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Research Article

Spousal communication about the risk of contracting HIV/AIDS in rural Malawi

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Table of Contents

1	Introduction	248
2	Data and methods	250
21.	Quantitative Data	251
2.2	Qualitative Data	254
3	Study context	256
4	Results: Correlates of spousal discussion of HIV/AIDS	257
5	Content of spousal conversations about HIV/AIDS	262
5.1	Joint fates	262
5.2	Stimulus HIV/AIDS conversations	264
5.3	Risk perception	265
5.4	Marital relationship	269
6	Conclusion	272
	References	275

Demographic Research – Special Collection 1: Article 8
-- Social Interactions and HIV/AIDS in Rural Africa --

Research Article

Spousal communication about the risk of contracting HIV/AIDS in rural Malawi

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Abstract

This paper uses qualitative and quantitative data from married men and women in rural Malawi to examine how they comprehend their risk to HIV/AIDS and what preventive strategies they consider within marriage. Program efforts to promote behavior change have consistently focused on promoting chastity before marriage and fidelity while married or using condoms. These behavioral prescriptions are suitable for extramarital contexts but not within marriage, where the condom is far from being accepted as a suitable preventive tool and spouses face the reality that one's vulnerability to AIDS is not confined to his/her behavior alone. The survey data show, unsurprisingly, that those who have the most reason for concern (e.g. those worried about contracting the disease) and those who have greater program and informal social contacts are most likely to communicate. The semi-structured interviews show that husbands and wives use subtle and gendered strategies to encourage fidelity; they talk to each other about the consequences of HIV/AIDS on their children's and their own lives as a prelude for highlighting and justifying joint sexual prudence. These results show that rather than giving up to fate, marital partners are actively challenging and persuading each other to reform sexual behavior to avoid the intrusion of HIV/AIDS into the home.

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1. Introduction

HIV/AIDS prevention programs in sub-Saharan Africa began with efforts to reach marginal and high-risk groups such as truck drivers and commercial sex workers. Once the epidemic went beyond such core groups to become generalized, many new infections are likely to take place through ordinary conjugal relations. Yet even today in countries with high prevalence of HIV, married couples are rarely the primary targets of HIV prevention programs. Most preventive strategies emphasize abstaining from sex or using condoms, strategies that are appropriate for individuals to avoid infection outside marriage but are not perceived by couples to be appropriate within marriage. How, then, do married couples attempt to protect themselves from infection by their spouse? One potential strategy is to initiate a discussion of the threat of AIDS in order to persuade the spouse to be faithful. This may be difficult: a number of studies have documented the difficulties that both men and women perceive in raising the topics of infidelity and of condom use within marriage (Fapohunda and Rutenberg 1999, Blanc et al. 1996, Knodel and Pramualratana 1996). Yet spousal communication may be an effective means of protection from HIV/AIDS among married people.

Much more research has been done on the relationship between spousal communication and use of family planning than sexual behavior relating to HIV/AIDS. Studies on spousal communication and family planning typically show a strong positive correlation between spousal communication and contraceptive use: women who report using family planning are more likely to report that they have discussed family planning with their spouse than women who do not report such use (Dodoo 1998, Ezeh 1993, Fapohunda and Rutenberg 1999, Isiugo-Abanihe 1994; Lasee and Becker 1997). A recent study using longitudinal data from Northern Ghana demonstrates that spousal communication predicts contraceptive use (Bawah 2002). Given that spousal communication is so key for adoption of contraception, there is need to understand not only the effect of communication on contraceptive use in various contexts, but also the largely ignored impact of various factors on spousal communication on such reproductive health issues. This is important particularly for IEC programs that may need to encourage spousal communication for adoption of positive reproductive health innovations.

The positive relationship between spousal communication and contraceptive use suggests the potential importance of spousal communication in AIDS prevention. A few studies have examined and shown a positive relationship between partner communication and adoption of condoms among adolescents as well as adults (see, for example, Shoop and Davidson 1994; Rickman et al. 1994; DiClemente 1991; Zamboni, Crawford and Williams 2000). Survey data from Uganda show that men who have discussed HIV prevention with their wives are more likely to have used condoms at last sexual intercourse, although the impact of spousal communication about AIDS diminishes significantly among those who

also discussed use of family planning with their wives (Gage and Ali 2003). Although spousal communication is positively associated with having an HIV-test, the Uganda data do not conclusively show a significant positive relationship between spousal talk and condom use as well as fidelity. So, while further work is needed to establish whether there is actually a causal linkage between spousal communication and adoption of preventive sexual behaviors, these studies are suggestive that spousal communication can indeed promote adoption of protective sexual behaviors.

Rather than focus on the relationship between spousal communication and reproductive behavior (as done by most studies on family planning), this study uses quantitative data to examine factors that facilitate husband-wife communication about the risk of contracting HIV/AIDS. Additionally, the study goes beyond the survey data and quantitative analysis that many past studies on spousal communication have utilized (for an exception, see Blanc et al. 1996) to analyze what husbands and wives actually say to each other when they talk about their risk of contracting HIV/AIDS. The quantitative findings on factors that influence whether or not a conversation about AIDS occurred are compared with qualitative reports of contexts under which spousal conversations take place. The content of conversations between husbands and wives is valuable in clarifying how couples in rural Malawi comprehend and express their fears and risk to HIV/AIDS and what strategies they are exploring to prevent the intrusion of AIDS into the home.

It should also be noted that husbands and wives might use non-verbal forms of communication (Dodoo, Ezeh and Owour, 2001; Blanc et al. 1996). Thus, when one spouse perceives a need but the other does not, the topic may not be broached because the other spouse is believed – perhaps correctly - to oppose the issue being considered. Husbands and wives may also avoid direct verbal communication if one or both of them perceive that the topic of HIV prevention is so sensitive that to broach it would threaten the tranquility of the marriage. Indeed, a number of options exist for couples beyond talking about the risk of contracting HIV/AIDS when one of them feels that the other is endangering his/her life by indulging in extramarital affairs. One sometimes adopted by women, is to discourage the "other woman" by harassing her - by going to her home and asking "Is my husband there?" or even physically assaulting her (Schatz 2002). The aggrieved person may also report the matter to the marriage counselor or elderly members of the extended family to intervene, and in extreme cases, resort to divorce. Discussions within marriage and ultimately involving the extended family, however, are less drastic. It is also more consistent with the local view of married life, which acknowledges that there will be disagreements in the home but holds that disagreements should be resolved amicably through "discussion" or, if that fails, through the mediation of relatives.

As in other countries of sub-Saharan Africa where the AIDS epidemic has become generalized, married husbands and wives are the largest sexually active group at risk of infection from HIV in Malawi. Our data show that the vast majority of rural husbands and

wives understand that AIDS is a threat to their lives, and that many perceive, correctly, that their fates are joined—that they are at risk from their spouse. It is widely believed that if one spouse becomes infected, the other one will probably be infected as well. Infection is understood to be equivalent to death, since it is known that there is no cure for AIDS. Both wives and husbands believe that regular sex is a central aspect of marriage; both also believe that men and women (particularly men) may seek extramarital partners, which are perceived to be the vectors through which AIDS reaches the bedroom. The irony of this perception is that there is also a widespread belief in Malawi and many other African countries that a single person is at a higher risk of HIV infection than a married person since the former is more likely to be involved with multiple sexual partners. Consequently, single people are urged and even pressured to get married in order to reduce their risk of contracting HIV/AIDS. However, simulation of HIV-infection rates among newly married people in Malawi show that HIV infection is already present in 13-20 percent of the couples (Bracher, Santow and Watkins Forthcoming). Although young women are more likely to be HIV positive than men of the same age, the study shows that marriage puts women at a greater risk of HIV infection than men since only around 2% of the brides are estimated to be HIV-positive at the time of marriage Considering the central place of sex within marriage, and the realization that married people may indulge in extra-marital affairs, it is important to understand how husbands and wives express their fears against AIDS, and how they attempt to protect themselves.

