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Social Pathways from the HIV/AIDS Deadlock of Disease, Denial and Desperation in Rural Malawi

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For the past 20 years, AIDS in Sub-Saharan Africa has been considered a disease of high mobility largely associated with political strife[1] or urbanization.[2] With its largely peaceful recent history and heavily rural population, however, Malawi poses several challenges to existing assumptions about this demographic and social profile of the disease. Adult HIV prevalence in the country was estimated at 14.1 per cent in 2005, among the highest in the world. More than half a million Malawians have died of AIDS to date in a country of approximately 11 million people.

Over the past decade, HIV has spread in Malawi against the backdrop of depeasantization and food shortages, devastating local economies, traumatizing communities and eroding traditional safety nets. Causal links between HIV/AIDS and frequent, widespread famine in the country have been postulated. In 2004, CARE Malawi commissioned a study to investigate the livelihood strategies and social forms that have evolved within rural households and communities to contend with the threat of HIV and AIDS. The study examined community responses to the three main stages of the HIV/AIDS disease cycle: 1) infection and transmission; 2) debility and death; and 3) the aftermath of death encompassing widows, orphans and household reconstitution. Both qualitative and quantitative research methods were used in three village sites in Lilongwe rural district to study recent social change with the aim of identifying points of opportunity for nurturing social pathways that could propel rural communities towards future well-being.

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1 For example, Uganda, Rwanda, Burundi and the Democratic Republic of Congo.

2 The rapid spread of AIDS in the more heavily urbanized countries of South Africa, Zambia, and Botswana accords with this assumption. So too, there is much higher HIV prevalence in urban as opposed to rural areas throughout Sub-Saharan Africa.

Transmission and Infection

The major form of HIV transmission in Malawi continues to be heterosexual sex. The tragedy of this situation is that sex has been transformed from being a natural and pleasurable part of everyday rural life, bringing birth and renewal to the community, to its current status as a conveyor of disease and death. The denial and fatalism prevailing in rural Malawi holds back the adoption of safer sexual practices and perpetuates a high-risk environment in which many people, especially youth, are contracting HIV unnecessarily.

Farming households' earnings from agricultural exports and remittances declined during the 1990s, engendering rural income diversification, deagrarianization and depeasantization. The famine of 2001-02 and the on-going AIDS epidemic have been intricately embedded in these processes. Over the past five years during the famine and its aftermath, *ganyu* casual labour has gained in importance as a source of income for all economically active household members, particularly women and youth. Widely reported cases of women and girls exchanging sex for basic foodstuffs took place in the context of their having nothing else to offer in exchange. They were reduced to transacting an 'essential exchange' in all respects: sex for basic food needs.

Traditionally, sexual behaviour was proscribed throughout one's lifetime on the basis of gender and age and these norms were embedded in concepts of community harmony and well-being. In interviews, villagers identified three main social tendencies, which reflected people's demoralization, economic desperation, or more light-hearted desire for psychological escape, namely: village extra marital sex, women's increasing transactional sex, and men's drinking and womanizing leisure time activities. Youth are increasingly amongst the ranks of heavy drinkers.

Illness and Death

Villagers sympathize with people living with HIV at the same time as they are uncomfortable and fearful about

them. Village Action Committees have made important contributions to AIDS care, providing much needed practical support and helping to alleviate the feeling of shame that AIDS-affected families experience. They also provided forums for open discussion of the behavioral causes of AIDS. Rural people's search for medical care is apportioned between traditional healers, spirit healers and western medical facilities. Traditional and spirit healing is directed at the remedial reworking of the patient's social relations to attain spiritual balance. 'Well-being' in this sense is spiritual and relational rather than physical or psychological. Our evidence suggests that rural medical practitioners tend to refrain from telling patients that they have AIDS based on the obvious clinical symptoms that their patients present, and that cross-referral between clinics and traditional healers is common. Asset-stripping to cover medical costs impoverishes rural households.

Aftermath of Death and Household Reconstitution

In the aftermath of death, families may experience dislocation in terms of the return of an 'incoming' spouse to his/her home village vis-à-vis matrilineality or patrilineality. Since the deaths so far seem to have been biased towards men, it is widows under patrilineality who have been most affected. Asset stripping is widespread and can detrimentally impact on their welfare and that of their children. Twenty-six per cent of our random sample of 141 households was hosting one or more orphans, amounting to 0.53 orphans per family on average or 1.79 orphans per orphan-keeping households. Some orphans are marginalized within the host family and suffer from very low self-esteem, and they may seek escape from what they consider a life with little future.

Given the debilitating effects of HIV and AIDS on the village community and the recent experience of famine, the timeframe of villagers' coping strategies has been drastically reduced. Our survey findings indicate that only 15 per cent of households received assistance during the recent famine in the form of food from extended family and only 19 per cent accessed food aid from external agencies. Many now operate on the day-to-day resolution of household hunger through '*kusokola*', looking for food. Besides increasing reliance on *ganyu* labour markets, land markets are appearing in which male farmers have been seeking urban or other patrons to help finance their access to fertilizers and land rentals and sharecropping arrangements have ensued.

Conclusions

The majority of the Malawian population is HIV negative and lives in rural areas on the basis of insecure agrarian livelihoods. Nevertheless, the findings of this study indicate that a culture of denial and fatalism in the face of HIV and AIDS is widespread in rural areas of the country. The researchers recommend a focus on human agency, responsibility and rights to bring AIDS under control. As a first step, rural defeatism and spiritual fatalism must be addressed, with a focus on the immediate need for food security and finding alternative productive and recreational activities to alcohol. Aid agencies must work with communities on alleviating the tension between traditionalism and modernism in local government. It is critical to be aware of differences in perceptions and availability of services between urban and rural areas, particularly when it comes to voluntary counselling and testing and antiretroviral therapy. Households need support in making health care decisions for their AIDS patents that do not contribute to deepening impoverishment and destitution. Finally, widows and orphans need livelihood support and social protection in overcoming the effects of the epidemic in themselves, their families and their communities.

About RENEWAL

RENEWAL is a growing regional "network-of-networks" in Sub-Saharan Africa. Currently active in five 'hub' countries (Malawi, Uganda, Zambia, South Africa, and Kenya), RENEWAL comprises national networks of food and nutrition-relevant organizations (public, private, and nongovernmental) together with partners in AIDS and public health. RENEWAL aims to enhance understanding of the worsening interactions between HIV/AIDS and food and nutrition security, and facilitate a comprehensive response to these interactions. Core objectives are (1) to reduce critical gaps in understanding how livelihoods, particularly those deriving from agriculture, (a) contribute to the further spread of HIV (susceptibility), and (b) are affected by HIV and AIDS (vulnerability); (2) to generate new policy-relevant knowledge on how households and communities may strengthen both their resistance to HIV transmission and their resilience to the impacts of AIDS, and (3) to enable relevant institutions (in particular, governments) to generate and to act upon realistic priorities for responding to the interactions of AIDS epidemics with food and nutrition insecurity.

RENEWAL is both a network and a process, with the process of network development being viewed as both a means and an end. The aim is to enhance and sustain impact through pro-actively establishing links between locally-prioritized research, capacity strengthening and policy communications.

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Note: This brief is based on a RENEWAL working paper containing preliminary material and research results. These papers have not been subject to formal external reviews managed by IFPRI's Publications Review Committee, but have been reviewed by at least one internal or external researcher. They are circulated in order to stimulate discussion and critical comment.

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