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**An Investigation of Community-Based
Communication Networks of Adolescent
Girls in Rural Malaŵi for
HIV/STD Prevention Messages**

by

Deborah Helitzer-Allen

on behalf of

A Team of Collaborators

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Executive Summary

In Malawi, HIV infection rates among women attending antenatal clinics have increased from approximately 3% in 1985 to over 30% in 1993. Approximately 90% of women live in rural areas where access to information on AIDS and sexually transmitted diseases is limited (STDs). Traditionally, information regarding sexual norms and practices is passed on to young girls by older female relatives and advisers. In order to influence sexual behavior among adolescent girls, therefore, it is important to investigate the feasibility of using traditional communication channels within communities for HIV/STDs prevention efforts.

Objectives

The objectives of the formative research conducted between September 1990 and September 1991, with 10 to 18 year old females in the Thyolo District of Malawi, was to understand:

- Adolescent girls' HIV/AIDS related knowledge, attitudes, and reported behavior;
- Adolescent girls' information sources and social networks related to sex, marriage, STDs and HIV/AIDS;
- Reported and actual social norms related to sexual knowledge and behavior;
- How the ritual initiation ceremony for adolescent girls impacts on sexual behavior and knowledge related to HIV/AIDS; and
- The relationship between adolescent girls and traditional advisers (*nankungwi*) and/or other female adults in the community.

The intent was to use the results to design community-based interventions to prevent HIV infection in adolescent girls.

Methodology

The study used a combination of qualitative methods (participant observation, in-depth interviews, focus groups) and quantitative methods (household census, survey) in twelve rural communities in one district. Two communities participated in the hypothesis-building intensive research phase; ten communities participated in the hypothesis-testing phase of the study. Two hundred and twelve households participated in a household census in two villages totalling 2,212 persons. In these two villages, 215 adolescent girls, ages 10 to 18, participated in the initial adolescent survey. Sixteen in-depth interviews were conducted with village dignitaries. One hundred twenty in-depth interviews, focus groups, and 12 participant observations were conducted with adolescent girls. Twelve focus groups were conducted with mothers of adolescent girls. Finally, 300 adolescent girls and 23 *nankungwi* or traditional advisers participated in the final survey in ten different villages. Analysis of qualitative data was contextual; analysis of quantitative data was conducted with the use of SAS-PC.

Results

The research showed that there are strong traditional norms about gender roles in rural communities. From an early age (five years old), girls are taught to perform specific duties and to take on responsibilities of home and family. Most (87%) girls had acquired some education, 78% were currently enrolled in school, and many (55%) could read Chichewa, the local language. However, the average length of attendance for girls was reported to be shorter than that of their brothers, mostly because of the belief that a girl's role is to take care of the household and that a likely pregnancy will force the girl to stop her education eventually anyway.

Communication networks are clearly delineated by subject. Communication about reproductive health or "female matters" such as menstruation, hygiene and illness happens cross-generationally (often from grandmothers and older female

community members), while communication about sex is mostly between peers. Sixty % of girls report having learned about menstruation from either their grandmother, mother, or traditional adviser (*nankungwi*), while 75% reported learning about sex from a friend. Sixty-six percent of girls say that their best friend is a reliable source of information about sex. Girls who have not yet menstruated do not admit to knowing about menstruation in a focus group or on a survey (although other more in-depth qualitative data clearly show that they do know about it), and there are strictly enforced social norms about interactions between prepubescent and postpubescent girls.

The research showed that while there are reported to be social norms about sexual behavior, community members also report that these norms have broken down in recent years. In in-depth interviews, elder women report that girls should not have sexual intercourse before marriage, but young girls report having had sexual intercourse as young as 12 years-old, often before they begin menstruating, and before attending the initiation ceremony. The survey results corroborate this information: 69% of girls report either having had sexual intercourse before they began menstruating and/or before being initiated. The mean age at first intercourse was 13.63. Fifty-eight percent reported having had sex before menstruation; the mean age of menstruation was 14.50. While much of this sexual intercourse is initiated by older boys, girls report being interested in having sex.

There is strong ritualized behavior relating to growing up and becoming a woman, especially around the time of menstruation. This period is marked with a special initiation ceremony, run by the elder women of the community, and in some cases, by the church. This ceremony teaches girls about hygiene, being a woman, sexuality, their roles as wives, respect for elders, and how to behave "properly" as an adult in the community. This ceremony is held once a year, and girls usually attend this ceremony slightly before, or in the year immediately after, they begin menstruating. The mean age of initiation in this population was 13.83; 23% had been initiated before menstruating, but the majority were initiated after they began menstruating

(64%). A small proportion of girls were initiated twice (16.5%) and fewer were never initiated (6%).

Much information about menstruation, sex, and perhaps STDs is passed on during the initiation ceremony. Girls who attend the initiation but have not yet menstruated are sequestered and given different information from those who have already menstruated. Ninety-four percent of girls report that the initiation ceremony is an important ceremony for the village, but it is very expensive for the families of initiates, who pay more than US\$35 in direct and associated costs for the ceremony. However, because the ceremony is such an important one for the village, not to participate could have substantial costs in terms of acceptance and ability to participate in other types of community ceremonies. Observation and reports of initiates showed that the content of the ceremony could in itself be a motivating factor in encouraging girls to begin sexual activity.