We begin in Section 2 with a discussion of the data we use, which come from a household survey conducted in 1998 and semi-structured interviews conducted in 1999. In Section 3 we briefly describe the context in which the data were collected. In Section 4 we use household survey data to analyze the correlates of spousal conversations about AIDS. We examine whether characteristics of the couple, indicators of risk to infection, and access to both formal and informal sources of information on AIDS are associated with whether or not they report having had a discussion with their spouse. In Section 5 we use qualitative data to examine the content, structure and themes of spousal discussion. Our conclusions follow in Section 6.

2. Data and methods

This study uses data from the Malawi Diffusion and Ideational Change Project (MDICP), which involves longitudinal interviews with wives and husbands in three regions of rural Malawi. The project examines 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 about AIDS transmission and acceptable preventive strategies. A household survey was conducted in 1998 (we call this survey Malawi 1, as it was

followed by re-interviews of these respondents in 2001, which we call Malawi 2) Eligible respondents were ever-married women aged between 15 and 49 years and their husbands. In 1999, semi-structured interviews were conducted with a randomly chosen sub-sample of the 1998 survey respondents. This study uses the 1998 survey data and the 1999 qualitative data. The project is described in detail on: http://www.ssc.upenn.edu/Social_Networks/ and in Watkins et al. (2003).

2.1 Quantitative Data

The 1998 survey interviewed 1541 ever-married women of childbearing age (15-49) and 1065 men (husbands of the currently married women) in three rural districts in Malawi: Rumphi in the Northern Region, Mchinji in the Central Region, and Balaka in the Southern Region. All of the areas are poor, with little in the way of development: roads are poor and electricity is largely confined to nearby towns. The three regions are, however, quite different in some aspects: the South is predominantly matrilineal and matrilocal, the North is predominantly patrilineal and patrilocal, and the Center is mixed (historically matrilineal and matrilocal, but over the last century it has been shifting to patrilineal and patrilocal (Zulu 1996). These differences may imply regional differences in gender systems that may be relevant for the woman's autonomy and consequent role in spousal communication. For example, where land, the basic economic resource, is passed through the maternal line, it is expected that wives would have more autonomy than where inheritance is through the husband (Caldwell and Caldwell 1990).

The final sample size for husbands was smaller than for wives primarily because some of the husbands were not present at the time of the survey, usually because they were working, doing business elsewhere or attending funerals. Because some wives were away as well, we were only able to interview 812 couples in the 1998 survey, of which 706 identified themselves as monogamous (that there was no other wife in the relationship), while the rest of the couples gave discrepant responses on the type of marital union they were in. The quantitative analysis is restricted to the 706 couples where both the husband and the wife reported that they were in a monogamous marriage to avoid the uncertainty of not knowing which wife the husband was referring to when answering questions about the spouse. The sizable percentage of couples that gave discrepant responses on the type of marital union (13%), however, suggests that there are either a substantial number of unions with hidden relationships or differential understanding of the meaning of polygamy. The restriction of the quantitative analysis to couples where both reported monogamous status, thus, potentially under represents couples in which there is high chance of infidelity and perhaps a greater chance of discussion if, as the qualitative data show, most spousal

discussions about HIV/AIDS risk come about following suspicions or knowledge about a spouse's infidelity.

During the survey, respondents were asked, "Have you ever talked with your spouse about the chances that you or she/he might get infected with AIDS?" A study examining husband-wife discordance in various issues using the 1998 survey data has shown that husbands and wives sometimes do not agree in answers to a range of questions where they would be expected to give similar responses (Miller, Zulu and Watkins 2001). These discrepancies were observed not only in spousal discussions about AIDS, number of children to have and use of family planning, but also on responses referring to ownership of various household goods. These discrepancies, also observed in the Malawi and Kenya Demographic and Health surveys, were systematic and gendered, in that when couples differed in their responses, husbands were more likely to respond in the affirmative than wives. The discrepancies were particularly large with respect to spousal conversations: 30%, 35%, and 37% of the monogamously married couples gave discordant responses on the occurrence of conversations on family planning, AIDS, and desired number of children, respectively (Table 1). Given this discordance, it would not be appropriate to use the husband or the wife's response alone in analyzing couple communication on such issues. These patterns also highlight the need to understand determinants of discordance in reporting spousal communication. In order to take account of the couple discordance, we use multinomial logistic regression to simultaneously examine factors that influence whether husbands and wives talk about their risk of AIDS or not, and whether they agree about the occurrence of such a discussion. The factors that we expect to be associated with the likelihood that spouses report talking about the risk of contracting AIDS, based on the analysis of the qualitative data in section 5, are in three categories: stimulus factors, risk factors, and couple characteristics.

Stimulus factors: These are indicators of the extent to which the respondents have been exposed to information about HIV/AIDS from *program sources* (such as hearing messages from radios, health clinics, and community based health workers) as well as *informal social networks* (such as the number of people respondents have discussed AIDS with, and the number of people they know who they think died of AIDS or have AIDS). Since discussion of community experiences with HIV/AIDS mostly travels through informal social networks, we use the number of people respondents have talked to and the number of people they know who they think have died of AIDS as a general indicator of exposure to informal sources of information for the respondent. Our expectation is that couples that have been exposed to more information (whether formal or informal) would be more likely to talk with each other about AIDS than couples that have less exposure. In the analysis we combine the husband and the wife's responses about exposure to formal

Table 1: *Percent of monogamous husbands and wives who have discussed HIV/AIDS risk, number of children to have and use of family planning, 1998 Malawi survey*

		REPRODUCTIVE HEALTH ISSUE DISCUSSED		
REGION		HIV/AIDS Risk	Number of Children to have	Use of Family Planning
All Three Areas				
	% yes among husbands	79	62	66
	% yes among wives	70	53	59
	Crude agreement	65	63	70
	Number of Cases	583	581	584
North				
	% yes among husbands	73	51	59
	% yes among wives	75	50	66
	Crude agreement	64	65	61
	Number of Cases	126	125	126
Central				
	% yes among husbands	84	71	73
	% yes among wives	71	59	63
	Crude agreement	66	61	71
	Number of Cases	297	294	297
South				
	% yes among husbands	77	54	57
	% yes among wives	64	44	48
	Crude agreement	65	64	73
	Number of Cases	161	162	161

Note: Crude agreement is the percentage of couples where both husbands and wives gave the same response on the occurrence of a conversation on the risk of contracting HIV/AIDS
Source: Miller, Zulu and Watkins (2001)

sources of information (radio, health clinics, and community health workers). We have a series of four-category variables distinguishing: 1) where both the husband and the wife acquired information from the source, 2) where only the wife acquired information from the source, 3) where only the husband acquired information from the source, and 4) where neither acquired information from the source. Men and women's network measures have been included in the analysis separately because they differ remarkably.

