

Chapter One

1.0 Introduction

Almost 20 years have past since the first HIV case was identified in Malawi. Since then one million young and adult population in Malawi has so far been affected by HIV/AIDS. The national adult population prevalence rate is estimated at 14.2 percent. However there is a disproportionate prevalence rates, women represent 56.8 percent of all HIV positive adults (MDHS, 2000). Although many reasons are cited for this disparity, some cultural practices which promote promiscuity contribute to this disparity. For instance having multiple sexual partners is condoned for men, similarly early exposure to sex. The sexual behavioural tendencies by men embedded in cultural practices which aim to demonstrate masculinity, have had an impact in the way women are rendered vulnerable to the virus. Culture assigns women to different attributes and roles from men. This facilitates in the way the virus that causes AIDS is spread but also in the capability to protect themselves from HIV/AIDS. The gap that exists in gender plays a major factor in the way men, women, boys and girls are at risk to contracting the HIV infection, the ways in which AIDS affects them, but also the kinds of responses to the epidemic.

Although HIV/AIDS has had far reaching impact on Malawian society, there is still occasion for hope. HIV is not spread by casual contact or by mosquitoes or in the air or water. There is no need to wait for expensive vaccines to be developed at some time in the unknown future to protect themselves. As HIV is spread by certain types of human behaviours; therefore, changing those behaviours and practices can control the spread of the virus. What is needed is continued involvement from all sectors of society to promote interventions to reduce high-risk sexual behaviours, treat and control other sexually transmitted diseases, maintain a safe blood supply, ensure gender balances and equality.

It against this background that the study aims at exploring the factors that put women and men vulnerable to HIV infection. In order to achieve the objectives of the study, the examines the internationally recognized HIV/AIDS indicators as laid down by Measure Demographic Health Surveys (Measure DHS). For the purpose of this study, the indicators are confined to sexual related behaviour, such as condom use and number of sexual partners, gender relations and decision making, perceptions on sexuality. The study thus uses hegemonic masculinity as a theory in an attempt to understand the gender relations and risk behaviour.

1.1.0 Relevance of the study

Research on how men and women are vulnerable to HIV infection and vulnerability to the consequences of the disease is crucial for understanding the course of the epidemic and identifying more effective interventions to prevent or slow the spread of the disease and treat those affected, particularly among poor and vulnerable groups such as women. Social science and epidemiological research applied to these questions can generate knowledge on factors that generate susceptibility to infection and influence the vulnerability of infected or affected groups, for example gender inequalities that force

risky sexual behaviours ought to be understood in greater detail. This study can increase understanding of risky sexual behaviours, perceptions about sexuality and gender disparities, informing interventions that aim to reach bridge the gap between men and women in order to mitigate its impact.

1.2.0 Research questions

The overall aim of this master thesis is to explore and explain how certain sexual behaviours put women and men at risk to HIV infection. On the basis of this objective, specific research questions were formulated to answer a particular sexual behavioural practice and power relations.

- What is the general level of condom use among men and women in Malawi? To what extent do socio-demographic characteristics have an influence on condom use?
- To what extent do men and women engage in risky sexual practices?
- In terms of power relations, to extent do women able to make independent decisions.
- what are the general perceptions on sexuality?

1.3.0 Objectives

The overall aim of the study is to explore the factors that render men and women aged 15 to 49 (men 54) at risk to HIV/AIDS in Malawi.

1.3.1 Specific Objectives;

Specifically the study will;

- examine general level use of condom among sexually active men and women aged 15-54 years.
- examine the differences the role socio-demographic background characteristics of condom use.
- estimate the extent women are able to make independent decisions.
- identify some risky behavioral practices that render men and women risk to HIV infection.

2 Literature Review

HIV/AIDS world Scenario

According to recent estimates from the UNAIDS/WHO Global Report (May 2006), around 36.3 million adults and 2.3 million children were living with HIV at the end of 2005. This number exceeded what the WHO projected in 1991 by 50 percent. In 2005 some 4.1 million people became infected with the human immunodeficiency virus (HIV), which causes AIDS at the same time there were 2.8 million deaths from AIDS - a high global total, despite antiretroviral (ARV) therapy, which reduced AIDS-related deaths among those who received it. The overwhelming majority of people with HIV, some 95 percent of the global total, live in the developing world. The proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care fuel the spread of the virus (UNAIDS, 2006).

2.1 Sub-Saharan Africa

Sub-Saharan Africa is by far the worst-affected in the world by the AIDS epidemic. The region has just over 10 percent of the world's population, but is home to over 60 percent of all people living with HIV. An estimated 2.7 million adults and children became infected with HIV during the year 2005, bringing the total number of people living with HIV/AIDS in the region to 25 million by the end of the year. HIV prevalence varies considerably across this region - ranging from less than one percent in Madagascar to over 30 percent in Swaziland (UNAIDS, 2006).

HIV prevalence (the proportion of people living with HIV) appears to have stabilised in this region because the number of new infections is roughly equal to the number of deaths each year. However, the total number of people living with HIV is still rising because of overall population growth.

In sub-Saharan Africa, AIDS killed approximately 2 million people in 2005. Although ARV drugs can dramatically extend survival, allowing many affected people to live a healthier and longer life, the drugs remain unavailable to most Africans (WHO 2003, UNAIDS, 2005)

Unlike women in most other regions in the world, studies show that women in sub-Saharan region are considerably more likely - at least 1.4 times - to be infected with HIV than men. A number of reasons have been suggested why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex and the younger age at initial infection for women (NAC, 2001).

A study in Durban, South Africa, which focused on the experiences of women living with HIV who were pregnant, highlighted the extent to which women's empowerment has been neglected (Tallis, 2002). The study showed that women interviewed had limited understanding of and information about AIDS and other STIs, many of the women

acknowledged that their partners were not monogamous, but had not had the opportunity and space to think through, analyse and personalise what this could mean for them (Tallis, 2002). Thus women are compelled to stay in these relationships mainly through fear of violence, and because of financial dependence on men. The scenario made worse if women are unemployed, and few have skills that would make them employable, hence independent (Desmond et al, 2000).

Women in sub-Saharan Africa are infected more often and earlier in their lives than men. Young women aged 15–24 are between two and six times as likely to be HIV-positive than men of a similar age. Although the rates even out in older age groups, it highlights the vulnerability of young women and girls and unequal power relations in many societies.

2.2 HIV/AIDS in Malawi

Malawi, like its neighboring sub-Saharan countries, has been severely affected by HIV/AIDS. The first case of AIDS in the country was diagnosed in 1985. Since then, epidemiological data show an escalating epidemic (National Aids Commission [NAC], 2001). For example, in a sample of pregnant women attending antenatal clinics in urban Blantyre, HIV seroprevalence rose from three percent in 1986 to over 30 % in 1998, decreasing only slightly to 29 % in 2001. In 2001, Malawi's national adult prevalence (15-49 years) was estimated at 15 %, translating into almost 740,000 adults living with HIV/AIDS (National AIDS Commission [NAC], 2001). There is a notable disparity in HIV prevalence rate between the urban and the rural areas, 25% and 13% respectively. Annual deaths due to HIV/AIDS are estimated at over 80,000, amounting cumulatively to 555,000 deaths since 1985. Consequently, the impact of the epidemic has affected all sectors of the Malawian society, especially social service delivery. The economic viability of most households has deteriorated due to loss of breadwinners and leaving behind a large number of orphans cared by the elderly and older siblings.

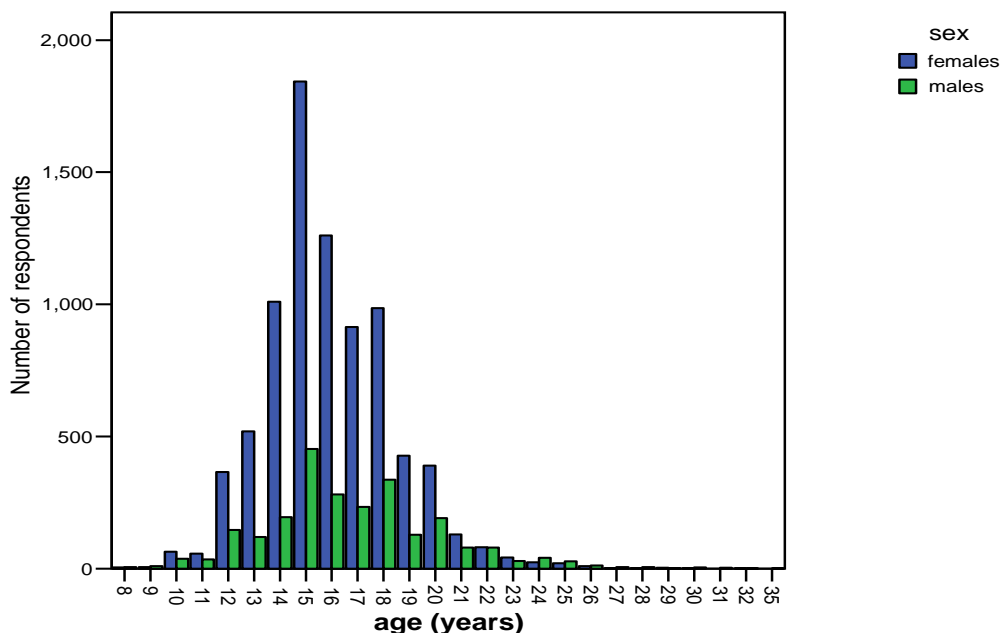
Although knowledge about condom is estimated at 97 % (MDHS, 2000), some men believe that using condom is being cheated out of their right to a high-grade sexual experience (Zulu, 2002). Women are placed at a disadvantage in terms of information on sex (UNAIDS, 1999). Such low knowledge has often led to misconception about condom use. For instance, a study conducted by UNAIDS (1999) reported that some women had misconception about condom use, and believed that a condom could harm internal organs (ibid). Other findings show that condom is not popular if used within a married couple; men may interpret requests for condom use as betrayal or attempts to deprive them of their rights in sexual decision-making within the relationship. There still exists unmet need on adequate information on condom use; consequently this puts them at risk to HIV (UNAIDS, 1999). Malawi National AIDS Commission [NAC] (2003) admitted that both men and women are at both risk but stressed that women are more vulnerable to the infections and diseases but HIV/AIDS affect both sexes differently (Rivers and Aggleton 1998, UNAIDS, 1999).

