Mat and Go!': Rural Malawian Women's Strategies in the HIV/AIDS Era." *Culture, Health & Sexuality* 7:479-92.
- Security Council. 2000. *Security Council Resolution 1308*. Durban: United Nations.
- Smith, Kirsten P. and Susan C. Watkins. 2005. "Perceptions of Risk and Strategies for Prevention: Responses to HIV/AIDS in Rural Malawi." *Social Science & Medicine* 60:649-60.
- Swidler, Ann. 2001. *Talk of Love: How culture matters*. Chicago: University of Chicago Press.
- Therborn, Goran. 2004. *Between Sex and Power: Family in the World, 1900-2000*. New York: Routledge.
- Thomson, Elizabeth. 1997. "Couple Childbearing Desires, Intentions, and Births." *Demography* 34:343-54.
- UNAIDS/Pennsylvania State University. 1999. "Communications Framework for HIV/AIDS: A New Direction." *A UNAIDS/Penn State Project* Geneva: UNAIDS.
- UNAIDS. 2006. *Report on the global AIDS epidemic*. Geneva: UNAIDS.
- Warner, Rebecca L., Gary R. Lee and Janet Lee. 1986. "Social Organization, Spousal Resources, and Marital Power: A Cross-Cultural Study." *Journal of Marriage and the Family* 48:121-8.
- Watkins, Susan C. 2004. "Navigating the AIDS Epidemic in Rural Malawi." *Population and Development Review* 30:673-705.
- Watkins, Susan C., Gigi Santow and Michael Bracher. 2007. "Epistemology and Epidemiology: Local Interpretation of AIDS Epidemiology in Rural Malawi." Working Paper presented at 2007 Population Association of America Conference.
- Weber, Max. [1922] 1946. "Class, Status and Party." Pp. 180-195 in *From Max Weber: Essays in Sociology*, edited by H.H. Gerth and C.W. Mills. Reprint, New York: Oxford University Press.
- Wooten, Stephen. 2003. "Women, Men, and Market Gardens: Gender Relations and Income Generation in Rural Mali." *Human Organization* 62:166-77.

The World Bank Group. 2006. "Sub-Saharan Africa Data Profile." *World Development Indicators Database*. Retrieved April 3, 2006. (<http://devdata.worldbank.org>)

Yoder, P. Stanley and Priscilla Matinga. 2004. *Voluntary Counselling and Testing (VCT) for HIV in Malawi: Public Perspectives and Recent VCT Experiences*. Calverton, Maryland: ORC Macro.

Zulu, Eliya M. and Gloria Chepngeno. 2003. "Spousal Communication about the Risk of Contracting HIV/AIDS in Rural Malawi." *Demographic Research Special Collection* 1:247-76.