Risk factors: These are factors that increase/decrease the need for a discussion, based on the extent of perceived risk of AIDS faced by the couple (for instance, whether at least one spouse suspects the other of infidelity or the extent of worry about the likelihood of contracting the disease). We also include correct knowledge of the fact that a person can contract the HIV virus from a healthy-looking person as a general measure of the

comprehension of the disease and associated risk. The expectation is that the greater the extent of perceived risk, the more likely the couple is to have discussed their joint risk.

Marital Relationship Factors: The third category of factors reflects characteristics of the couple that may hinder or facilitate discussion. The expectation here is that couples that freely discuss other issues (like family planning) and share information about other aspects of their lives (such as income made) should be more predisposed to talk, given that there is need for them to do so. Additionally, couples that are socially close (small age difference) or more educated may be more likely to discuss the risk of HIV/AIDS and other issues.

2.2 Qualitative Data

In 1999 we carried out semi-structured interviews with randomly selected wives and husbands (from the 1998 survey respondents) in order to understand what they say to each other when they talk about their risk of contracting HIV/AIDS. Such interviews are the only practical way to learn about the content of their conversations. The sample was determined by estimating the sample size that would be sufficient to provide variation across respondents that was similar to the variation in the 1998 survey, guided by the distribution of relevant responses to attitudinal questions about family planning in the survey. Taking the pronounced differences in responses in the 1998 survey, we estimated that we would need a sample of at least 20 wives and 20 husbands in each of the three regions. Based on the non-response experience of the 1998 survey, we selected a large enough sample to end up with around 25 male and 25 female interviews in each region. In the South, we selected 38 women and 41 husbands, of whom 23 and 28, respectively, were interviewed. In the Center we interviewed 26 women and 27 men from a selected sample of 37 women and 37 men. In the North, the sample consisted of 41 men and 41 women, of whom we interviewed 27 women and 25 men. Thus, in the three areas, we interviewed a total of 80 men and 76 women.

The interviewers were the best of the local interviewers who had participated in the 1998 survey; they were thus familiar with the overall emphasis of the project on informal conversational interactions. In order to encourage the interviewers to shift from the structured approach of the 1998 survey to a more conversational approach in these interviews, they were given a guide that listed the four major areas (family size, family planning, HIV/AIDS and characteristics of network partners) that we covered in the interviews, with a small set of questions in each area that we were interested in addressing. For each issue, we asked the respondents what people in the communities say about these issues and went on to ask about the last conversation that they had on the issue. We also

asked specifically if they had ever had a discussion on the topic with their spouse, and asked for details about the last conversation. For HIV/AIDS we asked the respondents how people tell who might be infected, what people say about their worries about contracting the disease, and details about the last conversation with their spouse. In training, we first concentrated on explaining the rationale for each of the four areas, and we emphasized that as much as possible the interviewers should try to get who-said-what-to whom, rather than just a summary of the conversations. The transcripts show that the interviewers did understand the issues; although the discussions may be shorter as reported than they were, in fact there is a sense of conversations both between the interviewers and the respondents and between the husband and the wife.

The more informal approach taken in these interviews means that respondents' answers were more spontaneous, and thus perhaps more valid. A disadvantage, however, is that the informal approach means that we do not have equivalent information for all respondents. For example, below we note how many respondents' recall a conversation with their spouse about AIDS mentioned the danger of children becoming orphans if the parents were infected and died, and how many respondents did not mention children in this context. Because the respondents *remembered* the conversation as including children, we interpret these answers as representing the importance of children in spousal discussions of AIDS. For respondents who did not mention children in the last conversation, however, it may be that children were indeed less important during that conversation, although it is possible that they had referred to children in other conversations that took place prior to the last one.

The interviews were conducted in the mother-tongue of the respondent, and usually transcribed and translated by the interviewer. An *a priori* coding scheme was developed, and the interviews were coded in NUD*IST. Additionally, we conducted special coding for this paper to depict the salience of the key themes coming out of the interviews. The coding permitted us to describe typical responses as well as to indicate diversity. In the analysis of the semi-structured interviews that follows, we use quotations that in our opinion best illustrate the perceptions of respondents in their approach to communication with their spouse, and the content of their conversations. Our interpretation of both the quantitative and the qualitative data are aided by three separate projects directed by members of the research team in one or more of the same sites: interviews with parents of our respondents (Kaler 2001), interviews with respondents from the 1998 survey about marriage (Schatz 2002), and about sexual partnerships (Tawfik 2002).

3. Study context

In rural Malawi, HIV/AIDS is widely recognized as a new disease, one that was not there before, and as the most serious disease confronting society. When asked which disease is considered most serious, close to two-thirds of the qualitative interviewees mentioned HIV/AIDS. Many also recognize the need for innovations in sexual behavior to protect them from this new disease. Since the levels of public and private discussion of innovations are believed to be related (Caldwell 2000) it is useful to briefly summarize public activities in relation to AIDS in Malawi.

Malawi has one of the highest rates of HIV/AIDS infection in Sub-Saharan Africa. The first cases of AIDS were officially acknowledged in 1985 (Chirwa 1998), and the current HIV prevalence of 15% of adults is among the highest in the World (www.unaids.org). As in most sub-Saharan African countries, the government was slow to acknowledge the extent of the potential threat or to take visible action (Caldwell 2000). Blood screening began early, but it was only in 1989 that the government began to implement a World Bank Medium Term Plan, considered the first evidence of the government's commitment to AIDS prevention. Program efforts to promote behavior change have consistently portrayed AIDS as spread by extramarital and premarital sex, with the solution being chastity before marriage and fidelity after. Consequently, Information, Education, and Communication (IEC) campaigns have been intensified throughout the country to educate people about the virtues of chastity and fidelity to avoid HIV/AIDS infection. Most of the AIDS posters we saw in local clinics focused on warning against extramarital sex to prevent AIDS. There is also considerable advertising of condoms associated with programs on social marketing of condoms by Banja La Mtsogolo, a local franchise of Marie Stopes that began in 1991 and by Population Services International (PSI) that began in 1994.

The link between public activities and private discussion is probably weak for HIV/AIDS, since the rapid spread of HIV has been accompanied by an increase in deaths that would occasion comment even in the absence of public discussion. It is thus, not surprising that most of the respondents in the 1998 survey reported having discussed AIDS with others in their social networks: only 16% of women and 7% of men said they had not had such discussions. Funerals are frequent–about half the 1998 survey respondents had been to 1-4 funerals in the previous month, and about half had been to more than four. The vast majority of the respondents (83% of women and 72% of men) were either moderately or very worried about getting AIDS. Further analysis of factors that influence whether a person is worried about the disease or not show that perception of one's fidelity is one of the most significant determinants of worry (Smith forthcoming). Respondents are very aware of the risk posed by the behavior of their spouse. When those who said they had a high risk of being infected were asked how they thought they were most likely to get

infected, 80% of women and 79% of men answered that it was through heterosexual sex, either with another partner or with a spouse who had been infected by another partner. The majority of the survey respondents believe that AIDS is highly infectious, such that if one spouse is infected the other will also be infected. In the 2001 survey, 64% of female and 68% of male respondents reported that infection is certain if one has sex once with an infected person (Smith Forthcoming). When asked whether divorce is appropriate if a spouse is believed to have AIDS, the majority (84% of men as well as women in 1998) said it was not, often explaining that: "if the spouse has it you have it too, so what's the point of leaving?" However, the majority of the respondents (94% of men and 68% of women) reported that it is appropriate to divorce a spouse if she/he is unfaithful.

In summary, conversations about AIDS both in informal networks outside the family and with a spouse suggest that our respondents perceived the issue as important.