The situation is such that there 20 to 40 % more women infected than men. Similarly young female prevalence rates (16 %) were twice as much as for the young male adults (eight percent) (UNAIDS, 2000); citing that girls tend to have early sex with sexually active older men for social and economic reasons. The study attributed biological reasons such as women having a larger surface areas exposed to contact. In gender context, the study pointed out that due to women's lack of autonomy in making decisions on sexual health and the fact that culturally are taught from childhood to be submissive to the males, put them at greater risk to contracting the virus that causes AIDS (NAC, 2003). Yet an adolescent reproductive health and patterns of sexual behavior by NAC (2003) revealed that as a survival strategy, it was common among younger women to enter into relationships whereby they exchanged sex for money or gifts from males. In the absence of which, younger women, according to the study, would proceed to form new ones with someone. Why do women have to put up with it? Probably there is lack of alternatives. Some studies identified women's economic reliance on men, lack of access to education, poverty, sexual exploitation, rape and coercion, operating behind a line and hence being enhanced, by ideologies of masculinity and femininity (Aggleton, 1998). This makes it more acceptable and normal that women should be placed behind when it comes to economic decision making, opportunities for advancement, expressing their sexual desires and satisfying their sexual needs (*ibid*). Only rarely do women have direct control over the contexts, occasions and forms which sex takes place (*Ibid*). Angleton and Warwick (1998) suggest that women carry the blame for HIV infection and attract guilt from the community. In contrast men are more likely to be cared for by the community (*ibid*).

Women lag behind economic development, have less chances to be educated and female autonomy are low. Women in many cases have to seek consent from their husbands to seek medical help, access reproductive health services and not to mention to suggest condom use during sex. Injecting new meaning into the social constructs of masculinity that underpins the behaviour of men is all the more urgent in order to balance the gender difference (Kaler, 2003). Currently, attempts to reverse the spread of HIV/AIDS must address the critical role that gender relations plays in sexual and reproductive life, and how it affects HIV prevention. Indeed, the changing face of the epidemic brings into sharp relief the gender and social inequalities that shape people's behaviors and limit their choices (UNAIDS, 2004). Some studies have documented that much sexual risk-taking girls and young women is marked by unequal gender relations, and unequal access to resources, assets, income opportunities and social power (Bancroft, Janssen and Carnes, 2004).

Sexist customs and practices such as the payment of *lobola* (bride wealth) and *chithyola khola* (payment of 'damages' to the women's family for pregnancy) render women as commodities, and in some case have little or no say in within marriage (Tallis, 1997). Similarly age at which young boys and girls is begin sexual intercourse in Malawi is low (see figure 2). At age 15, most young adults have already had an experience of sex. Such practices risks HIV infection in that exposure period to sex is long and chances of changing partners are high (MDHS, 2000).

Figure 1: Age at first sex debut, MDHS 2000



Despite the available data showing alarming trends of HIV prevalence among women, women know less than men how HIV/AIDS is transmitted and how to prevent infection. What little they do know is often rendered useless by the discrimination and violence they face and their relative powerlessness to refuse sex or negotiate safe sex, especially in the context of marriage (Bridge, 2001). Thus Vulnerability to contract the virus is increased with lower education attainment.

It is assumed that women who are educated are more likely to be aware of their rights and are less likely to follow commands blindly (UNAIDS, 2004). Currently, attempts to reverse the spread of HIV/AIDS must address the critical role that gender relations plays in sexual and reproductive life, and how it affects HIV prevention. Indeed, the changing face of the epidemic brings into sharp relief the gender and social inequalities that shape people’s behaviors and limit their choices (UNAIDS, 2004). Some studies have documented that much sexual risk-taking girls and young women is marked by unequal gender relations, and unequal access to resources, assets, income opportunities and social power (Bancroft, Janssen and Carnes, 2004).

A review of the studies shows that much progress has been done in attempt to understand the mechanism facilitating spread of the virus that causes AIDS. It is no doubt that epidemic’s impact on demographics, social and economic sectors are well understood. Furthermore, detailing how some risky behavior inherent in cultural beliefs put women at greater risk than men have also been discussed in many research circles. However, most interventions and researches targeted on certain groups such as commercial sex workers.

Interventionist programs have aimed at behavioral change as the main avenue of fighting the epidemic. Considerably less attention has been given to the understanding of the role of gender plays in the way one is at risk to HIV. Gender based factors that influence men and women involvement in risky behaviors are not well understood. Research primarily focused socio-economic background characteristics of individuals more likely to engage in risky behaviors known to transmit HIV, is therefore needed to enhance the development of effective strategies to prevent the spread of HIV. Identifying risky groups may help reconsider responses to gender based determinants of risk to the virus that causes AIDS.

3 Theoretical Framework

Introduction

One of the pressing problems facing this line of research is the conceptual challenge of defining what masculinity actually is, and how it could be measured or surveyed in a manner useful to tackle problems arising from societal and cultural values and norms. Since the 1970s, masculinity has increasingly been defined with an emphasis on social factors and less with an emphasis on essentialist (often biological) understandings of men. Yet, clarity on how masculine identities can be socially conceptualized remains ambiguous. The current analysis and inquiry, is the concept of masculinity which explains the gender relations in terms men's dominance role in the society and their involvement in risky behaviours.

3.1 Theories of masculinity

In Connell's understanding, masculinities are relational: different masculinities are constituted in relation to other masculinities and to femininities through the structure of gender relations and other social structures such as class and colonialism. Masculinities can be categories into four main categories: dominant, complicit, submissive, and oppositional or protest. He argues that contestation between these masculinities occur and that these analytical categories are themselves fluid:

‘any one masculinity, as a configuration of practice, is simultaneously positioned in a number of structures of relationship, which may be following different historical trajectories. Accordingly, masculinity... is always liable to internal contradictions and historical disruptions’ (Connell, 1994 p73).

Cornell (1995) suggests that various forms of masculinity performances exist. However, an important element in masculinity performances is that they are positioned hierarchically according to their relationship with a normalised construction of masculinity (Martino, 1999). Such performances have been likened to the men and boys who privilege their interests over women and girls. Such a setup of power is referred to as hegemonic masculinity and is often exemplified in men and boys who are perceived to be strong, sporty, rational, stoic and risk takers (Ouzgane and Coleman, 1998).

3.2 Hegemonic Masculinity

According to Connell understanding, hegemonic masculinity relates to the configuration of gender practice which embodies the currently accepted legitimacy of the patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women (Connell, 1995). He argues that hegemonic masculinity is not fixed, but is culturally constructed (*ibid*). It must be emphasised that very few men are actively pursuing hegemony, but the majority of men benefit from it because of the overall advantage available to men of the subordination of women (*Ibid*). In many aspects, hegemonic masculinity, men have stronger positions socially, culturally and

economically. This gives them more control in deciding when and where to have sex, as well as whether or not to use condoms. In some traditions masculinity is constructed and measured by how many sexual partners one has. Such macho attitudes that encourage multiple sexual partners and risk-taking put men and their partners at risk of HIV infection (UNAIDS, 2003).

‘Hegemony Masculinity is an attempt to recognize male dominance as a material being, privileged and powerful within a particular setting. It promotes dominance over women; characterized by physical strength, aggressiveness, viewing women as sex objects. The form is considered as a legitimized privilege for men.’ (Whitehead, 2002 p97)

To understand this conceptual arrangement, Connell argues that certain constructions of masculinity are hegemonic in that they reflect and reproduce a social dynamic, while others are subordinated or marginalized. He argues that this hegemonic masculinity not only oppresses women, but also silences or subordinates other masculinities. There are varying reasons for men's resistance to gender equality: material benefits – the "patriarchal dividend" to men from gender inequalities (Connell, 2002). Men may have an expectation of informal benefits, such as receiving care and domestic service from women in the family. Godenzi (2000) has emphasized material inequalities of income and time: "Men's violence against women is both a means and an expression of the conditions of inequality between men and women."

Other researchers put more emphasis on fluidity and multiple identities of masculinity, suggesting that there can never be a totally comprehensive dominant masculinity that ever completely controls subordinates (Cornwall & Lindisfarne, 1994). From this comparative cultural perspective, less agreement appears to exist on what masculinity means.