It is clear that government-led efforts to increase knowledge about AIDS has had considerable impact. Eighty-two percent of the girls who participated in the study reported having heard of AIDS. Perceived risk of AIDS among this population was significantly lower than for other sexually transmitted illnesses. Only 14% of adolescent girls believe their chances of contracting AIDS are "good or moderate," while 65% on average believe they need to protect themselves from the three major STDs. Over 90% of adolescent girls reported being able to avoid AIDS by "not receiving blood, not sharing toothbrushes, and not having sex with 'easy' partners." Few girls report that their sexual partners, either boyfriends from the city or boyfriends from their village, fall into the category of "easy partners." Most girls (63%) say that a person cannot have the AIDS virus and look healthy; and only 20% say the need to use a condom each time they have sex to prevent AIDS.

Girls do not appear to be in a position to affect change in their sexual activity without training in negotiation and condom use skills, nor without easy access to condoms. Fifty-five percent of girls say they are often forced to have sex and 66% have accepted money or gifts (payment) for sex. Girls also report that having an older boyfriend (five years older or more) is a common occurrence, although no

individual girl would admit to having an older boyfriend herself. Survey results show that 75% of adolescents would like help in learning how to convince a boy to use a condom, and 77% would like to gain skills in condom use. Fifty-seven percent said it was easier to risk pregnancy than to ask a boy to use a condom; and 48% think it would be difficult to convince a boy to use a condom. Currently, condoms are distributed through the District Hospital (for many villages, a round trip of 25 miles) or in limited number through shops and other outlets. All community members surveyed supported the concept of community-based condom distribution, although no consensus on the point of distribution at the community level exists.

Conclusions

It seems that community-based condom distribution, accompanied by skills training in negotiation and condom use, would be an effective HIV/AIDS preventive intervention for those girls already engaging in sexual intercourse. For younger girls, including specific information on HIV/AIDS and risk in the community-based communication networks (peers, initiation ceremony, church activities) as well as in school lessons, would also be useful. Most important, however, would be a commitment on the part of community elders to (1) strengthen currently unenforced social norms about abstaining from sexual behavior before menstruation and initiation and (2) delaying initiation until *after* the onset of menstruation. As reported above, the mean age of initiation was not significantly different than the mean age at first intercourse, 13.83, and 13.63, respectively. The mean age of menstruation, however, is significantly older at 14.50. The data show clearly that if the practice of holding initiation after the onset of menstruating was strictly enforced, and if girls did not have sex until after initiation, 69% of adolescent girls would delay intercourse for at least one year. This would provide more time for girls to learn about risk for HIV/STDs and AIDS, about how to successfully negotiate condom use with their partners when they were ready to have sex, and would provide

reinforcement for parents to continue girls' education at least until they completed Standard 8.

Community-based research, while useful to understand determinants of sexual behavior and effective in documenting social change, also has positive and negative effects on social change in itself. In a positive direction, the research conducted in these communities encouraged elder women to think about how social norms had broken down over the years. The research methods utilized, especially focus groups, enabled women to talk among themselves about subject which may have been "taboo" for casual group discussion. It encouraged them to consider solutions to prevent younger girls from engaging in risk behavior before they were prepared or able to negotiate safer sexual practices.* On the negative side, however, the fact that outside organizations were conducting research in these communities led to considerable expectations on the part of community members about "payment" for participating in a research study. Since water collection is a female responsibility, the community requested, and were given, funds to build safe wells for community water consumption. The year of the study coincided with a drought and consequent severe food shortage in the research communities. In order to assure that the initiation ceremonies would be held, the principal investigator was requested and agreed to provide food for the ceremony participants. Finally, the field supervisor provided, at her own discretion and expense, school fees for all adolescent girls in the research site. This contaminated the research site, creating an unnatural situation where there was no distinction between families where the need for education of girls was considered important, and those where educating girls was considered to be a waste of resources. While it is certainly fair that communities which participate in research should be compensated for their efforts, researchers should work with community

* It is questionable, however, whether women or girls in these communities will be likely to attain enough power to be able to successfully control their sexuality or their fertility in the near future. This has more to do with the role of women generally in these communities and their interest or willingness to change the system.

representatives to find ways to compensate participants in a manner which will benefit the community but minimize artificial social change.

1. Introduction

The process of systematic data collection leading to the development of a theory of the problem is described in the literature as "grounded theory."¹ Unlike other social science researchers whose aim it is to test or verify theories, grounded theorists prefer to discover the relevant concepts and hypotheses that affect the problem at hand and inductively create a theory from those data. In the case of this study, the problem at hand is the prevention of HIV transmission in adolescent girls in rural Malawi. The research methods (described in Chapter 3) were utilized in such a way as to develop a theory of this problem from which strategies and interventions could be developed.

One of the first steps in the grounded theory approach is to inform and thereby guide the data collection through the examination of other research and literature discussing the same or similar problems in other populations or related to other, in this case, health topics. In relation to this study, previous work had been done with adolescents and with HIV prevention which was useful in helping to understand the special needs of the target population and the peculiar issues surrounding HIV prevention programs. In general, as well, much work has been done to understand how cultural issues, particularly social norms, prevent the adoption of new knowledge and new behaviors, despite vigorous attempts to promote them within traditional societies. Finally, it was useful to review the experience of other HIV/AIDS prevention programs, particularly since this experience related not just to the acquisition of knowledge but to behavior change in particular.