4. Results: Correlates of spousal discussion of HIV/AIDS

Table 2 shows multinomial logistic regression results for the analysis of determinants of spousal communication about AIDS. The reference category for the dependent variable is "both said they did not talk". Because the interpretation of the parameter estimates in a multinomial logit regression is not straightforward, the same results are presented in Table 3 as estimated probabilities that a man/woman in a given couple would fall in any of the three categories of the dependent variable. The probabilities are calculated for each covariate, while holding the remaining factors at their mean values.

The results highlight the importance of both formal and informal sources of information in influencing spousal discussion of the risk of contracting HIV/AIDS. Couples where both the husband and wife have accessed information about AIDS from clinics and those who interact with more people are associated with significantly higher probabilities of talking about their risk relative to those with less exposure to such information. The big difference in spousal communication among couples where both accessed information about the disease from clinics and where only one of them did suggests that husbands and wives individualize such information. Couples where the wife talked with more than five people about HIV/AIDS are significantly more likely to disagree that a conversation took place (probability of 0.145) than among couples where the wife talked to less people. This suggests that talking to many "outside" people about HIV/AIDS may influence some respondents to say they talked with their spouse, even when the conversation did not take place.

The quantitative results are also consistent with the hypothesis that spousal discussion of the joint risk of contracting HIV/AIDS is significantly promoted by the extent of worry about contracting the disease. The likelihood of discussing the risk of contracting

HIV/AIDS is highest when both spouses are very worried (as opposed to being slightly worried or not worried at all) about contracting the disease. When only the wife is worried, the likelihood of spousal discussion about HIV/AIDS is not significantly different from cases where both are worried. However, when only the husband is worried about the disease, the probability of discussing the joint risk to HIV/AIDS is significantly lower than when both are worried. This is in line with the qualitative data that show that discussions about the joint risk of contracting the disease are initiated by women, and usually when they are worried or suspicious that the husband is having an affair. It should be noted, nevertheless, that a spouse's perception of risk can also be influenced by the spousal discussion itself, which raises a potential problem of endogeneity. As the qualitative data (presented in section 5) show, some respondents appear to indicate that their perception of the disease and sexual behavior reformed following conversations with their spouses. However, the variable is included in this analysis because the vast majority of the transcripts show that worrying about being infected, which is mostly influenced by the spouse's knowledge or suspicion of the partner's infidelity, is the key factor that pushes spouses to talk about their personal and joint risk of HIV/AIDS infection. The wife's correct knowledge that a person can contract the HIV virus from a healthy looking person is associated with higher probabilities of spousal communication. Considering that most men who have extra-marital affairs do so with "healthy-looking women", wives who think that a healthy-looking person can not transmit the HIV virus would be less worried about the husband's extramarital liaisons and, consequently, less likely to initiate a discussion about the need to take precautionary measures.

Most of the couple-characteristic variables that we examined (e.g. education, age gap between spouses, sharing information on income, etc) did not have a significant impact on spousal communication about the joint risk to HIV/AIDS. Couples where both the husband and the wife said they have never talked about family planning, however, exhibited the highest probability (0.16) of both of them saying they have never talked about HIV/AIDS, implying that some couples are simply not predisposed to discuss such reproductive health issues.

The Z-score ranking of the most important determinants of spousal communication (included in the model) about the risk of contracting HIV/AIDS are the size of the woman's informal social network, accessing information about the disease from clinics, and whether the couple have also discussed use of family planning or not, followed by the husband's social network, women's correct knowledge that one can contract HIV/AIDS from a healthy-looking sexual partner, and the extent of worrying about contracting the disease. Region of residence was included in the model to check whether there were contextual differences in the extent of spousal communications about HIV/AIDS. The results show that couples in the Center are significantly more likely to discuss the risk of HIV/AIDS than couples in the North and South, while there was no significant difference between those in

the South and the North. The Center follows a mixed kinship and lineage system, while the North is predominantly patrilineal/patrilocal and the South is predominantly matrilineal/matrilocal, which suggests that spousal communications on HIV/AIDS may be influenced by lineage systems and associated differences on female autonomy and status. In the analysis of spousal discordance on various survey questions using the same data, it was found that spousal differences on family planning and AIDS conversations were statistically significant in the Center and the South, but not in the North (Miller, Zulu and Watkins 2001). Given that one of the key differences across the three areas is that the North has higher levels of women's status as measured by levels of education and freedom of movement (Schatz 2002), the study suggested that women's status could be positively associated with spousal agreement. It is not clear what aspects of the contextual differences actually affect spousal communication.

The results for spousal disagreement are not as consistent and clear-cut as the ones distinguishing couples where both reported either that a conversation took place or did not take place. Couples where the wife has more network partners and the ones where the wife correctly knows that one can contract the disease from a healthy-looking person increased the likelihood of discordance while cases where the husband was worried about contracting the disease significantly reduced the likelihood of discordance.

Table 2: *Effect of various factors on the likelihood of spousal discussion of HIV/AIDS risk (Multinomial logistic regression coefficients and standard errors: Reference category is "husband and wife say they did not talk about HIV/AIDS), 1998 Malawi survey*

BACKGROUND FACTORS	BOTH SAID THEY TALKED	ONE SAID THEY TALKED
STUDY AREA		
North (reference category)	-	-
South	-0.320 (0.455)	-0.260 (.461)
Center	0.831 (.386) **	0.636 (.340)
STIMULUS FACTORS		
AIDS network partners (wife)		
0-4 (reference category)	-	-
5+	1.089 (.306) ***	0.704 (.310) **
AIDS network partners (husband)		
0-4 (reference category)	-	-
5+	0.888 (.328) ***	0.367 (.329)
Heard about AIDS at Clinic		
Both say they have (Reference Category)	-	-
Only wife says they have	-0.927 (.402) **	-0.538 (.405)
Only husband says they have	-1.618 (.437) ***	-0.782 (.424) *
Both say they have not	-1.492 (.638) **	-1.009 (.628)
RISK FACTORS		
Worry about getting AIDS		
Both are very worried (Reference Category)	-	-
Only wife is very worried	-0.510 (.467)	0.681 (.477)
Only husband is very worried	-1.071 (.506) **	-1.292 (.523) **
Both say they are not very worried	-0.879 (.495) *	-0.342 (.495)
Wife aware that that one can contract HIV from a	1.099 (.452) **	1.019 (.456) **
COUPLE CHARACTERISTICS		
Talk about FP		
Both say they talked (reference category)	-	-
Only wife says they talked	0.165 (.515)	0.404 (.523)
Only husband says they talked	-0.022 (.464)	0.349 (.471)
Both say they did not talk	-0.931 (.368) **	-0.462 (.374)
Wife's Age		
15-24 (reference category)	-	-
25-34	0.371 (.354)	0.244 (.359)
35-49	0.854 (.382) **	0.478 (.386)
CONSTANT	0.396 (.689)	0.321 (.694)
Number of Cases	705	
Log Likelihood	-574.099	
Pseudo R-squared	0.093	

Note: * - p<0.10, ** - p<0.05, *** - p<0.01

Table 3: *Estimated probabilities for spousal discussion about HIV/AIDS Risk, 1998 Malawi survey*