Hegemonic masculinity, which always defines itself as different from and superior to femininity, is a particular culture's standard of "real" manhood, that is, the most lauded form of masculinity at a particular time in history (Connell, 1987). Hegemonic, or normative, notions of masculinity (e.g., dominance over women and other men, physical strength, aggressiveness, bravado, exclusive heterosexuality, emotional detachment, competitiveness, viewing women as sex objects) are evident in societal institutions where men attempt to separate themselves from and hold power over women (Connell, 1990; Kane & Disch, 1993).

Hegemonic masculinity is the acceptance of masculinity as the defining characteristic of Western society that places women in a lower social position. In a society of hegemonic masculinity, women are considered off limits in certain areas, sport being one of the most obvious. Women are kept out or limited because sport, through its emphasis on masculinity, affirms men's power and control (Theberge, 1987). The powerlessness of women and other subordinated groups is explained away as commonsense or the natural order of things (Donaldson, 1993).

The concept of hegemony, originated from the work of Gramsci (1971), includes not only the expression of the interests of a ruling class, but also contains the idea of acceptance as "normal reality" or "commonsense" by those subordinated to it (Williams, 1985). As a social theory, hegemony is the condition in which certain social groups within a society wield authority through imposition, manipulation, and consent--over other groups. It is not the maintenance of power by force rather, it is the maintenance of power by consent to what appears to be inevitable (Hartley, 1982). It is the simple acceptance of the status quo in society.

Different societies perceive masculinity differently. Some communities, masculinity takes the shape of taking risks that are seriously hazardous to health. Though the gender distribution of the labour force is now changing, none the less, men from the poorest communities still do the most dangerous jobs. Alongside these potential risks in the workplace, many men also feel compelled to engage in risky behaviour in order to "prove" their masculinity. In most societies they are also more likely than women to drink to excess and smoke, which in turn increases their biological predisposition to early heart disease and related problems. They also seem to be more likely than women to desire unsafe sex.

``Real men ignore precautions for AIDS risk reduction, seek many sexual partners, and reject depleasuring the penis. Abstinence, safer sex, and safer drug use compromise manhood" (Levine, 1998 p 146-147).

However for some men ignoring the risks associated with multiple sexual partners or unprotected anal intercourse can serve as a means of protesting masculinity. Inherently, this means that masculinity can be contested and protested.

Again, many of these hazards are likely to be more common among men in the poorest communities. It has been argued that "growing up male" renders many men unable to realise what might be their emotional potential. The need to be seen as "hard," for example, may prevent them from exploring the caring side of their nature. An unwillingness to admit weakness may prevent many men from taking health promotion messages seriously and from consulting a doctor when problems arise. Consequently, this has led to higher mortality rates among men than women. Such differences reflects men's reluctances to seek help when required (McVittie and Wallock, 2005). Further studies show that there significant differences in health, with men experiencing highr mortality and morbidity rates (Blanc, 1998; Courtney, 1998; Labor, 1996; Sabo and Gordon, 1995 cited in McVittie and Wallock, 2006). Indeed, illness itself may be especially feared because of its capacity to reduce men to what one recent study has called "marginalised masculinity." (Doyal, 2003). Thus men perceive health and illness to be closely linked to other aspects of masculinities, including the idea of what it means to be a man. In this regard, health issues do not only concern an individual, but have a wider implication in creating the identity of man (Hodgetts and Chambers, 2002).

It is mostly men who commit acts of personal violence - against women and girls, as well as towards other men and boys. Men are also most often implicated in other types of “organized” or institutional violence as victims and perpetrators of violence (<http://toolkit.endabuse.org/Resources/MenMasc>, 27-04-06).

Conclusion

Indeed there is a need to use the theory arises for the fact that intervention programs which entails research methodologies ought to take into account the identity constructions of men within varying social, economic and cultural contexts, hence its applicability to this thesis.

The section has outlined the need to incorporate theory into research. Theories, as seen above, serve as a guiding tool to explain certain individual behaviour. The extent to which women are at risk resulting from the dominant male behaviour can be explained to understand the male construction of identity.

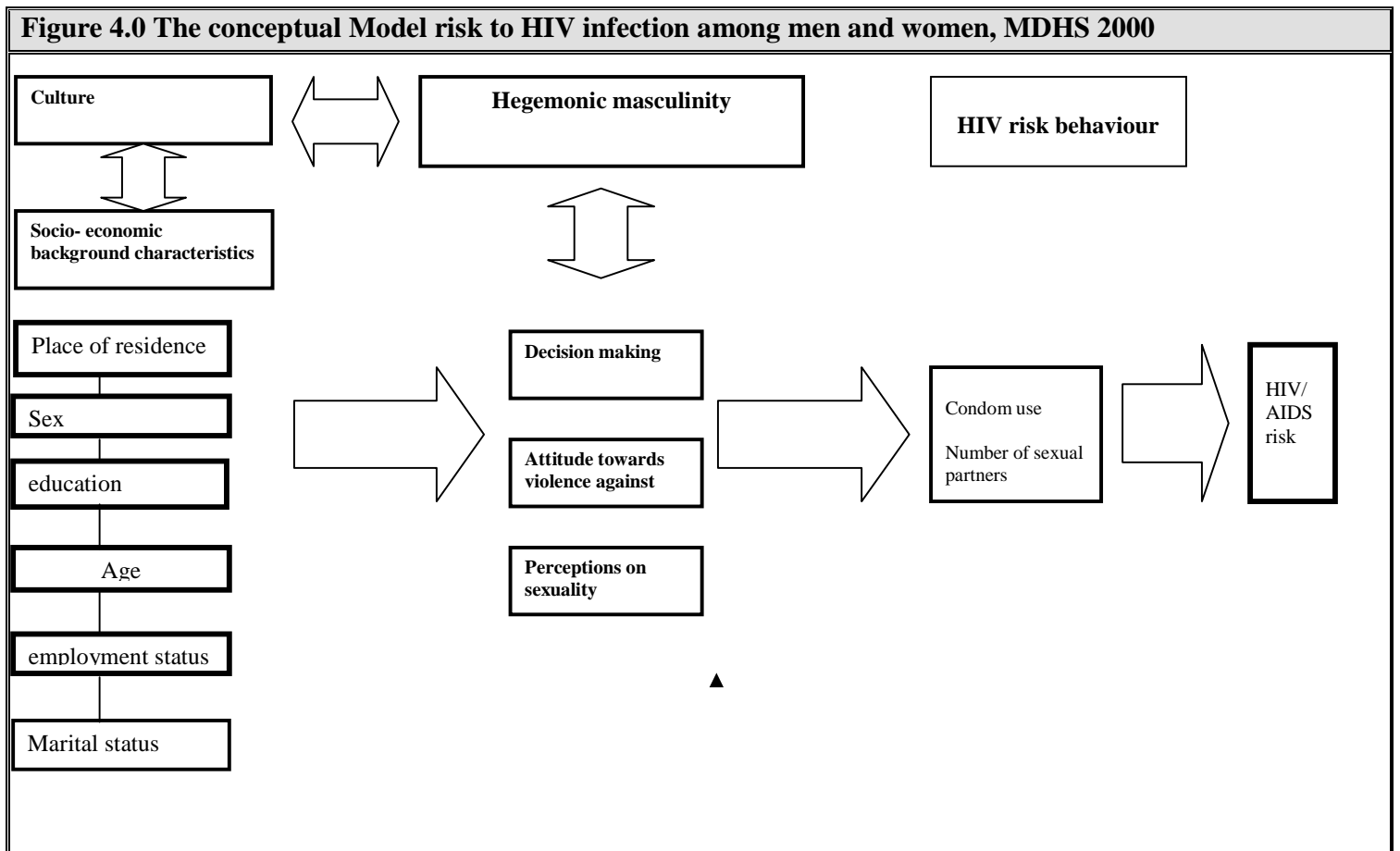
4 Data and Methodology

4.0 Introduction

In this section, the conceptual data sources and quality are discussed first. Following in this chapter, is the how each research question was operationalised. The techniques used to answer each research question and the variables used are discussed later.

4.1 Conceptual model

The conceptual framework as illustrated in Figure 4.0 (below) focuses on three main parts underlying the study, and how each is influenced by the other. The first part includes the background characteristics, and their influence on factors related to hegemonic masculinity (second part). The last part includes key indicators of risk to HIV infection. The variables from the hegemonic theory which attempts to describe how the variables are related in explaining risk to HIV infection. For consistency and completeness of the conceptual model the concept of culture was included, although it was not investigated in the analysis.



The framework attempt to explain that HIV risk infection among men and women can be explained by an array of socio-cultural factors which arise from sexual behavioral

practices and factors related to the concept of hegemonic masculinity. The interplay of these factors as studies have shown, have an influence on how one is at risk to HIV infection (Doyal, 2006). For example, some cultural beliefs assume that men have to prevail in all circumstances. Signs of weakness, emotional or sexual inefficient are considered as a major threat self esteem. Men seeking to demonstrate sexual prowess among peers engage in such risky sexual behavior (Zulu, Watkins and Kohler, 2003). In order to demonstrate masculinity to their peers, some men tend to have more than one sexual partner, hence increasing their risk to HIV infection.

Consistent use of condom in non spousal relationships reduces the chances of HIV infection, however, the belief by some men that the condom deprives quality sex and that real men ignore the precautions of AIDS risk, discourages it use (Levine, 1998). In addition, where power relations are biased towards men, women are less likely to suggest condom use. The practice is likely to vary from one region to another. Similarly, the level of education may have an influence in the way men and women follow the cultural beliefs. Thus socio-demographic characteristics affect men and women differently.