Thus, the following section outlines the literature related to communication, especially as it relates to HIV/AIDS prevention programs; to knowledge-behavior gaps; to social norms; to cultural adaptation to illness; to the cultural, social, and economic constraints to HIV-prevention related behavior change; and, to the special needs of adolescents related to HIV risk and prevention. This literature became the framework for the research design and for the collection of specific types of information from our target populations.

Communication Issues

The Malaŵi National AIDS Committee (NAC), in conjunction with the World Health Organization² has developed a medium-term plan to combat AIDS. Communication strategies are considered central to achieving of the AIDS-related behavior change objectives of the plan. In Malaŵi, as elsewhere in Sub-saharan Africa, significant attention has been paid to communication about HIV/AIDS³ because experience has shown that messages can raise awareness about AIDS and STDs and be an effective tool to pass information.

Well designed and executed communication interventions can be effective in promoting behavior change.⁴ Programs are effective if the message is straightforward and simple, it reaches its target audience, it is relevant, the behavior it promotes is "do-able," it provides skills to perform the behavior, it is backed up by a service or product delivery system that provides access enabling the behavior, and there are sufficient reinforcements for maintaining the behavior. Because communication programs are effective, however, they can also be dangerous. For instance, they can convey a misleading impression that current behavior is sufficient or that the target audience is not at risk. In order to change behavior, messages must communicate a true sense of risk, an action to undertake, and a benefit (reinforcement).

While AIDS communication programs, except in a few small, tightly woven communities,^{5,6} have succeeded in transmitting information about AIDS, most have not been effective in changing behavior, especially the adoption of AIDS preventive behaviors. The limited documentation available on communication strategies used in Sub-Saharan Africa suggests that they have the following features in common:⁷

- Messages have been based on fear (Uganda - Iron Fist, WHO early logo of death on a heart) but give the receiving party no action to use the fear to motivate the correct behavior (response). Research to date indicates that appeals based on fear are likely to backfire, making the behavior even more resistant to change.⁸
- The core transmission group model has been used as the basis of much of the communication about AIDS, and messages singling out these groups as the

virus transmitters, combined with denial of the risk of the general public, have led to misconceptions about the most important transmission routes.⁹

- Messages have been mostly intended for the general public rather than specific target audiences. Communication strategies which consider several target audiences can play upon individual characteristics such as early or late adoption tendencies, distinct psychographic profiles, or position in communication networks.

Ager and Collins recommend that health marketing strategies be used to promote AIDS prevention strategies in Africa. They present a model which distinguishes four levels at which a health message may be successful: (i) in creating awareness of health risk; (ii) in producing an inclination towards certain patterns of behavior; (iii) in establishing a clear intention to behave in that manner, and finally (iv) facilitating the overt practice of that behavior.¹⁰

Knowledge and Behavior Gaps

Prior research on behavior change has shown that knowledge and behavior are not linearly connected. The provision of information does not necessarily mean that a concept is understood and integrated as knowledge, nor does it necessarily lead to a change in behavior. However, it is clear that some forms of knowledge are more closely related to changes in behavior. These are the kinds of knowledge that increase one's perception of risk, support protective social norms, and provide the skills needed to implement behavior change. Understanding the types of knowledge important in changing behavior, in relation to the knowledge that encourages individuals to remain comfortably within the status quo, is therefore crucial to the development of a communication intervention.

HIV/AIDS communication programs for adolescents should have additional features: (1) Protective social norms need to be reinforced to prevent early initiation of sexual activity and to provide a forum for the dissemination of specific and sensitive kinds of information about HIV and risk of transmission. (2)

Communication social networks need to be understood and utilized to pass information concerning sexuality and sexual behavior, which may be more appropriately passed along in an informal manner. (3) Access to condoms and information about condom use must be accelerated and sanctioned to encourage the adoption of protective behavior once sexual activity is initiated.

Social Norms

Cognitive-social learning theory,¹¹ reasoned action theory,¹² and the theories of behavior change readiness and maintenance¹³ have all proved useful in health communication efforts in other health areas such as smoking cessation and drug abuse prevention. More recently, conceptual frameworks grounded in cognitive-attitudinal and social learning theories have been formulated that are more specific to AIDS risk behavior change.^{14,15} Although these perspectives show considerable promise as frameworks for developing prevention strategies in North America, they require translation and adaption for use in other cultures such as that of rural Malawi.

Concurrent theoretical developments in cultural anthropology represented in the works of Schweder,^{16 17} and D'Andrade,¹⁸ among others, offer a framework within which more specific and focused psychological theories can be adapted and applied to HIV/AIDS prevention programs for Malawian adolescents. This recent work in cultural theory shares a concern for the ways in which cultural models take on motivational or directional force; how, in other words, shared meanings guide individual behavior in concrete social contexts.

Kleinman's studies¹⁹ of how biomedical and "lay" models of disease and illness play out in non-Western health systems provides an additional anchoring point. Kleinman argues that health-related activities are informed and shaped by associated sets of explanatory models and cultural frames which guide the behavior of everyone involved in the process of disease prevention. HIV/AIDS communication then, is not simply a process of information transfer; it is also cultural translation, and more

specifically, translation between distinctive cultural models, e.g., between biomedical models of HIV/AIDS and "lay" or popular models—such as the construction of AIDS in Africa as the "radio disease," and "illness of women," or more generally, a sickness of (stigmatized) "others" (foreigners, prostitutes, etc).