BACKGROUND FACTORS	BOTH SAID THEY TALKED	ONE SAID THEY TALKED	BOTH SAID THEY DIDN'T
STUDY AREA			
North (reference category)	0.559	0.336	0.105
South	0.551	0.330	0.119
Center	0.607	0.337	0.057
STIMULUS FACTORS			
AIDS network partners (wife)			
0-4 (reference category)	0.487	0.368	0.145
5+	0.633	0.314	0.053
AIDS network partners (husband)			
0-4 (reference category)	0.456	0.406	0.139
5+	0.619	0.311	0.071
Heard about AIDS at Clinic			
Both say they have (Reference Category)	0.636	0.305	0.059
Only wife says they have	0.449	0.393	0.157
Only husband says they have	0.397	0.436	0.167
Both say they have not	0.407	0.407	0.185
RISK FACTORS			
Worry about getting AIDS			
Both are very worried (Reference Category)	0.595	0.329	0.076
Only wife is very worried	0.641	0.275	0.085
Only husband is very worried	0.615	0.260	0.125
Both say they are not very worried	0.493	0.422	0.085
Knowledge that one can contract HIV from a healthy			
Wife does not know (reference Category)	0.472	0.302	0.226
Wife Knows	0.586	0.338	0.077
COUPLE CHARACTERISTICS			
Talk about FP			
Both say they talked (reference category)	0.663	0.284	0.053
Only wife says they talked	0.556	0.367	0.078
Only husband says they talked	0.541	0.385	0.074
Both say they did not talk	0.459	0.377	0.165
Wife's Age			
15-24 (reference category)	0.532	0.356	0.112
25-34	0.594	0.332	0.074
35-49	0.613	0.311	0.076
OVERALL	0.577	0.335	0.088

5. Content of spousal conversations about HIV/AIDS

In what follows, we use semi-structured interviews to describe the content of spousal communication on AIDS in our study communities. We emphasize that we were not able to overhear conversations as they actually occurred: we only have access to what the respondents chose to tell us about them. Many conversations are reported in "he said, she said" format, giving the impression of a real conversation. They appear, however, to have been brief and somewhat laconic. This may adequately reflect the actual conversations. On the other hand, spousal conversations are clearly private: almost all respondents said that they occurred when the husband and wife were alone, and respondents–perhaps some more than others–may have wished to protect this privacy by being brief about what they discussed.

In presenting the results, we identify respondents by region (S=SOUTH, C=CENTER, and N=NORTH), gender (M=male, F=female) and ID number. The interactions between interviewers and respondents include many repetitions and murmurs (e.g. "Mmm", "Eeeh"); we include these as they give a sense of the conversational flow. There are evident gender differences in some aspects of respondents' approaches to spousal conversation, and we comment on these. We did not detect regional differences, but since region was significant in the preceding analysis of correlates of spousal discussions, we provide such identifying information as well. The lack of regional differences in the content of spousal conversations suggests that despite the structural differences (in kinship, residence, and religion, etc.) across the three regions, husbands and wives use the same conversational strategies and raise similar issues when they discuss their joint risk of contracting HIV/AIDS.

5.1 Joint fates

Overall, it is evident that both spouses perceive their fates to be joined: that if one becomes infected, the other will also be (see, also Schatz 2002, Tawfik 2002). The word "move" used below is one of a set of terms (moving, movements, "movious", walking) that are often used to refer to sex outside marriage:

> I: *What made you talk about AIDS*? R: We saw a certain woman from our village, then my wife started warning me that 'my husband, these days do not move anyhow, because the times are bad, if you catch this disease then I will automatically catch it too, then our children would be orphans when we die' (N-M-04)

Over and over again, both husbands and wives emphasize that it is not enough for one spouse to take precautions against infection with HIV but that both of them must do it.

I: *So did you speak with your wife about the dangers of the world, that there is AIDS?* R: Yes. I have. I: *So, what made you speak with your wife?* R: Because we see how people die of AIDS, and how dangerous it is. So it acts as a lesson to both of us that if I do this, I might die. So we stay without going with other partners. I: *What did your wife say about it when responding to what you said?* R: It's the same. She says that we need to take care of ourselves, because we might say that we don't have it while we have got it. So, let us continue the way we are, avoid other partners, because if you do not, you die soon. That's what she said. (C-M-04)

I: *Have you ever talked with your husband on the AIDS issue*? R: Yes. I: *O.k.!* R: We were talking that 'My darling, this time it's dangerous...I: *mmh*....R: maybe I can be moving with others, you can die because of me....I: *mmh*....'R: But that is not good.' I: *Eeh.* R: We were both agreeing that it's not good and comforting one another...I: *Mmh*...R: ...I should be looking after my partner and the partner looking after me." (S-F-08)

I: *Can you tell me when you talked with your husband about how you can protect yourself from this disease in your house?* R: With my husband, we talk daily. I: *Day by day?* R: Yes. I: *What does he say when you talk to him?* R: Aah! The answer is the same –'I can take care of myself'–so I cannot know the life of my partner inwardly. Mmh! Eeh! I: *What makes you talk day after day?* R: I have seen the danger in the world, oh! (N-F-04).

These segments are typical not only in portraying perceptions of a joint fate, but also in the assumption that the major source of infection is from a spouse who "moves" around. This is supported by the 1998 household survey data, where respondents were asked what they thought was the way they were most likely to contract AIDS. For males, 38% answered that it was from "other partners"; while 23% reported that it was from their spouse. More female respondents than male respondents thought their most likely risk was from their spouse (51%), while 21% said it was from another partner. The qualitative interviews, however, suggest that when women attributed risk to "other partners", they mostly meant "other partners of my husband" or "other partners of myself if I had them." This is not to say that all wives are faithful, but rather that both men and women are reluctant to acknowledge the unfaithfulness of a wife to an interviewer. A man who has evidence that his wife is unfaithful is expected to divorce her, and the norms about fidelity for a woman are such that we expect women to under-report extramarital affairs. That women's extramarital affairs are under-reported is suggested by the contrast between the low proportion of female respondents on our survey that reported an extramarital affair and

the higher proportion (about double) of their "best friends" who the respondent said had an extramarital affair. In addition, an intensive study of a sub-sample of the 1998 survey respondents by Linda Tawfik asked women about the extramarital affairs of their married female friends and men about their affairs with married women. Broaching these sensitive questions only on a third interview with the respondent, Tawfik found that extramarital affairs by women were not rare (Tawfik 2002).

5.2 Stimulus of HIV/AIDS conversations

If a respondent reported that the couple had not discussed AIDS, the interviewer asked why that was the case. The answers were typically short; the respondents either simply repeated that they had not talked, or said they did not talk because there was "no point". It may also be that respondents simply did not wish to tell the interviewer about a conversation. On occasion, however, the "no point" was amplified as the respondent explained that there was no need to talk because they trusted each other or that the respondent (in this case, always a wife) could not believe what the man would say, so there was no point in addressing the topic.

> I: *Have you ever discussed with your spouse the dangers of AIDS?* R: We have never discussed the issue. I: *Then why didn't you discuss with the spouse?* R: There is no reason. I: *Therefore it means you don't get worried with the disease?* (laughter) R: It's a very dangerous disease and we do fear it. I: *Then why not [discuss]*? R: It's because though we will discuss, there is nothing [we can do].I: *There isn't what?* R: Though you try your best to discuss this, he will still continue deceiving you and go with other women. I: *Oh.* R: Therefore you will be just wasting your time and energy telling him. I: *It means you don't totally trust him that you think he does move with other women.* R: Yes. I: *Is there anywhere you got the information that he has a girlfriend? R: I* have never heard it. (S-F-19)

> I: *Why didn't you talk with him?* R: Because everybody thinks that maybe my friend [husband] takes care of himself. I: *Ooh! You just think of that*? R: Yes, thinking that maybe he takes care of his body (S-F-21).