The perception on sexuality varies; men and women from different socio-demographic backgrounds have different perception about women. Some societal norms where women are taught to be submissive to their husbands, and they are duty bound to please their husbands sexually even if their husbands are infected wit STIs, refusing sex, may be seen as challenge to masculinity, hence justifiable to beat a wife. In this way, customs that promote male dominance, not only render women at risk but also their husbands.

4.2 Definition of Concepts

Introduction

The topic of HIV/AIDS is broad. Consequently the concepts are defined in many ways with different connotations. For the sake of consistency, the study defined the concepts closely related to the topic under study.

Human Immunodeficiency Virus (HIV) is the virus that causes a gradual depletion and weakening of the immune system. This results in an increased susceptibility of the body to infections, such as pneumonia and tuberculosis, and can lead to the development of AIDS. Most people infected with HIV do not know that they have become infected, because symptoms do not develop immediately after the initial infection, but they are highly infectious and can transmit the virus to another person.

Background characteristics such as demographic and socioeconomic assign the sample respondents by their marital status single, married or living together, widowed, separated divorced, age in five year age group intervals, education as the highest level of education attained by the respondent.

Risky behavior is referred in the study as men and women who reportedly engaging themselves in behaviors that could transmit HIV because they perceived themselves or their partners to be at low risk for infection. The definition also classifies the men and

women who reported to have engaged in sexual behaviour likely to be exposed to the virus that causes AIDS.

Condoms are considered a barrier method of contraception and helps people who are sexually active avoid sexually transmitted infections (Mbivzo, 1997)). Thus *condom use* means an attempt or failure to use during a risky sexual encounter, as a means of protection from sexually transmitted infections.

4.3 Operationalisation

In this thesis, *Condom use at last intercourse* was operationalised as the number of respondents (male and female) who reported using a condom the last time they had sex (MDHS, 2000). The aim is to assess the level of condom use among men and women. The assumption is, if everyone used condoms, specifically in non spousal relationships, a heterosexually transmitted HIV epidemic would be almost impossible to sustain.

Wife beating justified if a woman refuses sex if husband has STI. The indicator is designed to measure public perception of a woman's negotiating power in sex. It is confined to exploring norms within marriage, which in some cultures define a woman's sexual universe. By specifying that the husband has an STI, the indicator measures attitudes to a woman's ability to protect herself from the known risk behaviour of her husband.

Decision making, we used the variable to assess decision making pattern among men and women. The variable is used here to estimate power relations, but also gender relation between men and women. We relate that the power relations among men and women influence access to and use of condoms, number of sexual partners.

4.4 Data sources

The analysis for this master thesis was based on the secondary data from the 2000 Malawi Demographic Health Survey (2000 MDHS) requested from Measure DHS, the US based organisation responsible for the collection and use of data to monitor and evaluate population, health, and nutrition programs.

4.5 Sample

The survey, among other population issues, collected information on HIV/AIDS as well as Sexually Transmitted Infections (STIs) from men ($n = 3092$) and women ($n = 13220$), aged 15-54 and 15-49 respectively. The analysis will make use of questions sexual behaviour, AIDS Behavior, AIDS Knowledge–related questions which assess knowledge, sources of knowledge and ways to avoid AIDS.

4.6 Software package and techniques use

Statistical Package for Social Sciences version 12.0.1 (SPSS) was used to analyse the data. The study made use of the following proxy indicators that serve as indicators of risk to HIV infection. These were taken as dependent variables. Each indicator explains a particular behaviour that may put men and women at risk to HIV infection. The following key proxy indicators thus were considered as dependent variables.

4.7 Dependent variables

The main dependent variables for this study were

- a) *Condom use at last sexual intercourse*, men and women were asked if ever used a condom at last sex intercourse. This was a yes or no response; as such it was already dichotomous.
- b) The variable *number of sexual partners* was used to measure extent to which men and women engage in risky sexual behaviour. The respondents were asked whether they had sex in the last 12 month other than with their regular sex partners. The variable was a dichotomous with yes/no response.
- c) Measure of decision making. Men and women were asked:
Who in your family usually has the final say on the following decisions-Large household purchase?
This variable was used as an indicator to assess decision making pattern among men and women. Related to decision making, we use the variable to assess the extent to which women are able to make independent decisions regarding large household purchase. The question generated the following response options: 1) themselves (respondent), 2) husband/partner, 3) partner alone, 4) someone else. For logistic regression, the variable was recoded into a binary form with 1, if the decision was made by self for either sex or 0 otherwise.
- d) *Sometimes a husband is annoyed or angered by things which his wife does. In your opinion, is a husband justified in beating his wife in the following situations-If she refuses sex with him?*

The variable was already dichotomous, yes or no response. An index was created on the basis of whether women and men think it is justified for a husband to beat his wife or not. This variable is used as a proxy to measure women's status or lack thereof (self-perceived) but also perception on sexuality.

4.8 Independent variable

Measures of socio-demographic characteristics such as age of the respondents recoded in 5 year age groups from 15 to 54 years, sex (male or female), place of residence (dichotomous variable based on the respondent's place of usual residence, rural or urban), employment status (dichotomous working or not working). Marital status was recoded into three groups, single, married and widowed and other (separated). Level of education was coded in four levels: no education, primary school, secondary and higher.

4.9 Statistical analyses: descriptive, univariate and multivariate analyses

The analyses were completed using three methods of analyses; descriptive, univariate and multivariate logistic regression analyses depending on the requirement of the research question and the type of relationship. The research questions answer the relationships as displayed in the conceptual framework.

What is the general level of condom use among men and women in Malawi? To what extent do socio-demographic characteristics and masculinity factors influence condom use?

To begin with, we use descriptive analysis in form of cross tabulation stratified by sex, to examine the relationship between background characteristics and condom use among men and women. Since the focus is to compare between the two sexes, separate models for either sex were performed.

We use multivariate logistic regression analyses to examine the relationship among socio-demographic variables and masculinity factors with condom use.

To what extent do men and women engage in risky sexual practices?

We use descriptive analysis to explore the relationship between background characteristics variables and the number of sexual partners. Following descriptive analysis, multivariate logistic regression was used with number of partners as a dichotomous dependent variable. The covariates included all variables that proved statistically significant in univariate logistic regression analysis between the relationships; background characteristics and masculinity factors, and masculinity factors and number of sexual partners.

In terms of decision making, to what extent do women make independent decisions? Does decision making pattern among women and men influence the likelihood to use condom?

The research question attempts to examine if there are any variations in decision making between men and women from different backgrounds. Thus descriptive analysis was used to explore the relationship. In turn, univariate logistic regression was used to explore if decision making pattern among men and women was statistically significant to predict the likelihood of condom use.

Are there any differences between men and women regarding perceptions on sexuality?

The research question assess if perceptions on sexuality between men and women differ. Thus descriptive analysis was used to examine the relationship between perceptions on sexuality and background characteristics; in addition univariate logistic regression was applied to examine which background is statistically significant to predict a particular opinion on sexuality among men and women.

5 Results

Introduction

The section begins by giving the results from the descriptive and univariate analyses of the relationship between background characteristics and variables related to the concept of masculinity i.e. decision making, attitude towards wife beating and perception on sexuality. The relationship between masculinity concepts variables and variables related to sexual behavior were examined by descriptive and univariate analyses and finally, using multivariate logistic analyses the section shows the results from relationship between the background characteristics and masculinity factors on sexual behavior variables such as condom use and number of sexual partners. The findings in this chapter mainly focus on the results that were significant in the analyses.

5.1 Decision Making

Table 5.1 Percentage distribution of men and women who makes the final decision making on large household purchase, MDHS 2000

Socio-demographic characteristics	Resp.	Women				No.	Men				No.
		Joint	Partner alone	Someone else	Resp. alone		Joint decision	Partner alone	Someone else		
Residence	urban	12.2	13.9	48.6	25.4	2871	48.1	13.7	2.9	35.2	721
	rural	14	6.9	60.7	18.4	10349	57.4	9.5	2.9	30.2	2371
Age	15-19	3	3.5	29.1	64.4	2914	7.7	1.5	0.7	90.1	914
	20-24	9.5	8	65.7	16.7	2998	46.4	4.6	1.5	47.4	674
	25-29	12.4	10.5	71.5	5.5	2358	73.5	12.9	3.1	10.5	584
	30-34	18.2	11.2	67.3	3.3	1574	73.4	16.7	6	3.9	544
	35-39	21.1	10.6	66.3	2	1410	79.9	15	3.3	1.8	335
	40-44	25.3	11.2	61.7	1.8	1052	73.8	19.6	3.8	2.9	333
	45+	30.5	8.6	58.4	2.4	2914	77.5	17	5	0.5	240
Education	No education	13.3	8.3	58.8	19.5	3003	64.2	9.7	2.1	24	670
	Primary	13.9	8.3	58.1	19.8	8454	53.1	10.6	3.2	33.1	1856
	Secondary	12.8	9.4	56.9	20.8	1732	52	11.3	3	33.7	558
	Higher	6.5	12.9	54.8	25.8	31	37.5	0	0	62.5	8
Marital status	single	4.6	2	2.5	91	2284	12.9	1.4	0.7	85.1	1064
	married	6.1	11.3	81	1.7	9361	78.4	16.1	4.3	1.2	1903
	widowed/other	71.3	0.8	2.9	25	1575	63.2	2.4	0.8	33.6	125
Employment	Unemployed	8	6.7	57.6	27.7	5708	8	38.6	6.7	1.8	52.9
	employed	17.8	9.7	58.5	13.9	7512	17.8	66.2	13	3.6	17.1

The variable on *who makes the final decision on large household purchases*, assess the autonomy of women in decision making as well as examining the extent to which the society is patriarchal. Table 5.1 summarizes the responses from men and women from different background characteristics. The findings generally show lower proposition of women than men who made the final decision. Taking type of residence into account, we see that women (urban 12%, rural 14%) were four times less likely to make independent decision than men (urban 48%, rural 57%). In contrast, close to three percent of men reported that the final decision was made by their partners.