Cultural models both entail and activate rules and norms for individual behavior—this is how they take on directive or motivational force. There is increasing evidence (and recognition in the public health community) that social norms play an important role in facilitating (or hindering) changes in risk behavior. The concept of "norm" has traditionally been associated with a highly socialized view of human behavior which holds that people's actions are tightly constrained by internalized rule-systems. But more recent work in cultural anthropology (and in social psychology, particularly on perceived norms) suggest that rules and norms operate on the surface of social cognition and interaction—behavioral rule-systems are not so much "deep structures" as they are interpersonal resources to be used in negotiating social relationships and interactions. Although cultural models of illness, gender, or sexuality entail rules, a great deal of social life is about bending, evading, manipulating, and going beyond official or ideologically dominant codes of conduct. This is particularly true in the domain of sexuality,²⁰ where sexual encounters are often more a matter of skilled performances, of casting and scripting, than of the mechanical working out of rule-systems.

An important lesson is that just as rules can be bent and manipulated, the norms which underlie risky sexual behavior can also be negotiated and changed. Educational packages emphasizing skills building through the modeling of protective behaviors and negotiation strategies have proven effective with respect to other health behaviors. The same principles might be applied to the development of HIV/AIDS-related interventions in Malaŵi.

Focusing on the ways in which social norms are grounded in cultural models, and how both are linked (tightly or loosely) to individual behavior, is especially important for HIV prevention interventions for another, quite basic reason. AIDS communication is, in essence, the use of communicative tools (words, images, symbols

and meanings) to construct new (or reshape existing) cultural models (and thereby, norms and behaviors). By examining the cultural grounding of social norms in a community, and the way these norms are posited and either reinforced or ignored, one can utilize these frameworks in the development of a communication strategy. Related literature calls this the hermeneutic-dialectic model of communication.²¹

Finally, a cultural-models approach is particularly useful in guiding the development of communication strategies for youth. Although there was much to be learned about the sexual behaviors of Malawian adolescents, we know more generally that sex is a central preoccupation in youth cultures worldwide.²² For young adults, issues of sexuality are closely intertwined with processes of maturation and identity formation. Sexual choices and behaviors are influenced by models which define the meanings of gender and sexuality, establish the ground rules for male-female negotiations, and inform youth's sense of risk and danger. That these models are not necessarily shared by older age cohorts (parents, grandparents) or across gender lines is also clear. But, this lack of complete overlap among the cultural models and meanings of different social groupings and segments creates the very openings and spaces within which innovation and change become possible. It also suggests that peer reference groups and communication networks are particularly important targets for intervention. This is because the subject of sex is channeled through a specific network, relative to the transmission of other kinds of information. Understanding and ultimately utilizing that network²³ is essential to the success of a communication strategy.

Cultural Adaptation to Illness

Studies of illness and health systems reveal that a response to illness within a culture is socially organized.²⁴ Once a culture or community recognizes an illness, it develops ways of coping with it, including defining the "sick role" and appropriate sick role behavior, defining and testing preventive methods and curative therapies,

and developing and sustaining health care systems to address it. This cultural adaptation can be seen readily from studies of malaria,²⁵ diarrhea,²⁶ and STDs.²⁷

One important goal of this study was to learn to what degree HIV/AIDS is accepted as a threat to the community in rural Malawi. The National AIDS Committee communication strategy had relied, to a large degree, on a core transmission group model. The hypothesis of the study team was that this reliance on a core transmission group model would (1) translate into ignorance/denial about self-risk; (2) show that AIDS is almost always believed to be an illness of bar girls and truck drivers; and that in this context (3) HIV/AIDS is perceived as easily avoided by limiting contact with these groups. In this case, being "external" (to the community) means that these sources of illness can be avoided because they can be easily identified and "kept out." If this "non-acceptance" of HIV/AIDS existed, the culture would not perceive HIV/AIDS to be a significant risk to its integrity and therefore would not yet have developed a "response" to it. This state of non-adaptation to HIV/AIDS would be particularly worrisome for adolescents, who as a rule perceive themselves to be invulnerable to illness and death. Their awareness that elders do not perceive the community to be at risk of HIV/AIDS would be a powerful reinforcement for continuing unsafe behaviors.

Cultural, Social and Economic Constraints to HIV/AIDS-Prevention Related Behavior Change

Ulin argues, in her paper on African Women and AIDS, that AIDS prevention campaigns have not yet taken into account the cultural, social and economic constraints on most African women's ability to comply with advice encouraging them to limit partners and use condoms.²⁸ It is because of the pressure for economic survival and personal autonomy that many women continue to form relationships with new sexual partners. As men and women travel between rural and urban areas, their contact with new sexual partners increases and their risk of acquiring the HIV virus is increased as well. For adolescent girls, the "Sugar Daddy" phenomenon is the most

heinous, as urban-employed men travel back to their rural communities in search of younger and younger "clean" women. The allure of these men is that they are in the position to provide substantial enticement in the form of clothing, school fees, and other "gifts."²⁹ Indeed, messages which wish to impact sexual behavior in women must consider these complicated issues.