> R: We already know that there is AIDS in the world and we hear about that in the radio but we have never discussed. I: *What do you hear on the radio*? R: That they have searched everywhere, but there is no cure for the disease...I: *Since you say this is in the mouths of people everywhere, haven't you discussed with her?* R: She already knows there is AIDS in the world, so we need not discuss because she also

> hears it on the radio that the disease exists. So how do we discuss this when we already have access to all the information we need from the radio? (N-M-18)

"No point" was likely to be explained in terms of either an expected disagreement with the spouse, as in the segment above or the respondent explains that both husband and wife have similar views so there is no point in a discussion. Of all the qualitative respondents, 7 women and 2 men said they had never discussed AIDS with a spouse.

If the respondent said that spousal discussion about AIDS had occurred, the interviewer asked how the issue came up and who initiated the discussion. In the 14 cases where women indicated who initiated the discussion, half were initiated by men and the other half by women. The same breakdown was noted for men: 7 initiated by women, 8 by men and 2 by both. However, in cases where the couple talked specifically about their own risk or contracting the disease or where one spouse suspects the other of infidelity, wives were more likely than husbands to initiate the conversation on AIDS. Out of the 18 cases were one spouse suspects the other of infidelity, women initiated conversations in 13 and men in 5 cases. It seems, therefore, that when couples are discussing HIV/AIDS in general, men and women are equally likely to initiate the discussions, but women are more likely to initiate discussions relating to the couple's own risk of contracting the disease. A study of factors affecting husband's infidelity using the 1998 and 2001 survey data demonstrates that suspicions about a spouse's fidelity are often not baseless; wives' suspicions remained significantly associated with husband's infidelity even after controlling for other factors typically associated with infidelity among men (Clark 2003).

In 37 cases the conversation began with a reference to something outside the domestic sphere–hearing something about HIV/AIDS from the formal system (9 from the radio, 1 from clinic or health facilities), a conversation with a network partner (3), or, particularly, mention of seeing or hearing about someone who was very ill or who was suspected of having died of AIDS (24). Certainly the illness or death of friends, relatives or neighbors is a topic of intense interest. But it may also be that beginning a discussion of AIDS with a spouse by referring to something outside the home provides cover for the introduction of what could be a sensitive topic, given the normative importance of marital fidelity and the strong perception of the link between AIDS and infidelity.

5.3 Risk perception

In addition to conversations that were apparently provoked by something outside the domestic sphere, some may have been provoked by an immediate need, specifically by the perception of one of the spouses that the other needed to be persuaded to reform. In 41 of the cases, the spouses caution each other against extramarital affairs, while in 20 cases the

wife cautions the husband, and in 4 the husband cautions the wife. The fact that concerns about the risk from a partner is a central theme of the conversations is also evident in examining the explanations that the 9 respondents who said they had never discussed AIDS with their spouse gave:

> R: That one's heart is the same as mine....I: *How do you know?* R: Ah, I see him. I: *Oho*. R: Yes, because if a person is doing this and that, it is easy to see him. I: *Just to see a person, you can know his heart?* R: Yes, of course, because I got married to him long time ago but I never heard anything. I: *You never heard anything about him*? R: I never heard anything and I never saw him going here and there (S-F-22).

The closest any male respondent came to admitting suspicions of his wife was one man who, when asked whether he thought he might become infected by his wife, answered as follows:

> "I: *Now have you heard that others are afraid of catching the disease from their wives?* R: Aah! No, I have never heard. I: *Never?* R: Yes. I*: O.k., do you yourself have those thoughts that you might catch this disease from your wife?* R: I do have, in my heart. I: *If you do have, what do you tell your wife so she knows you are afraid of catching AIDS from her?* R: I do give her the family security, telling her to remember of these issues, mmm! I: *What do you tell her?* R: 'My wife, you should not forget the words I tell you, don't even once go out to walk with other men, because if you do you will cut off your life and my life.' Eeeh!" (S-M-23).

It may be that more men did have suspicions, but in the context of rural Malawi it would be embarrassing to admit that one was still married to an unfaithful wife. In contrast, many women doubted their husband. In four cases the wife referred to specific cases of infidelity. As evidence, women used observation**:** the husband returns from drinking late at night and the wife warns him that drinking is one thing but moving with other women is another. Or the wife may have found letters from another woman, found condoms in his pocket, or other people have told her that they have seen him with another woman. A woman with direct evidence has a number of options other than trying to persuade her husband to reform–she may seek mediation from relatives, she may divorce him, or she may harass the other woman by going to the other woman's house and challenging her by saying "Is my husband there?", or even fighting with the other woman (Schatz 2002). Women without specific evidence of a husband's infidelity may also have doubts based on the widespread assumption that it is difficult for men to be satisfied with only one sexual partner:

R: We have to care for our lives and he also tells me that even him, he doesn't go with other women, no! Only one, so I don't know whether he tells me the truth. That much I cannot know." ... Yes, I did tell him that night that 'you can be cheating me that you are not moving, well, it is better to go to those who have (keep) condoms and take them wherever you go', but that is where we do not agree' (C-F-09)

I: *Did you talk with your husband about how you can protect yourselves from AIDS?* R: Since I am a woman who always stays at home, we are tobacco growers and if we have money, my husband goes to the bars to use the money with bar-girls. Due to that problem, I do tell him that we are two wives so there is no reason for going outside. It is better to use one of us for what he needs at that time other than going to the bar and taking diseases for us. I: *Did he agree that he will be sleeping with the two of you only?* R: He agreed but I don't know if it was true. I: *Oooh! Don't you trust him?* R: I can't trust him much because it is always difficult for a man to depend on one woman. (C-F-03)

I: *Have you ever discussed with your wife in the house… about this story of AIDS?* R: We do discuss. I: *What do you discuss?* R: In discussing, we say that here, for us to prevent this disease, there is need that each one should not do adultery. I: *Who starts this AIDS story in your house?* R: My wife starts it. I: *So how does she start it?* R: In starting it, it happens that maybe you were somewhere chatting, and that you have come very late, and she asks you "aaa, when coming in this time, where were you? Nowadays, it's dangerous. Maybe you were with other women, explain it very well". So if you explain very well, it happens that she believes and that's how a woman starts it. I: *Now, when was the last time that you discussed this story of AIDS?* R: For the last time, the day before yesterday, I came very late, also the day before yesterday. So my wife asked, "where were you?" I: *So what did you say?* R: When she asked … I replied that I was up there (nearby village) at Chilito. When I told her that, she did not leave it there. In the morning, she went to ask if it was true that I was there. Fortunately, they acknowledged that I was indeed there. (C-M-16)

In a survey conducted in the same district in the South (Balaka) as the 1998 survey, women and men were asked whether they agreed or disagreed that women and men could be satisfied with only one sexual partner (Tavrow 1994). When respondents referred to the other gender, about 54% of women and 45% of men said they disagreed; when respondents referred to their own gender, about 40% of the men and 33% of the women said they disagreed.