Regarding age, lower proportions were observed for men and women especially 15-19 age group, three and 8 percent respectively. This could suggest that most adolescents are

still at their parents home hence the elderly are responsible for deciding large household purchases. The results further show that with increasing age women the influence on final decision rises. Although there is a similar pattern emerges for men, the proportions are much higher than for women.

Although, most women attained primary education, lone decision making is still low, close to 14 %. There are no major variations for women on decision making given the level of education. Men who had no education (64 %) tended to make final decision alone compared to women (13%).

The results further show that a higher proportion of married men (78 %) than women (six percent) took control of decision making. From the results, final decision making pattern mostly dominated by men across all background characteristics.

Table 5.2 Univariate regression results on final decision making by men and women by background characteristics.

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Residence	rural	0.01*	1.174	0.000	1.452
	Constant	0.000	0.138	0.315	0.928
Education		0.419		0.000	
	primary	0.467	1.046	0.000	0.631
	secondary	0.622	0.957	0.000	0.604
	higher	0.274	0.449	0.137	0.335
	Constant	0.000	0.154	0.000	1.792
Age		0.000		0.000	
	20-24	0.000	3.374	0.000	10.356
	25-29	0.000	4.557	0.000	33.226
	30-34	0.000	7.161	0.000	33.062
	35-39	0.000	8.569	0.000	47.489
	40-44	0.000	10.868	0.000	33.606
	45+	0.000	14.110	0.000	41.170
	Constant	0.000	0.031	0.000	0.084
Marital Status		0.000		0.000	
	married	0.01*	1.338	0.000	24.563
	widowed	0.000	51.560	0.000	11.621
	Constant	0.000	0.048	0.000	0.148
Employment	employed	0.000	2.490	0.000	3.116
	Constant	0.000	0.087	0.000	0.628

* Significance level at $p < 0.5$.

In order to examine if decision making could be influenced by background characteristics, univariate logistic regression was run and the coefficients with significance levels and odds ratios are shown in Table. 5.2. Final decision was transformed into a binary variable for both sexes, with self where the final decision was made by the respondent alone recoded as 1 and 0 anything else. Considering place of residence, the findings show that the odds ratios for men (1.45) are higher than for women (1.17). This implies that men compared to women are more likely to make lone decision in addition, this variation common among men (45%) and women (17 %)

residing in rural areas compared to those living in the urban. The findings also show that changes the level of education among women did not have an influence on decision making, for men it was significant ($p < .0001$). Men who attained primary (63 %) and secondary education (60 %) compared to those no education were less likely to make lone decision. The findings are similar to the findings of descriptive analysis in Table 1 whereby as increase in level of education for men, the lower the tendency to make lone decision.

Taking age into account, the variable was significant for both sexes at $p < .001$. A similar pattern emerged for both sexes, with increasing age; there was an increase in odds ratios. This indicates that men and women in the older age groups compared to the 15-19 year age group, were more likely to make the final decision by themselves. However the odd ratios are higher for men than for women at each successive age level, thus the likelihood to make lone decision among men is more common than for women. Similar observation occur for marital status, although the odds ratios for women are higher than for men, married women (56%) compared to single are more likely to make the final decision on large household purchase. In contrast, for men it was found that married men compared to single men made the final decision by 62 %.

5.2 Attitude towards wife beating

Table 5.3 Percentage distribution of men and women responding to wife beating justified if refuses sex, MDHS 2000

		Perception on wife beating for refusing sex					
		Women			Men		
		Yes (%)	No (%)	no.	Yes (%)	No (%)	no.
Type of residence	urban	15.9	84.1	2871	7.5	92.5	721
	rural	22.6	77.4	10349	13.3	86.7	2371
Age	15-19	26.4	73.6	2914	19.7	80.3	674
	20-24	20.9	79.1	2998	11.5	88.5	584
	25-29	19.3	80.7	2358	9.9	90.1	544
	30-34	18.8	81.2	1574	7.8	92.2	335
	35-39	17.5	82.5	1410	9.6	90.4	333
	40-44	19.7	80.3	1052	12.5	87.5	240
	45+	20.7	79.3	914	7.1	92.9	382
Education	No education	20.9	79.1	3003	10.1	89.9	670
	Primary	21.6	78.4	8454	11.7	88.3	1856
	Secondary	19.3	80.7	1732	14.9	85.1	558
	Higher	9.7	90.3	31	12.5	87.5	8
Marital status	single	27.5	72.5	2284	17	83	1064
	married	19.6	80.4	9361	9.2	90.8	1903
	widowed/other	20.8	79.2	1575	10.4	89.6	125
Employment	Unemployed	20.5	79.5	5708	15.6	84.4	1226
	employed	21.6	78.4	7512	9.5	90.5	1866

Central to understanding the concept of masculinity, is to relate how the society perceives women in making decision regarding sex. The study assessed the attitudes and perceptions of men and women toward wife beating.

Sometimes a husband is annoyed or angered by the things which his wife does. In your opinion, is husband justified in beating his wife if she refuses sex with him?

Table 5. 4 shows the responses generated from men and women regarding their opinion. There is a disparity in proportion between men and women, the later despite belonging to the same sex, had a higher proportion than the former, which reported that it was justified to beat a woman if she refuses sex. In this regard, the proportion of women in the urban (16 %) and rural (23 %) was higher than for men eight and 13 % respectively.

Although the findings show that in general there were high approval rates among women than men, such attitudes were concentrated among young men and women of adolescent ages where by women aged 15-19 and 20-24 was 26 % and 21 % respectively, while for men it was 20 % and 13 % respectively. In terms of education, there was a close match between women who attained no education (21 %) and primary (22 %), both approving that it was justified to beat a wife if she refuses sex. Thus it can be implied that lower education levels were associated with approving wife beating. Contrasting pattern emerged among men ranging from no education to higher education, although at lower proportions compared to women, there was a gradual increase among men who responded yes to beating a wife; the responses ranged from 10 % to 13 % in that order. Similarly, employed (22 %) and unemployed (21 %) women reported it was justified for a husband to beat his wife where for men, it was 16 % and 10 % respectively.

The results of univariate logistic regression in Table 4.4 (below), that the likelihood of to approve wife beating is higher for women in rural as compared urban women. Considering the model for men, a similar pattern emerges; men in the rural compared to urban are more likely to approve wife beating.

Table 5.4 Univariate regression results of attitude towards wife beating, MDHS 2000

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Residence	rural	0.000	1.543	0.000	1.892
	Constant	0.000	0.189	0.000	0.081
Education		0.071		0.083	
	primary	0.431	1.042	0.280	1.172
	secondary	0.180	0.904	0.013	1.547
	higher	0.138	0.405	0.827	1.265
	Constant	0.000	0.264	0.000	0.113
Age		0.000		0.000	
	20-24	0.000	0.738	0.000	0.527
	25-29	0.000	0.669	0.000	0.448
	30-34	0.000	0.646	0.000	0.342
	35-39	0.000	0.592	0.000	0.432
	40-44	0.000	0.683	0.013	0.581
	45+	0.001	0.727	0.000	0.309
	Constant	0.000	0.359	0.000	0.246
Marital Status		0.000		0.000	
	married	0.000	0.641	0.000	0.494
	widowed	0.000	0.692	0.062	0.566
	Constant	0.000	0.380	0.000	0.205
Employment	employed	0.121	1.069	0.000	0.571
	Constant	0.000	0.258	0.000	0.185

The odds ratios for women in age group 20-24 compared to women aged 15-24, are lower. This means that the age group 20-24 for women is less likely than the lower age group, to report it is justified to beat a wife if she refuses sex. When we look at the model for men for that particular age group, a similar reporting pattern emerges. However, a close examination reveals that in the women model the level of likelihood for the age group 20-24 compared to the age group 15-19 is higher when we look at the men model for a similar age group, 0.74 and 0.53 respectively. The trend can also be observed in other variables that were significant in either model. We see that in relation to the reference category for each particular group, the odds ratios for the women model are higher than the corresponding group for the men model.

5.3 Perception on sexuality

Table 5.5 Perception on sexuality among men and women, MDHS 2000.