HIV/AIDS Risk and Prevention among Adolescents

In the adolescent population, more effort should be concentrated on reducing, delaying, or eliminating high risk behaviors to limit the spread of HIV.³⁰ Risk behavior theories that offer insights into the factors that result in undesirable risky behaviors suggest points of intervention to induce changes. Boyer and Kegeles' AIDS Risk Reduction Model (ARRM), theorizes that three steps are required to reduce risky behavior: (1) recognizing that one's activities makes one vulnerable to a bad outcome [in this case, contracting HIV]; (2) making the decision to alter risky [sexual] behaviors and committing to that decision; and (3) overcoming barriers to enacting the decision, including problems in [sexual] communication and [condom efficacy] knowledge.

Effective behavior change can be inspired by working within social norms as they adapt to changes in societies. This does not imply that one should learn about current social norms and try to change them, but rather to work to understand how social norms can be used as instruments of change.

Existing in most communities are social norms which provide protection from HIV/AIDS, as well as for other STDs. However, these norms appear to be breaking down, or at least to be unenforceable by the elders of the community in Malawi. This may be because those norms are idealized, rather than real, and that the actual "norms" are the behaviors as they currently exist and can be documented. Thus, efforts should be made to correlate the age at which sexual intercourse is permissible with the actual mean age at first intercourse. Other information to be collected concerns social and communication networks related to sex and human sexual

development as it is passed through community rituals such as initiation and the understanding about rules concerning who may talk about what when and to whom.

To reinforce adolescents' belief that they are at risk for HIV/AIDS, and therefore to decide and commit to limiting their risk-related behavior, two additional factors must be considered. First, the reinforcement mechanism will need to come from the elders of the communities. They will need to believe that these children require protection and that specific actions need to be taken. Second, programs for adolescent populations will have to give information, skills in communication and negotiation, as well as in the correct use of a condom. Furthermore, the products (condoms) will need to be provided to enable the sustainability of healthy risk-reduced behavior.

2. Objectives

The purpose of this study was to investigate:

- adolescent girls' knowledge, attitudes, and reported behavior related to sex, STDs and HIV/AIDS.
- adolescent girls' information sources and how they learn about sex, STDs and HIV/AIDS; particularly:
 - To learn more about the initiation ceremony for adolescent girls, its content, context, and potential for information transfer about HIV/AIDS and STDs.
 - To learn about the relationship between adolescent girls and *anankungwi* to see if *anankungwi* could be trained to be a resource for adolescent girls.
 - To learn about how communication networks change based on specific subject matter and how these networks can be utilized for HIV/AIDS prevention messages.
- To develop some hypotheses about communication channels and messages for HIV/AIDS prevention for adolescent girls; particularly:
 - traditional communication approaches specific to the setting of social norms and utilizing the traditional structure of the community; and
 - messages which could be effective specifically in increasing the perceived risk of infection for adolescent girls and which could have a behavioral impact on the timing of the onset of sexual intercourse.

3. Methodology

Malaŵi: The Country

Malaŵi is a landlocked country in south-east Africa of approximately 8.8 million inhabitants,³¹ at the southern end of the Rift Valley. It is part of a transportation channel which passes through Uganda, Kenya, Rwanda, Tanzania, and Zambia. Divided into three administrative regions and 24 districts, Malaŵi is one of the most densely populated countries in Africa. A recent UNICEF State of the World's Children³² listed Malaŵi as having the sixth highest under-five's mortality rate (258/1000) and the fourth lowest per capita GNP (US\$170). Malaŵi is experiencing ever-increasing prevalence of HIV-infected adults and children and is just beginning to experience deaths from AIDS in significant numbers. Testing carried out in 1987 in the largest city showed an HIV seroprevalence among sex workers of 55.9% and 31.3% among prisoners.³³ Seroprevalence in a sample of pregnant women attending an antenatal clinic in the same city was measured at 26% by 1991.³⁴ As of March 1991, 17,755 AIDS cases had been reported to the World Health Organization by the Malaŵi Ministry of Health.

Chicheŵa is the language of the primary ethnic group; while the Chewa, is the *lingua franca*. English is the business language and is used for official purposes and taught in schools as a second language.

Most of Malaŵi is matrilineal and matrilocal, although there are a few patrilineal groups in some parts of the country.³⁵ Descent and inheritance among the matrilineal groups are passed through the female lineage, usually through the eldest sister in each generation. Prime responsibility for the wife and children rests with the maternal uncle. In rural villages, the husband establishes the household in the wife's village. A husband has a right to his wife's person and services but not over the children born of the union, who remain members of the mother's matrilineage. The extent of polygamy is hard to determine in Malaŵi, but some reports suggest that 25-33% of males over the age of 40 may have more than one wife.³⁶

Female marriage is almost universal in Malaŵi. The 1987 Census reports the median age at marriage to be 17.4 years, although these data are suspect due to the inaccuracy of self-reported age.³⁸ The fertility rate is 7.6 and estimated annual population growth rate is 3.56%.

Approximately 90% of the people of Malaŵi live in rural areas where subsistence farming is the primary economic activity. Per capita food production has decreased 17% since 1980.³⁹ In the rural areas there is little access to "modern" communication channels. There is currently one local radio station and no locally-produced TV in Malaŵi. The rural areas are not generally electrified, and a high tax on radios has made them unaffordable luxuries for most people. In addition, the cost of batteries is higher than the average daily wage of a rural laborer. At the time of this study, there was only one daily newspaper in the country, *The Daily Times*, costing MK 1.00 (U.S. 25 cents) per day.