When a woman did directly accuse her husband in a conversation with him, these were met either with denials or with the husband saying he had reformed and was not engaged in such activity any more, or sometimes the husband tried not to prolong the conversation by answering "Yes" or "No" and trying to be non committal. Women who had made an explicit accusation typically did not challenge the denials or expressions of reform. Some, however, indicated to the interviewer that they were not convinced:

> R: Talking with him that, 'as you know, the world is not good as it was before. What's needed now is that we should depend upon each other to avoid having it'...Eyaa! Since he is a man, he can just answer saying 'yes', since he knows all the ways to do things secretly. He knows, yes. Then everyday you just say 'aaa! But my friend, there is nothing good outside.' I: *Eeh! He! What did he respond when you said that?* R: He just responded saying 'aaa! I can't do that because I know that the world nowadays is not good, so I can't do it [move around], let us just depend on each other.' I: *Did you believe his denials?* R: I believe in him but not very, since nobody knows what someone else is thinking about. But I don't think that is true, because men are difficult. I: *Mmm! And now if the husband has answered you as he did, what did you answer then?* R: I just said that 'o.k., since you already know that there is a dangerous disease outside. If you trust me, let us continue.' (S-F-17).

> I: *O.k., what about your husband, have you ever talked with him about AIDS?* R: Yes, he talked also. I: *Oh. R: Eh. I: So can you remember the last time you talked about the issue?* R: Because for the men they can be saying 'There is a dangerous disease, I can't walk in the bush, I can't do this.' But sometimes they do what they denied they could do. For example, now he was saying that he can't have two wives, but as of now he has married another wife. So can I believe that he can't do bad things? I*: Eh.* R: He can do because he has already done it. He doesn't know if the woman he has married is fine or even that she has a disease, or even me, I cannot know. I: *ooh. So that day when he was saying that, what happened for him to talk like that?* R: Ah, only that he was happy himself. So when he was happy like that he started talking. I: *Eh.* R: So what was wrong in his mind, I can't know, for it is men. I: *Eh.* R: So I just heard 'I want to marry another wife'. Then I said, 'okay, go and marry.' Can I stop him while his heart wants? He can go. I: *So what did you tell him the day he started talking about AIDS?* R: I told him that "If a person moves around, you take diseases–for example, for you and me, for us women, you can be saying that 'You have your husband, you can't go in the bush [outside marriage], and you stay at home. But maybe you men can be saying that 'I don't want my wife to walk in the bush' but you are the one who walks in the bush and take the disease and gives it to your wife in the house, and the wife becomes sick and you the owner become

sick too. That is a very difficult way.' He said 'Oh me no, I cannot do that', but now he has done the same thing he said he cannot do. (S-F-18).

I: *So, what about this issue of AIDS? What conversation did you have with your husband?* R: We talked. I said: "You should stop moving around. There is AIDS these days. It is important to take care of yourself". I: *Ah ah! So what did he say?* R: He just said: "That's true". But I cannot trust what he says. I: *Why can't you trust what he says?* R: Ah, men move around too much. I: *Ah ah! They go this way and that way?* R: mmmh that's it. I: *So you fear that your husband might be going out with this woman and that woman?* R: Eeeh, these men, you can't tell. I: *Oh, you just wonder?* R: Yes, I don't know. I: *So you just fear?* R: Eeeh, it is really better to die from a disease from God [rather than from AIDS]. (C-F-18).

5.4 Marital relationship

Directly challenging a spouse about infidelity risks an argument, which both spouses try to avoid because persistent arguments are not compatible with a good marriage. This is evident in the persistent use of the pronoun "we" rather than "you", e.g. "We must be careful, my friend" rather than "you must be careful". There is perhaps a somewhat greater burden on the wife to avoid an argument, related to gender roles: wives' "rudeness" is often given by men as a justification for divorce (Schatz 2002), but the reciprocal is often not the case. Moreover, the woman faces the threats of violence, or the husband leaving her and taking another wife. Thus, when talking with their husbands, women were much more likely to talk in general terms about men's behavior (as noted earlier, only four made reference to specific infidelity) and to present women in general and themselves in particular to simply be "at home", in the domestic space while men were exposed to the temptations of the world.

African marriages are sometimes characterized as being based more on utilitarian than emotional considerations. The parents of our respondents interviewed in a separate project complained that marriages of today are shallow, quickly made and quickly broken, unlike those of their generation (Kaler 2001). Yet in interviews about marriage conducted in another project, respondents often spoke of marrying for love (Schatz 2002), and many of our interviews suggest some level of intimacy and closeness between husbands and wives:

R: "After we eat *nsima* [the staple food, made of maize flour] and get enough, we talk that "you have seen that there is AIDS nowadays...I: ...*eh*....R: ...so AIDS is difficult...I: *Eh*...R: Every person should be at home with his wife...I: *eh*...R: ...if you are not married keep quiet, and better get married....I: *eh*...R: ...because the disease

is difficult. I: *Eh*. R: It is different from other diseases. I: *Eh*. R: Some diseases get better if you take medicine, a person recovers....I: Ee*eh*...R: But this disease...I: *eh*...R: ...has no medicine. I: *Eh*. R: No medicine, we die (S-F-13).

R: As we're lying in bed at night, I often talk to my wife and tell her that 'My wife' and she said 'Eeh', 'know that this world is now dangerous, as we are married we should try to avoid moving. And take care about the family. The disease is now too dangerous, you may catch the disease and give it to me, or I may catch the disease and give it to you. Then we all die, and our children will suffer later on... (S-M-23)

Spousal discussions of AIDS were often framed in terms of care for the children: they give the strong impression of husbands and wives committed to the joint responsibility of raising and providing for their children. The speakers often explicitly note that if one is infected, both will die, but the emphasis is on the fate of their children should they be left orphans. Concern for the children appears to be genuine and profound, but it may also serve a tactical purpose, a way of emphasizing the importance of AIDS by noting its implications not for the health and well-being of the speaker but for their descendants:

R: Myself, I said...that you are seeing your friends are dying leaving the children. Is it good that your children should also be suffering like this? ...Because if it has affected one, killed one, the other is also finishing [dying]... So there is nobody to care for the children here on earth. Ah! We are seeing our friends dying–-how they are dying. In our family, our sisters, and our brothers–they have all finished [died] leaving children-–orphans. (N-F-23).

R: I talked with him that nowadays, we have to depend on each other because there is a dangerous disease of AIDS. I*: Was that sentence spoken by you or your husband?* R: I was the one talking. I: *What did he answer you?* R: He said that 'Of course, I am controlling myself to avoid the virus which causes AIDS because AIDS is killing many people and if I die my children will suffer because there is nobody to look after them since my mother is very old. I: *When he answered you, what did you say then*? R: I said that 'If you are controlling yourself, then you are right because I can control myself, but to a man it is difficult so you must try hard to control yourself.' (C-F-06)

I: *Eeeh, have you ever discussed with your wife this issue of AIDS?* R: We do discuss, that, 'see now out there it is dangerous, we must take care of ourselves. Because if we will go on unknown ways we are going to be injured. See, there are

children, they will be orphans, who would take care of them?' And she was agreeing that 'It is true, we must be careful.' (S-M-07)

Although children are often emphasized, this is not invariable: the majority (22 cases) referred to the importance of avoiding AIDS either for sake of the children alone or of the parents and the children. However, in 18 cases it was the parents themselves who were of central concern.

R: We talk...that 'my wife, sometimes men who move and women who move are problematic, because I can get the disease of AIDS outside and run into the house and then meet you and give it to you, thus...I have destroyed the marriage... So who is going to work for me then? ... Nobody to work with me... Or you will move and give me a disease, and who is going to help you with development [improving the family's wellbeing]? (S-M-13)

Sometimes women use examples of their friends, relatives or neighbors as a way of justifying the conversation and also to support their claims (12 cases). For instance, couples where one partner is having extra marital affairs is mentioned as a way of warning the partner to avoid having such affairs, and also as a way pointing out their dangers; for instance the danger of HIV/AIDS infection for both partners. The same strategy is also used in spousal discussions relating to use of contraceptives. Women mostly cite other people who are using family planning and how it has greatly assisted these persons or the problems they have faced because of using family planning methods depending on whether the conversation is for or against family planning. Examples of families with many children who are constantly sick or starving are mentioned as a way of bringing up a conversation on family planning.