		Women			Men		
		Yes (%)	No (%)	count	Yes (%)	No (%)	count
Residence	Urban	56.2	43.8	2728	62.5	37.5	704
	Rural	58.6	41.4	9813	67.0	33.0	2330
Age	15-19	47.9	52.1	2724	60.9	39.1	653
	20-24	56.80	43.20	2854	67.71	32.29	573
	25-29	57.63	42.37	2216	69.09	30.91	537
	30-34	62.43	37.57	1536	64.53	35.47	327
	35-39	64.56	35.44	1363	55.76	44.24	330
	40-44	67.25	32.75	1026	75.11	24.89	237
	45+	67.03	32.97	822	71.62	28.38	377
Level of education	No education	59.2	40.8	2839	69.1	30.9	660
	Primary	58.0	42.0	8025	65.3	34.7	1820
	Secondary	56.8	43.2	1647	64.2	35.8	547
	Higher	46.7	53.3	30	71.4	28.6	7
Marital status	Single	48.7	51.3	2126	64.3	35.7	1038
	Married	59.7	40.3	8912	66.7	33.3	1873
	Widowed/other	61.4	38.6	1503	67.5	32.5	123
Employment	Unemployed	55.6	44.4	5393	64.5	35.5	1200
	Employed	59.9	40.1	7148	66.8	33.2	1834

The reality among many communities in Malawi is that there is inability to address issues of sexuality openly and in a frank manner. To assess this view, men and women were asked if it was acceptable to discuss matters concerning sexuality including AIDS on radio. Table 4.5. shows the responses generated from men and women from varying background characteristics. The general pattern emerged that most men and women found it acceptable to discuss sexuality on radio. However, across all background characteristics, men had higher proportions than women. This is true when age is considered (with exception of age group 35-39) A similar pattern emerge for place of residence although men and women in the rural areas had slightly higher proportions than their counterparts in the urban. In addition, an almost identical trend is seen for level of education, marital status and employment; men were more accepting to have sexuality discussed on radio than women.

Table 5.6 Univariate Logistic regression background characteristics and perception on sexuality, MDHS 2000

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Residence	rural	0.023	1.105	0.029	1.216
	Constant	0.000	1.281	0.000	1.667
Education		0.234		0.000	
	primary	0.249	0.950	0.014	1.344
	secondary	0.110	0.905	0.004	1.432
	higher	0.169	0.603	0.277	1.165
	Constant	0.000	1.452	0.118	0.807
Age		0.000		0.000	1.933
	20-24	0.000	1.432	0.001	1.617
	25-29	0.000	1.481	0.000	1.561
	30-34	0.000	1.810	0.248	
	35-39	0.000	1.984	0.076	0.841
	40-44	0.000	2.236	0.071	0.801
	45+	0.000	2.214	0.894	1.118
	Constant	0.026	0.918	0.000	2.235
Marital Status		0.000		0.374	
Status	married	0.000	1.564	0.177	1.116
	widowed	0.000	1.677	0.480	1.154
	Constant	0.225	0.949	0.000	1.798
Employment	employed	0.000	1.197	0.182	1.110
	Constant	0.000	1.251	0.000	1.817

Table 5.5 illustrates univariate regression results of background characteristics on perception on sexuality among women and men. For women all background characteristics with the exception of level of education were statistically significant at $p < .001$ (type of residence at $p < 0.05$), while for men, education and age were statistically significant at $p < .001$ (type of residence at $p < 0.05$).

On average women and men residing in the rural compared to urban areas were more likely by 11 % and 22 % respectively, to report that it was acceptable to teach sexuality on radio. As the level of education increases for men, their acceptance attitude increases; this is true considering that men who attained primary and secondary were more likely to report so by 34 % and 43 % respectively, with the exception of higher education which was not statistically significant. An increase in age was associated with positive response on perception on sexuality. Here the findings show that the odds ratios increase with increasing age with the exception with women over 45 years old. This finding may not be surprising considering that old women would rather keep the tradition, hence lower odds ratios. Similarly, married compared to single women were 1.56 times as likely to have a positive attitude toward sexuality, while the widowed were 1.68 times likely. Among women who were employed, the findings show that they were 20 % as likely to accept that sexuality teachings on radio.

In all the models considered, it was found that type of residence, age, marital status and employment were significantly associated with acceptance attitude toward sexuality among women. Whereas for men, residence and level of education were statistically significant. For men, although age as a whole was significant, the age groups 20-24 and 25-29 proved to be significant.

5.4 Decision making and condom use

To what extent does decision making influence the use of condom use? Table 5.7. shows descriptive results of influence of decision making on condom use. As shown, close to seven percent for both sexes who made the final decision made by themselves, reported to have used condom at their last sex encounter. However, where the decision was made by the partner, disparities in condom use arise, about four percent of women reported to have used a condom while men it was close to two percent. Where the final decision was made by the male partner, there was an increase in condom use; there was an opposite effect when the final decision was made by a female partner.

Table 5.7 Influence of final decision making on condom use among men and women, MDHS 2000.

		Women			Men		
		Yes (%)	No (%)	no.	Yes (%)	No (%)	no.
Decision making	Self	7.0	93.0	1346	6.5	93.5	1313
	partner	3.8	96.2	894	2.2	97.8	271
	joint decision	4.7	95.3	6182	2.9	97.1	68
	someone else	13.9	86.1	2098	11.2	88.8	776

The results of univariate regression (see Table 4.8.) show that decision making overall was statistically significant at $p < 0.005$. Partner decision making made women 52 % less likely to use a condom. The tendency for men if decision making is done by their partners decreased the chance for them to use a condom by 32 %. The results for both sexes shows that if decision making was made by male partners, there was a low chance to suggest condom use.

Table 5.8 Univariate logistic regression, final decision making on condom use MDHS 2000

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Step 1(a)	Final decision	0.000		0.000	
	partner	0.002	0.527	0.009	0.327
	joint decision	0.001	0.658	0.256	0.438
	someone else	0.000	2.145	0.000	1.824
	Constant	0.000	0.075	0.000	0.069

a Variable(s) entered on step 1: final decision making.

* $p < 0.05$

In order to examine whether decision making can be linked to risky behavior, a descriptive analysis, (see table 4.9.) was run. The findings show that there was higher proportion of among men than women who were engaged in multiple relationships. Men who exercised more power in decision making were more (10.1%) likely to have another

sex partner. This was true for women (close to six percent). Although there was equally a high proportion of men (11 %) who reported that the final decision was made by a joint agreement, having more than one partner was associated with men than women (2.4 %).

5.4 Decision making and number of sexual partners

Table 5.9 Final decision making and number of sexual partners, MDHS 2000

		Women			Men		
		Yes (%)	No (%)	no.	Yes (%)	No (%)	no.
Decision making	Self	5.5	94.5	567	10.1	89.9	1492
	partner	1.4	98.6	1055	6.2	93.8	307
	joint decision	2.4	97.6	7568	11.0	89.0	82
	someone else	1.9	98.1	155	4.5	95.5	22

As Table 4.10 (below) shows, the likelihood of women to have casual relationships if the final decision was made by their partners compared to those the decision was made by themselves, was less likely by 25 %. By observing the pattern of decision making, where decision was mainly controlled by one partner, the chance to have a casual partner diminishes. For instance, when the final decision on large household purchase was made by their partners, men were 59 % less likely to have more than one partner. The result was statistically significant at $p < 0.05$. However sole decision making for men increases the chance of having more than one partner.

Table 5.10 Univariate logistic regression of final decision on number of sexual partners, men and women

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Step 1(a)	Final decision	0.000		0.159	
	partner	0.000	0.249	0.036	0.590
	joint decision	0.000	0.426	0.787	1.103
	someone else	0.079	0.341	0.406	0.426
	Constant	0.000	0.058	0.000	0.112

a Variable(s) entered on step 1: final decision

In order to examine if the perception of men and women on violence against women has an influence on the tendency to have more than one sexual partner, a cross tabulation was performed. The views solicited which are summarized in Table 5.11, show that a small proportion (close to three percent) who reported justified beating a woman if she refuses sex, had more than one sexual partner. This is consistent with the fact that women were less likely than men to have a casual partner. However, 16 % of men who reported justified bating a woman, had more than one sexual partner compared to nine percent who reported not justified. This reflects the fact that acts of violence against women is associated with casual relationships.

5.5 Attitude towards wife beating and number of sexual partners

Table 5.11 Attitude towards wife beating and number of sexual partners, MDHS 2000

		Women			Men		
		Yes (%)	No (%)	no.	Yes (%)	No (%)	no.
Wife beating justified	Yes	2.6	97.4	1829	16.0	84.0	175
	No	2.4	97.6	7516	8.7	91.3	1728

Similarly, the result of logistic regression (shown in Table 4.12 below) show that men who reported that it was justified to beat a woman compared to those who disapproved, were 99 % more likely to have a casual partner. Thus it can be predicted that approval of violence against women is characteristic of men who tend to have more than one sexual partner.

Table 5.12 Relation ship between wife beating and number of sexual partners among women and men, MDHS 2000.

		Women		Men	
		Sig.	Exp(B)	Sig.	Exp(B)
Step 1(a)	Wife beating (Justified)	0.640	1.080	0.002	1.989
	Constant	0.000	0.025	0.000	0.096

a Variable(s) entered on step 1: wife beating justified.

Table 5.13 cross tabulation of perception on sexuality and condom use among men and women, MDHS 2000.

		Women			Men		
		Yes (%)	No (%)	no.	Yes (%)	No (%)	no.
Perception on sexuality	Yes	6.7	93.3	5797	7.2	92.8	1562
	No	6.7	93.3	4183	8.0	92.0	817

Generally, there was a tie among women who disagreed and agreed that it was acceptable to teach sexuality on radio, who used condom use at last sexual intercourse. While for men, the difference on perception about sexuality was only close to one percent. However, in terms of numbers, more respondents agreed with open discussion about sexuality, reported to have used a condom. The results for univariate logistic regression (not shown here) of perception on sexuality and condom use for both sexes were not statistically significant. This was expected considering that there was little disparity in responses for both sexes.