Traditional education, especially in rural areas, remains a very important part of education for imparting traditional and cultural values. Formal education is divided into primary, secondary, and tertiary levels. The 1987 Census reported that 31% of females and 50% of males aged 15-19 had completed at least four years of school. Of persons attending school in 1987, 96.5% were attending primary schools. The same data show that persons aged five and over, 55% had never attended school, 42% had at least a few years of primary education, while only 3% had attended secondary school and above. These figures show hardly any change from the 1977 census. Table 1 shows the highest level of education received by persons aged five and above as recorded in the 1987 census.

The Study Sites

The study described in this report was undertaken in twelve rural communities in the southern region of Malaŵi, in the Thyolo District. In order to reach these villages from Blantyre, the urban commercial center of the country, one must drive first along a poorly tarred road for one hour, and then on a dirt road for another half

Table 1. Highest Level of Education Received by Persons Aged Five and Above

Attendance	Male	Female
Never Attended	44.7%	64.3%
Primary School		
Standard 1-3	19.6%	15.5%
Standard 4-8	30.4%	18.4%
Secondary School		
Standard 8+	5.1%	1.8%

hour. In the rainy season, at the end of the dirt road, one must get out and walk for another 15 minutes to get to the center of the villages. These villages were selected because they are different from each other, and were thought to be "typical" of other villages in the rural areas of southern Malawi. In two of the villages, Perusi and Pindani, most of the research for the exploratory phase was conducted. They are located within the Traditional Authority of Chilamiro, and differ significantly in their ethnic breakdown. Perusi has a larger proportion of Lomwe residents, while Pindani is constituted more significantly of members of the Mang'anga ethnic group. While both ethnic groups are matrilineal and matrilocal, they differ substantially in other culturally important factors, such as church affiliation, income generating activities, and intra-familial housing allocation, which will be discussed later. However, it is important to note that these differences were found to influence communication patterns of adolescent girls, and therefore had an impact on the outcome of the study. All the work with the exception of the Knowledge, Attitudes, Beliefs, and Practices surveys were conducted in these two villages.

Methods

Census and Mapping

The first two data collection activities undertaken by the research assistants were a household census and mapping of the two communities. The objectives were: (1) to introduce the research assistants to the residents; (2) to enable all residents to ask questions of the research assistants before the in-depth work with adolescent girls began; (3) to familiarize the research assistants with the villages and the locations of important sites, such as the church(es), the market, the school, the water supplies, and the homes of village dignitaries; and (4) to identify the homes where adolescent girls were living. The census and mapping exercises covered a period of one month. The information collected in the household census included:

- household or Malaŵi Census number;
- number of families per household (defined as *eating from the same pot*);
- for each household member: first and surnames, year and month of birth, and gender;
- the relationships between household members;
- kinship structure;
- number of children in birth order; and
- the relationship of this household to other households in the village (clan; lineage; *mbumba*^a).

^a *Mbumba* is a Chicheŵa term covering a group of younger sisters of an older brother; it is used both narrowly to define a family structure and broadly to suggest a protective relationship between an older man and unrelated women. The President considers all the women of Malaŵi part of his "*mbumba*."

In-depth Interviews with Village Dignitaries

The second formal research undertaking involved in-depth interviews with the village dignitaries. These dignitaries included the two village chiefs, the chiefs' wives, the Malaŵi Congress Party Chairmen in both villages, the wives of the Malaŵi Congress Party Chairmen, and the church elders (deacons) in both villages.

Adolescent Survey

The research assistants then undertook a survey of adolescent girls (ages 10-18), identified through the household survey. Of the 295 adolescent girls thus identified (Pindani = 142, Perusi = 153), 80 were dropped either because they were married or had children, or both; or because they were away at secondary school and not available to participate in the study. In total, 215 adolescent girls were interviewed (Pindani = 105, Perusi = 110) during a period of one month.

The data obtained from the survey were used to construct "profiles" of the adolescent girls. These profiles characterized particular behavioral attributes typical of girls within age groups. Girls were placed into six profile groupings by age. Groups A,B,C,E and F were common across both villages, as follows:

Group A was composed of 10-12 year old girls who reported having heard of menstruation.

Group B was composed of 10-12 year old girls who reported not having heard of menstruation.

Group C was composed of 13-15 year old girls who reported having had sexual intercourse.

Group E was composed of 16-18 year old girls who reported having had sexual intercourse.

Group F was composed of 16-18 year old girls who reported not having had sexual intercourse.

Group D profiles differed between villages. In Perusi, Group D was composed of 13-15 year old girls who reported not having had sexual intercourse, but did have older girlfriend(s) they could talk to, and had participated in an initiation

ceremony. In Pindani, Group D was composed of 13-15 year old girls who reported having had sexual intercourse, but did not have older girlfriend(s) they could talk to, had participated in an initiation ceremony, and had already begun menstruating.

Each group contained five girls who were not part of the same household and who had volunteered to be part of the study.

Participant Observation of Adolescent Girls

Within each profile group, one girl was selected for in-depth participant observation in each village. This observation entailed one full day, split over two days, of observation from sun-up to sun-down. The research assistants followed each girl as she performed her household tasks, interacted with family and community members, and played with her friends. The only exception to this was school activities, which were not observed. During the observation period, the research assistants talked with the girls about the activities as they occurred, the relationships between people they met and interacted with, and "the life of an adolescent girl." It was made clear to the study subjects when the appointments were made and continually throughout the observation period that this was a research activity.

