GENDER EMPOWERMENT IN THE CONTEXT OF THE HIV/AIDS EPIDEMIC; MARRIED WOMEN AND THEIR STRATEGIES OF PROTECTION

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Background

For over twenty years of research on women's roles in development, we know that women have less access to and control over productive resources than men – resources such as land, credit, and education. While the extent of this difference varies considerably from one country to the next, women's poorer social position relative to men's nearly always persists (Buvinic, 1995; Sivard et al., 1995). The power imbalance that defines gender relations and sexual interactions in most cultures increases women's vulnerability and affects women's access to and use of services and treatments. For this reason, since the late 1980s, women's empowerment has been the focus of much work on HIV/AIDS. Particularly, health educators and community activists have concentrated on women for education about prevention, at the beginning promoting narrow messages such as "ask the man to use condom" and "love faithfully" (Gupta, 1996) and more recently, promoting the use of female condom (Gollub, 2000). This approach disregards the possibility that, in the context of the AID pandemic, gender relations might evolve and thus that individual strategies of prevention might expand beyond the narrow range offered by family planning methods. Little attention has also been given to the interaction between perception of individual autonomy and perception of individual HIV risk, and their impact on AIDS-related behaviors. Yet it has been shown that men and women develop strategies of behavior on the basis of their perception of infection risks (Anglewicz and Kohler, 2005) and that they often then to overestimate their risk, especially married women (Smith and Watkins, 2004; Bignami et al., 2006).

To better understand the meaning of gender empowerment in the context of the AIDS epidemic, the focus of this paper is to measure the relationship between self-perception of autonomy, risk perception, and the most accessible AIDS-related behaviors for married women. The main goal of this paper os to measure the extent to which self-perception of autonomy shapes married women's response to HIV and AIDS-related protective behavior within their marriage. Despite the widely-promoted "ABCs" of prevention, in rural Malawi, some strategies of prevention may not be viable for some; for example, condom use within marriage continues to be seen as an "intruder" (Chimbiri 2007; see also Tavory and Swidle2007). The table below shows the distributions of married women's response to best ways of protection. Like these other articles based in Malawi, the percentages in this table show that condom use is not a popular method of protection within formal union. In contrast, 60% of married women believe faithfulness is the best way to protect against HIV/AIDS infection. The "A" of the ABCs, abstinence – which remains a strong emphasis by NGOs and governmental campaigns – ranks among the most accessible way to protect within marriage and autonomy.

	Center	South	North	Malawi
	n=341	n=349	n=274	Total n=964
	%			
Advise spouse to take care				
	41.9	42.7	65	**48.8**
Use condoms with all other partners except spouse				
	14.4	22.6	10.2	16.2
Use condoms with prostitues/bargirls				
	1.2	2.6	0	1.4
Use condoms with people from town				
	0.3	0.9	0	0.4
Use condoms with people you think might be infected				
	2.7	3.7	1.5	2.7
Avoid sex with with any partners except spouse				
	38.7	69.3	74.1	**59.9**
Avoid sex with prostitutes/bargirls				
	1.5	2.6	0.7	1.7
Avoid sex with many partners				
	10.6	10.9	24.1	14.5
Avoid sex with people from town				
	0	0.6	0.4	0.3
Avoid sex with people you think might be infected				
	2.9	3.2	2.6	2.9
Avoid transfusion, injections, and sharing razor blades				
	29	51.9	60.2	**46.2**
Abstinence				
	79.1	31.5	4	**40.5**

In addition, new evidence shows that divorce is increasingly becoming a strategy of prevention against HIV/AIDS by rural Malawians (Reniers, 2003). Finally, the perception of individual HIV risk also plays an important role in the behavior to protect against HIV/AIDS infection and I believe that perception/worry of being infected will motivate/stimulate a change in their behavior of protection.

Data & Methods

To explore these findings, the paper will use data from the most recent wave of the Malawi Diffusion and Ideational Change Project (MDICP), a longitudinal survey on the role of social networks in changing attitudes and behavior regarding HIV/AIDS, family size, and family planning in Malawi. The MDICP has collected longitudinal data for a population-based sample of approximately 3000 respondents age 15 or older to examine the role of social interactions in changing attitudes and behaviors regarding HIV/AIDS in rural Malawi since 1998. The MDICP collects information in rural areas of three Malawian districts across the country (South, Center, and North). A comparison of the characteristics of the 1998 MDICP sample with those of the rural population surveyed in the 2000 Malawi Demographic and Health Survey indicates that, at baseline, the MDICP sample was representative of the national rural population (more on sampling and fieldwork procedures, as well as the survey data, are available from the project's website: http://malawi.pop.upenn.edu). The MDICP has completed four survey waves in total (1998, 2001, 2004, and 2006). An evaluation of non-response and attrition by Bignami-Van Assche et al. (2001) shows such sources of bias do not significantly affect results. For the proposed analyses, I use data from the most recent wave (2006).

The main independent variables come from a series of survey questions that overall measure a woman's self-perception of her autonomy, defined as her ability to act on decisions without needing consultation with her spouse. Some research suggests that autonomy is a difficult/broad dimension which should not be regarded as homogeneous, but rather, as a grouping of measures such as mobility and decision-making (Jejeebhoy, 1997; Bloom et al. 2001). With the intention of building a single variable to look at autonomy, indexes were constructed based on previous work in the Indian setting (Balk, 1994; Jejeebhoy, 1997). The self-perception of individual autonomy for the selected sample is measured from a set of twelve questions. The questions are categorized to build five dimensions of women's autonomy: mobility, acceptability of divorce, acceptability of wife-beating, negotiation of safer sex, and acceptability of forced sex. The mobility dimension is built from two questions asking women whether they felt it was acceptability to got to the local market or local health center. Based on their score, women were categorized as having a high (score of 2) or w low (score of 0 or 1) perceived mobility. The acceptability of divorce dimension contains five questions asking women whether they felt that it was acceptable for a wife to leave her husband if: 1) he offers no financial support; 2) he cannot provide her with children; 3) he is sexually unfaithful; 4) he might have AIDS; 5) he does not allow family planning. This acceptability of divorce index is constructed by *first* summing each individual's score on these five questions, and *second*, assigning a value of "high acceptability of divorce" for those scoring at the median (three) or higher, and "low acceptability" for those scoring below the median of three. The wife-beating dimension measures women's view on the question "Is it acceptable for a wife to leave her husband if he beats her?" Women who answered yes scored one and were associated with a low acceptability of wife-beating, consequently, those who answered no had a high acceptability. Two questions asked women about their opinion on negotiation of safer sex; if they felt it was acceptable for them to use a condom or to refuse unprotected sex if they suspected their husband to be infected with AIDS. The same ranking was used to determine whether they had a high (score of 2) or low (score of 0 or 1) perceived power of negotiation of safer sex. The last dimension, forced sex, is also derived from a single question where women answered if they thought it was acceptable for their husband to sleep with them by force if they often refused sex. These dimensions enable us to evaluate the women's perceived level of autonomy. Finally, the perception of risk is assessed by women's answer to the question " How worried are you that you might be HIV positive?".

The table included in this abstract presents tabulations of this measure for all married women in the 2006 wave, as well as providing a breakdown by region, which vary along important socio-cultural and economic dimensions, which in turn are thought to influence a woman's level of autonomy. In future analyses, I will conduct a series of regressions using these autonomy contracts as they are correlated with divorce and risk perceptions. Each model will control for socio-demographic factors including age, education, religion, and measures of wealth. I expect to find a positive relationship between a woman's perception of autonomy and her HIV/AIDS-related behavior-methods of protection within marriage.

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