To what extent does one's perception on sexuality influence the tendency to have more than one partner? Table 4.14 (below), illustrates two facts, firstly women compared to men tended to have fewer casual partners, secondly men and women who have more than one sexual partner, their opinion on sexuality does not vary much. It therefore not surprising that the univariate logistic regression on perception on sexuality and the likelihood to have more than one sexual partner did not turn out statistically significant for the both women and men models.

Table 5.14 perceptions on sexuality and number of sexual partners, MDHS 2000

Perception on sexuality	Women			Men		
	> One partner	No or One partner	no.	> One partner	No or One partner	no.
Yes	3	97.5	5318	9.5	90.5	1250
No	2	97.5	3578	9.3	90.7	623

In the conceptual model, condom use is one of the indicators to HIV/AIDS risk; consistent use may decrease the chance to contract the virus, while non use may increase the chance of contracting the HIV. However, there are number of variables that may influence the use or condom. In Table 4.15 (below), two points worth noting emerge; firstly there is low condom use among men and women. Secondly, the proportion of men reporting condom use at last sex intercourse is slightly higher than women. For instance, the proportion of men reporting condom use increased with the level of education with the exception of secondary level. While for women, the proportion was around seven percent.

Table 5.15 women and men condom use at last intercourse by background characteristics, MDHS 2000.

		Women			Men		
		yes	no	No.	yes	no	No.
Type of residence	urban	7.2	92.8	2330	7.0	93.0	569
	rural	6.6	93.4	8190	7.5	92.5	1859
Age	15-19	10.4	89.6	2328	11.2	88.8	561
	20-24	6.7	93.3	2380	6.8	93.2	440
	25-29	5.8	94.2	1875	7.0	93.0	429
	30-34	4.2	95.8	1247	3.8	96.2	266
	35-39	4.5	95.5	1134	7.9	92.1	252
	40-44	6.2	93.8	844	4.9	95.1	184
	45+	6.2	93.8	712	6.1	93.9	296
Highest educational level	No education	7.0	93.0	2404	6.8	93.2	514
	Primary	6.6	93.4	6739	7.8	92.2	1459
	Secondary	7.0	93.0	1355	6.5	93.5	449
	Higher	0.0	100.0	22	33.3	66.7	6
marriage status	single	12.9	87.1	1834	10.4	89.6	847
	married	5.1	94.9	7506	5.9	94.1	1484
	widowed/other	7.9	92.1	1180	5.2	94.8	97
Employment	Yes	6.1	93.9	5832	5.5	94.5	1426
	No	7.6	92.4	4688	10.1	89.9	1002

Whilst Table 5.15 (above) mainly shows the distribution of men and women in condom use, in order to ascertain the predictors of condom use between men and women, multivariate logistic regression models for either sex were run (see Tables 4.16 and 4.16b.). The variables that were statistically significant in univariate analyses models for women are marital status, type of residence, age, employment and decision making. The same applied for men with an addition of variables education and wife beating that proved significant for the men model. The variable age was collapsed into one category,

when taken as five year age categories, it resulted in large numbers of odds ratios (Exp (B)) (de Maris, 1995).

5.6 Final models

From these findings we can see that for the women model, marital status, residence, age and employment are not statistically significant. Although they were significant in the univariate analyses, controlling for other variables, they do not exert independent effect. That is each of them does not necessarily predict the likelihood of women to use a condom. However, decision making is highly significant at $p < 0.001$. This suggests that controlling for other variables, the impact of partner decision among women has the odds of 0.42 times less than when the decision is made by themselves. The findings are consistent with earlier findings (see Table.4.8), whereby the odds ratios in condom use among women decrease if the final decision is mostly made by the partner.

Table 5.16 a. Women final model on condom use MDHS 2000

		Sig.	Exp(B)
marital status		0.069	
	Married	0.066	1.40
	Widowed/other	0.816	0.96
Residence (Rural)		0.800	0.98
Age		0.683	1.00
employment	employed	0.394	0.93
Decision		0.000	
making	partner	0.000	0.42
	joint decision	0.000	0.52
	someone else	0.000	2.34
Constant		0.000	0.07

Table 5.16 b. exhibits the results from the multivariate regression. In addition to decision making, employment status is also statistically significant $p < 0.5$. The findings suggest that controlling for other variables, the impact of being employed as opposed to being unemployed, decreases the odds ratios by 0.63 times to use a condom. Similarly, partner decision making among men decreases the odds ratios by 0.23 times as opposed to when the decision is made by themselves. For both sex, we can see that effect of partner decision is much stronger among women than men. This could suggest that men have a stronger influence on their partners, than the vice versa.

Table 5.16 b. men and condom use final model, MDHS 2000

		Sig.	Exp(B)
marital status	Married	0.57	
	Widowed/other	0.65	1.18
Residence (Rural)		0.76	1.06
Age		0.56	1.01
Education		0.22	
	Primary	0.97	0.99
	secondary	0.36	0.78
	Higher	0.09	4.56
Employment	employed	0.01	0.63
Decision making		0.01	
	partner	0.01	0.32
	joint decision	0.25	0.43
	someone else	0.06	1.98
Constant		0.00	0.07

Does the practice of risky behavior vary between men and women? What is the level of risky sexual behavior? Table 4.17 shows the distribution of men and women who reported the number of partners by their background characteristics. In this study, having more than one sexual partner is regarded as risky behavior; it increases the chance of contracting HIV. It is interesting to note that there are notable differences between men and women who reported having more than one sexual partner. Generally, men are more likely than women to have a number of partners. Specifically men in the rural area (11 %) reported to have more than one partners, in contrast there were only three percent of women who reported to have more than one sexual partner. Understandably, the pattern that emerges shows that with increasing age, men tend to have more partners, especially over 45 years (18 %). However, it is lower for women.

Table 5.17. Proportional distribution of men and women by number of partners by background characteristics

		Women			Men		
		More than one partner	One or no partner	No.	More than one partner	One or no partner	No.
Residence	urban	1.1	98.9	1849	4.0	96.0	399
	rural	2.8	97.2	7496	10.8	89.2	1504
Age	15-19	0.3	99.7	945	0	100	22
	20-24	1.4	98.6	2345	2.5	97.5	237
	25-29	2.0	98.0	2038	5.4	94.6	444
	30-34	2.8	97.2	1308	10.0	90.0	311
	35-39	4.2	95.8	1177	10.1	89.9	307
	40-44	4.5	95.5	837	10.1	89.9	228
	45+	4.5	95.5	695	18.1	81.9	354
Educational level	No education	2.2	97.8	2134	9.5	90.5	461
	Primary	2.6	97.4	5970	9.4	90.6	1106
	Secondary	2.3	97.7	1220	9.3	90.7	333
	Higher	4.8	95.2	21	0	100	3
Marital status	married	2.5	97.5	9345	9.4	90.6	1903
Employment	Yes	2.7	97.3	5543	9.3	90.7	1396
	No	2.1	97.9	3802	9.7	90.3	507

As explained earlier on, the number of partner was regarded as an indicator of risky behavior. Thus ultimately in order to examine the likelihood of having behavior between men and women, two models were developed for either sex. The variables that were statistically significant in univariate analyses models for women are marital status, type of residence, age, employment and decision making.

Table 5.18 Final model of men and women on likelihood to have more than one partner, MDHS 2000.

	Women		Men	
	Sig.	Exp(B)	Sig.	Exp(B)
Employment (employed)	0.528	1.09	0.918	1.02
Decision making	0.002		0.273	
partner	0.000	0.31	0.049	0.60
joint decision	0.001	0.52	0.950	0.98
someone else	0.367	0.57	0.927	0.91
age	0.000	1.06	0.000	1.06
Residence (Rural)	0.001	2.28	0.001	2.56
Wife beating(justified)*			0.003	2.00
Constant	0.000	0.00	0.000	0.00

* wife beating proved significant for the men model in the univariate analysis (see Table 4.12) for men only, hence its inclusion here.

In Table 4.18, controlling for other variables, we see that final decision on large household purchase, age and place of residence were statistically significant at $p < 0.005$ for the women model. It is also important to note that the significance level for the variable decision making for men ($p < 0.05$) was not as strong as for women. By examining the odds ratios for either sex, we see that for women, if the decision was mainly made by the partner, the odds ratios decreased by 0.31 times. On the other hand for men, the odds ratios decreased by 0.60 times. This means that the likelihood to engage in risky sexual activities is higher among men than for women.

6 Discussions and Conclusion.

Introduction

In this chapter results are discussed in depth and possible explanations are offered. The order of the discussion follows the research questions. Descriptive results are discussed first followed by the results from logistic regression model.

6.1 Decision making

To begin with, in examining whether women are able to make independent decision, a general picture that emerges from the descriptive analysis, demonstrate that the proportion of women which reported to make lone decision was lower than for men. This pattern is consistent across all background characteristics. Specifically, men in the rural area tend to dominate in decision making regarding large household purchase. Further, with increasing age, men compared to women, tend to make sole decision. A similar pattern emerged when two models for either sex were compared. The odds ratios for men were higher than for women.