Each research assistant also spent two full days observing activity at the point of water collection (a borehole, open well, or spring). During this period the research assistants took notes on who came and went (together, in groups, and separately), and the conversations that occurred during these periods.

In-depth Interviews with Adolescent Girls

After the participant observation exercises were complete, the research assistants began an intensive phase of 120 in-depth interviews—60 in each village (6 groups x 5 girls x 2 interviews). Each girl participated in two in-depth interviews, during which they discussed subjects such as family and household, school, travel, friends, health and personal hygiene, sex and marriage, and STDs and HIV/AIDS.

Focus Groups with Adolescent Girls

Each girl, then, participated in three focus group discussions which included discussions pertaining to daily activities and household chores, community life, treatment of girls and boys in the community, and rules about girls and boys playing together.

Focus Groups with Mothers of Adolescent Girls

At the request of some mothers, after all the profile girls were interviewed both one-on-one and in groups, focus groups were held with them to discuss issues related to being an adolescent girl. The mothers' groups paralleled those of the girls. Mother who would have been eligible for two groups were invited to participate in the group in which their youngest daughter was a member.

Initiation Ceremonies: Observation and Key Informant Interviews

The research assistants observed and participated in initiation ceremonies in each village, being invited to do so by the chiefs' wives in each village. Due to the prevailing drought conditions, there had been some discussion about whether or not to hold the initiation ceremonies at all, but when the project offered to supply food the ceremonies were held.

There were two ceremonies, one in each village. The ceremony in Pindani was run by the chief's wife, the elder women of the community, and four *anankungwi*. It covered a period of two weeks, and a total of 27 girls attended. In Perusi, the ceremony was run by the church, the church deacons, the elder women of the church, and the four *anankungwi* affiliated with and trained by the church. This ceremony lasted six days and a total of 13 girls attended.

After the ceremonies had been observed, several key informant interviews were held with *anankungwi* and chiefs' wives to clarify points of information raised during the observation.

Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys in Ten Villages

Village selection. After the ethnographic component of the study was complete, the investigators reviewed the data and arrived at a series of hypotheses about adolescent girls, *anankungwi*, and their communication; teachings about sexual behavior and other issues during initiation; and communication and knowledge about HIV/AIDS. These hypotheses were used to develop two KABP surveys that were implemented in ten villages in Thyolo District.

The villages were selected by the following criteria:

- At least one village should be within each of the seven Traditional Authorities (TA) in Thyolo;
- five villages should have traditional, community-led initiation ceremonies and five church-affiliated ones;
- each village should have at least 1000 residents; and
- the chief should give permission to the adolescent girls to respond to the questionnaire.

Adolescent Girls. A questionnaire was developed and administered to 300 girls in ten villages. Within each village, a sample of thirty girls between the ages of 10 and 18 were selected for questioning. Because earlier work had shown that reported age was not accurate, a biological indicator was used to divide the sample. The earlier work had shown that the average age of menstruation was approximately 14.5 years of age, and that 30% of the girls would be under 14 years of age. Therefore, the sample was divided into two groups: 10 girls who had not yet begun menstruating and 20 who had begun menstruating. The girls were selected randomly based on standard sampling procedures. Five interviewers, starting at the chief's house as a hub of a wheel, moved outward along a radius, selecting every other house until their sample of six girls [two non-menstruating, four menstruating] was complete.

Anankungwi. At the same time that the adolescent KABP survey was being administered, a small survey was undertaken of all *anankungwi* within these ten villages. The chief of each village was asked to identify the *anankungwi* to be

interviewed and a total of 23 *anankungwi* participated. The questionnaire was developed to test a series of hypotheses derived from the exploratory phase of the study.

Figure 1 summarizes the different research methods and the data collected through each instrument. Because the in-depth interviews and focus group discussions were conducted in Chicheŵa and translated on the spot into English, quotes from respondents are actually translations of quotes by interviewers.

Figure 1. Summary of Data Collection Methods Used in the Study, with Numbers of Respondents and Information Collected, Thyolo, Malaŵi 1992

DATA COLLECTION METHOD	NUMBERS OF RESPONDENTS	INFORMATION GATHERED
In Two Thyolo Villages		
Household Census	n = 2,268 residents	ethnic group; sociodemographic information; numbers of persons and ages; kinship patterns;
In-depth Interviews with Village Dignitaries and <i>Nankungwi</i>	n = 14 interviews	history of village; ethnic distribution; ceremonies; influences on adolescent girls; kinship patterns; information about selection, role and responsibilities of chief, chief's wife, nankungwi, church dignitaries in village life;
Survey of Adolescent Girls [ages 10-18]	n = 215 respondents	ethnic group; education; role and responsibilities; travel and exposure to communication channels; communication networks; menstruation; initiation; knowledge about AIDS and STDs; sexual behavior; and socio-demographic information;
Participant Observation of Profile Adolescent Girls and Activity at Village Boreholes	n = 20 girls observed 1 day each	observing typical life of 10-18 year old girl from morning to night;
	n = 2 boreholes 2 days each	observation of activity at boreholes from 5 AM to 5 PM;
In-depth Interviews with Profile Adolescent Girls [ages 10-18]	n = 120 interviews	ethnic group; education; role and responsibilities; travel and exposure to communication channels; communication networks; menstruation; initiation; knowledge, attitudes, and behavior related to AIDS and STDs; and sexual behavior;