Although we did not specifically ask the respondents whether the discussions about the risk of contracting HIV/AIDS helped in promoting preventive sexual behavior, there is a sense in the reports that those who initiated the discussions believed, or at the very least hoped, that the discussions would lead to reform in behavior. Many women who had doubts about their husbands' fidelity pleaded with them to stop moving around or avoid the temptations of the world to save their own lives, and ensure that their children do not suffer when orphaned. In some cases, as the examples below show, some of the men conceded that the discussions got them to think twice about their behavior:

I: So, *did you speak about AIDS in your house?* R: We had a conversation. I: *Who started to speak about this story?* R: Who started to speak was my wife. She said, 'My husband, the greatest thing, I'm your wife. Don't just say if you go to Ulongwe or Liwonde (nearby small towns) or elsewhere and start gazing at women (being

attracted to). I: *mmh!* R: 'No, my husband, not that.' so I listened to her...I: *mmh!* R: Because I know that when this woman is warning me with these words, she is giving me life.' I: *mmh!* R: If I ignore her and say what she tells me is useless, in the end I might get into problems …. So I listen to her…I must hear what my friend (wife) says. (S-M-02)

I: *Oh! So what did you say?* R: I said that, but in this world there is a disease, we must fear for each other...I: *eh...* R: in what we do I: *Ooh, so you just said so?* R: Yes. I: *Didn't you continue?* R: No, I didn't continue. I: *So what did he answer?* R: He said, oh, I think each person should take care of himself. I: *Oh, so what did he mean by "take care of yourself?"* R: Taking care of yourself means that they should avoid moving around with other women outside. I: *Eh* R: Mmmm. I: *Ooh. So for you to start this story that there is AIDS, as you have explained, how did it start, what started it*? R: I was surprised with his movements. Eh, he was coming late at night, and then I started saying 'aah, he will bring me what? He will bring me AIDS.' I: *Have you ever heard your husband express his worried about AIDS?* R: Him? I: *Yes.* R: He talks. I: *What does he say?* R: He says that...I: *Eeeeh*. R: 'me, though they are saying that I do move around...I: *Eeeeh* R: Those people ... they are not saying good things, nowadays I have changed. (S-F-20).

Whether the conversations actually lead to a reform of sexual behavior or not is a critical issue that is beyond the scope of this paper. As mentioned before, some studies suggest that spousal communication may be associated with adoption of preventive behavior, including HIV testing (Shoop and Davidson 1994; Rickman et al. 1994; DiClemente 1991; Zamboni, Crawford and Williams 2000; Gage and Ali 2003).

6. Conclusion

While various studies have shown that spousal communication facilitates adoption of modern family planning, little is known about the relationship between spousal communication and adoption of protective behavior against HIV/AIDS, as well as factors that facilitate or inhibit spousal communication. In this study we use quantitative and qualitative data collected from rural Malawi to examine correlates of husband-wife communication about the risk of contracting HIV/AIDS and what husbands and wives say to each other about their risk of contracting HIV/AIDS in order to understand the strategies that couples are following to prevent the intrusion of AIDS into the home.

The quantitative data show that the most important factors influencing spousal communication about the risk of contracting HIV/AIDS are size of the woman's informal

social network, accessing information about the disease from clinics, whether the couple have also discussed use of family planning or not (which we interpret as a proxy for the general level of spousal conversation about reproductive health issues) and the extent of worry about contracting the disease. Similar factors generally determine whether husbands and wives agree that they talked or not, although the results for spousal discordance are less clear-cut and consistent. These data, thus, highlight the importance of access to information about AIDS and worrying about the disease in spousal communication; people who interact with others more and those who report more program information are more likely to bring up the issues with their spouses than those who do not have large social networks and program connections.

The qualitative data show that spousal communication is an important mechanism through which married people express their fears and anxieties to their partner as a result of the recognition that controlling their own behavior is not sufficient. The discussions of HIV/AIDS risk and preventive strategies within marriage are often introduced with reference to specific stories and events relating to AIDS and irresponsible sexual behavior. These discussions on HIV/AIDS are conducted cautiously, and, for the most part, to avoid marital conflicts and disagreement. The common strategy that is followed to achieve a harmonious discussion is to introduce the discussion with reference either to something or to someone outside the domestic sphere or to concerns about the implications of the disease on their children should both parents die. Contrary to the pessimistic accounts in the literature about how people have lost hope and given up to fate on HIV/AIDS in Africa, the qualitative data show that husbands and wives in rural Malawi are actively confronting and challenging their spouses to prevent the intrusion of the vicious disease into their lives. When the couple fails to achieve such a discussion, the recourse is to seek intervention from relatives or friends, although serious disagreements on these issues may lead to physical confrontations or divorce.

Most discussion on the joint HIV/AIDS risk, especially those where one spouse suspects the other of infidelity, are introduced by women. This is not surprising, since it is generally understood in these communities by both men and women that men indulge in extra marital relationships more than their wives. Women often make reference to discussions that they have had with their friends about AIDS and how the disease is devastating their communities by killing husbands and wives, leaving children to suffer. So, rather than the women arguing that the man should not indulge in reckless sexual behavior because he would infect and kill her, she focuses on what would happen to the children if both of them die. While the discussion may become confrontational if the woman directly accuses her husband and the man denies her accusations, the focus on the future of the children or talking about men's irresponsible sexual behavior in more general terms appears to be a strategy to ensure that the discussion is constructive and that the couple agree that there is indeed need to be careful and/or reform sexual behavior. Men

normally respond to such general discussions, and even to direct accusations of infidelity, by saying that they are aware of how dangerous the world has become, and that they are not foolish to be sleeping around recklessly, even when the evidence is there that they have been doing otherwise. The wives are often not fooled by such responses, though, because when asked what they think about what the husbands responded, some say that it is just a man's way of saying "no", and that it is not easy for a man to stick to one woman. Although the reported conversations are brief, they give a clear indication that verbal communication is actively utilized as a key strategy by marital partners, particularly wives, to persuade each other to avoid extramarital affairs to avoid falling victim of the AIDS menace. The urgency to fight the threat of HIV/AIDS to marital partners has been paused as one of the key factors leading to the decline in the period of postpartum sexual abstinence in Malawi and other settings in sub-Saharan Africa (Cleland, Ali and Capo-Chichi 1998, Zulu 2001). Wives, who bear most of the responsibility for observance of abstinence, are increasingly giving in to their husbands' demands to resume intercourse before the end of the normative duration of postpartum abstinence because of fears that the men may go to other women and bring the HIV/AIDS virus home (Zulu 1996)."

It is noteworthy, however, that none of the spousal discussions reported in this study made reference to use of condoms when discussing strategies to deal with the joint risk of contracting HIV/AIDS within marriage. The one reference to condoms was made by a woman who was telling her supposedly promiscuous husband to use condoms with his other women; all discussions of preventive strategies within marriage focused on fidelity. This confirms many other findings that signify the negative view associated with condom use within marriage. The condom is widely believed to be associated with extra-marital sex and asking for it, even in cases where the spouse knows or suspects that the partner is having other affairs, brings all sorts of tensions that many spouses are not prepared to deal with.

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