Controlling for other variables, decision making was significant in the final models for both men and women. For the women model, where the final decision was made by the partner, the likelihood of women compared to women who made the final decision themselves, decreased. In the case of the model for men, while the likelihood to use a condom decreased if the decision was made by their partners, we see that the effect for men was lower than for the women model. This suggests that although women may have the full authority in making decision, their say in suggesting condom use is limited.

By implication, when women are not involved in decision making, it reflects that women lack full authority. This may have an impact on decision-making regarding their sexual and reproductive health. The variable on decision making assesses the gender inequities and male domination in Malawi. Such relationships characterized by male dominance may increase women's risk of infection and limit their ability to negotiate safer sex practices such as condom use.

6.2 attitudes towards wife beating

The main aim of the research question about perceptions of wife beating served as an indicator for predicting whether men and women justify such actions (i.e., whether the respondent considers it acceptable or not for him/herself to beat a wife or approves of wife beating). Earlier studies suggest that attitudes about wife beating are strongly related to actual activity (UNAIDS, 2004). In our findings, the common response draws a picture that among the yes responses, more women than men were receptive of the opinion that it was justified to beat a wife if she refuses sex. The findings were contrary to the general expectations of men in society where men generally have a dominant position. However the results were consistent with some of the customary marriage practices in Malawi whereby women are taught to be submissive and please their husbands.

In descriptive analysis, it was noted that yes responses on wife beating were concentrated to lower age groups for women and men. Furthermore, it was found that the proportion of single women and men reporting it was justified to beat a wife if she refuses sex was high, though higher among women than men. In the univariate regression analysis, we see that the odds ratios for the women model were higher than the corresponding group for the men model. This pattern confirms the findings in the earlier studies that women have lower negotiating power. Thus if it acceptable norm that men are justified to beat their partners if they refuse sex, such acts of violence only increases women's risk to HIV infection. It can be argued that such norms may explain why women are more vulnerable to HIV infection than men. On the other hand, women's attitude according to the findings serves to demonstrate the concept of hegemonic masculinity that is women do not have control over their bodies.

6.3 Perceptions on sexuality

In our research question to what extent does perceptions on sexuality influence condom use among men and women. The findings show that perceptions on sexuality do not influence condom use for both men and women. As observed from the results there were low percentages among men and women who reported using condom, at the same time the distribution among men and women who reported yes does not vary from those who reported no.

6.4 Condom use

The findings show that in general condom use in Malawi is low. In addition the results show that there is little variation in condom use among men and women particularly between rural and urban areas. This is consistent with reporting from similar other research findings in Malawi on condom use (Kazembe, Norr and Kaponda, 2004). However, there exist notable differences between men and women on condom use when some socio-demographic background characteristics. The respondents aged 15 to 19 years showed higher use of condom. One possible explanation is that they are sexually active and try to use take preventive measures by using condom hence their high reported use of condom. The level of education, according to the results for men, has an effect in condom use. With exception for secondary level, findings show that there was consistent increase in the use of condom with increasing level of education, and was highest among men who attained higher education (33%). Thus the level of education may contribute to higher use of condom. The findings also confirm that condom use among married respondents is low. However, women compared to men insisted to use condom within marriage 13% and 10% respectively.

Condom use plays an important role in reducing HIV infection, consistent and correct condom use reduces the risk of HIV infection by 90% (WHO, 1999). As the results show, although there were no major differences in condom use between men and women, low condom use especially in non-spousal relationships may render men and women to risk to HIV infection

6.5 number of sexual partners

In an attempt to find the extent men and women engage in risky sexual behaviour, the results from descriptive analysis reveal that fewer women than men engage in risky activities of having more than one partner across all socio-demographic background characteristics.

In order to examine the factors that influence the likelihood of men and women to engage in risky sexual behaviour, a multivariate regression model was performed for either sex. In the multivariate analysis, the number of sexual partners assesses the sexual behavioural practices between men and women. We find that partner decision making decreased the likelihood of women to have another partner. However for men although the effect is the same, the odds ratios for partner decision are higher than the corresponding category for the women model. This suggests that men's partner decision has little influence on their likelihood to have another partner. Thus in a relationship where decision making is mostly made by women, men still engage in risky behaviour.

We also see that women in rural areas were more likely to have another partner compared to women in urban. Similarly, the findings show that men in the rural areas were more likely to have another sexual partner than their counterparts in urban, although the likelihood for men model was higher than the women model. Thus it can be concluded that men and women in the rural areas are more likely to have more than one partner.

When controlling for other variables, wife beating was significant for the men model. This suggests men who report that wife beating was justified compared to those who disapproved, were more likely to have another partner. Thus men who share a violent attitude towards women tend to have other sexual partners.

7.0 Conclusion and recommendations

This chapter aims to present the final reflections regarding the current study. It begins by outlining the summary findings. Significant aspects emerged in the results which deserve to be mentioned for future studies will follow and finally, recommendations will be made for better intervention programs aimed at curbing the spread of the virus.

7.1 Conclusion

The main objective of this Master's thesis was to explore factors that render men and women in Malawi through analyzing HIV/AIDS related indicators. The study incorporated the theory of masculinity in order to understand how some sexual behavioral and cultural practices may render men and women at risk to HIV infection. In this Master thesis, we used pattern of condom use and the likelihood to have more than one partners as main to examine sexual behavior. Decision making pattern, attitude towards wife beating and perceptions on sexuality assessed the norms embedded in the concept of masculinity among men and women.

From descriptive analysis it emerged that while there were not major differences between men and women in condom use, the findings show that condom use was low especially across all socio-demographic background with the exception of education, particularly men who attained higher education. Here it was determined that men who attained high education had the highest proportion of condom use with 33 %. It is therefore safe to conclude that high level of education may increase condom use. We find that when all background characteristics and masculinity factors namely decision making, attitude to wife beating and perceptions on sexuality are considered in predicting condom use among men and women, decision making was statistically significant. Further, it was also determined that partner decision among women decreased the likelihood to use a condom. This revelation is consistent with a patriarchal society where men are dominant over women. The study also shows that men who were employed compared to unemployed were less likely to use a condom.

We find that men, regardless of any background, were more likely to have more than one partner. In contrast, only small proportions of women reported having another spouse. In addition, we observe that the partner decision making for men was less influential on the likelihood to have sexual partners compared to women. Related to the likelihood to engage in casual sex relationship is the men's attitude on wife beating. The results show that the likelihood to have more than one partner for men is higher when men approve wife beating compared to those who disapprove it.

Men's actions such as the dominant role in decision making, and the tendency to have more than one sexual partner, make women more vulnerable to HIV infection. As women

lack full autonomy, coupled with the fact that women are physiologically more susceptible to HIV than men, this may explain why women are at higher risk to HIV infection, hence higher prevalence rates in Malawi.

7.2 Recommendations

The following recommendations are generic and meant to be suggestive only. However they provide a guideline of the types of information that need to be gathered for inclusion in intervention program design. The recommendations are necessary in order to identify the socio-cultural antecedents of behavioral change; and make program more reflective and responsive to local cultures and conditions, and hence more effective in HIV/AIDS prevention programs.

As the study has revealed low condom use, there is need for a concerted action to de-stigmatise the condom; a major effort is required to make the condom a symbol of reproductive health responsibility for men and women rather than illicit sex. There is a need to further explore more why condom use is very low in Malawi; perceptions and attitude towards condom, may dig out revealing information why the condom is not popular. The promotion of condom use should be accompanied by extensive sensitization covering issues such as how to raise the subject with a sexual partner, when to use condoms and how to use them properly.

It is recommended that some key socio-cultural norms that render women vulnerable to HIV infection need urgent attention. For instance aspects of female gender roles which impede the promotion of healthy Reproductive Health behavior i.e. the idea that women cannot refuse sex; that women should be passive and uninformed about sexuality; that men alone make decisions about when, where and under what circumstances sexual activity occurs.

Similarly there is a need to address aspects of male gender roles such as the idea of masculinity tied to sexual conquest, experimentation with many partners

The findings showed there was high proportions of young men and women who approved wife beating. This group requires needs to be targeted separately when designing intervention programs given the fact that their lifestyles, sexual behavior and learning abilities differ.

There is a need to develop strategies that not only capitalize on sexual behaviour change *per se*, but those aimed at addressing socio-cultural norms, including early sexual behaviour, STDs, alcohol and drug abuse, bar and disco culture, ritual cleansing and wife inheritance.

It is recommended that political leaders should demonstrate by stepping up open discussions on the impact and ways to prevent the epidemic.

AS research has shown that in Malawi, like in most sub-Saharan region, the main mode of HIV transmission is through heterosexual intercourse. Therefore, addressing issues of gender equity and promoting equal participation of men and women in negotiating safer sexual practices is highly desirable, and women have the right and should be encouraged to say NO to unsafe sex.

Malawi should also learn from other countries such as Uganda's successful ABC- abstaining from sexual activity, mutual monogamy, and condom use. However, abstinence and faithfulness should not substitute condom use as that is the case with main faith based organizations. A combination of these strategies if rooted in a community-based national response with the full and willingness support from both the governmental and nongovernmental sectors may yield the MSA successful.

To sum up, future research need to develop reasonable prevention plans based on high quality, appropriate research that takes into account the norms and the culture of the society. The findings of such systematic and scientific research can help disseminate accurate information about the mechanism of HIV/AIDS is spread. But also can serve as further inputs when designing problem-solving, action-oriented interventions programs.

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