Focus Group Interviews with Profile Adolescent Girls [ages 10-18]	n = 36 groups	ethnic group; education; role and responsibilities; travel and exposure to communication channels; communication networks; menstruation; initiation; knowledge, attitudes, and behavior related to AIDS and STDs; and sexual behavior;
Focus Group Interviews with Mothers of Profile Adolescent Girls	n = 12 groups	growing up and becoming a woman; sexual activity of adolescent girls; prevention of pregnancy and STDs/AIDS; abortion; condom use and distribution;
Participant Observation of Initiation Ceremonies	n = 2 initiation ceremonies	observation of two ceremonies; one traditional and one church-influenced;
Key Informant Interviews with Village Dignitaries	n = 6 interviews	cost of initiation; clarification of meaning of different activities within initiation ceremony;
In Ten Thyolo Villages		
Knowledge, Attitudes, Beliefs and Practices Survey with Adolescent Girls	n = 300 respondents	hypothesis testing related to: communication networks; meaning and content of initiation; sexual activity of adolescents; social norms related to sexual behavior; knowledge, attitudes, and behavior related to STDs/HIV/AIDS; condom knowledge and use;
Knowledge, Attitudes, Beliefs and Practices Survey with <i>Nankungwi</i>	n = 23 respondents	hypothesis testing related to: communication networks of adolescent girls; meaning and content of initiation; role of <i>nankungwi</i> in initiation; role and responsibilities of <i>nankungwi</i> in village; knowledge and perception of adolescent girls' risk related to STDs/AIDS; condom knowledge and distribution;

4. Results

Exploratory Phase

This phase consisted of the use of a combination of quantitative and qualitative methods to investigate in-depth a range of issues related to adolescent girls' lives and sexual development, in order to generate hypotheses for the next phase in the study. The data collection in this phase was conducted within two Thyolo villages: Perusi and Pindani.

Description of the Villages, Village Life, and Customs

A census of the two villages showed little difference between them in total population, number of households, and percent females ages 10-19 (Table 2). In both villages, the ratio of women to men was slightly more than one.

Table 2. Data from Household Census, by Village

	Pindani	Perusi
Total Population	1,047	1,165
No. of Households	212	232
Average Household Size	4.9	5.02
Females 10 - 19 years	142 (13.6%)	153 (13.5%)
Percent Males	48.3%	49.7%
Percent Females	51.7%	50.3%

The village of Perusi was started by a man named C. Perusi, a leader in the Mang'anga tribe, who settled there with his family and some of his married brothers and sisters. Other settlers followed and Mr. Perusi was chosen as the first chief around 1924. People were attracted to the village because of its location near the tea and coffee estates where residents often found employment. The Mang'anga ethnic

group exercises the strongest influence on social behavior in Perusi, although other ethnic groups such as the Lomwê and the Khokholas are also represented in the village.

Pindani, on the other hand, is composed of families from four ethnic groups, the Lomwê, Yao, Sena and Mang'anja. The Lomwê are the largest ethnic group and have the most influence on social behavior.

The chief's responsibilities in Perusi include collection and payment of income tax, settling minor disputes, sharing land with settlers, attendance at funeral ceremonies, and responsibility for the boys' initiation ceremony. The chief's wife is responsible for the girls' initiation ceremony. She grants permission to the *nankungwi* to hold the ceremony and sets the date for it. She relays messages to the chief in his absence. She also officiates at funerals for babies (between a week and one month old), because these are only attended by women.

In Pindani, the chief's responsibilities are similar to those in Perusi and include settling minor disputes, collecting taxes, and census-taking to predict how many girls will attend the initiation ceremonies each year. The responsibilities of the chief's wife include helping women with miscarriages, arranging funerals for babies, settling disputes among women, and knowing how many girls are going to be initiated every year. The chief's wife attends the initiation ceremony and helps to advise young girls, and, in exchange, receives gifts from them. The chairman's wife also advises the girls, from the time they begin menstruating, to take care of themselves and to respect elders. Teaching respect for elders is actually the responsibility of all women in the village who hold that status.^c

Residence in both villages is matrilocal—women stay in the village after marriage and their husbands leave their natal villages to live with their wives. There are some exceptions to matrilocality as, for example when the husband "is working class" (has a job in town) or when the husband occupies an important position such as being the chief. When the husband is from an ethnic group which is patrilocal, patrilocality

^c A woman is considered "elder" once her own daughter has been initiated.

takes precedence over the wife's marriage and residence customs. In Perusi, the chief's wife is a Tonga and came from another village to live in Perusi because her husband was the chief. The uncle (mother's eldest brother) of the girl and boy, *ankoswe*, is the person who gives official permission for marriage and divorce. In Pindani, furthermore, the matrilineal uncle of each party gives his consent for a marriage, and it is also the uncle who decides whether a marriage can be nullified.

Women in Perusi are responsible for keeping the household, including smearing the floors, washing clothes, cleaning plates, fetching firewood, cooking, pounding maize, drawing water from the bore-hole, farming, sewing, caring for children, going to the maize mill, going to the market, and ironing. Girls begin taking on these tasks at a young age, sometimes as young as five years old. The men's responsibilities in both villages include building houses, farming, basketweaving, and carving.

Women's roles and responsibilities in Pindani closely parallel those in Perusi. Norms and channels of communication for educating young girls about work, health, sex and marriage are also very similar.

Ceremonies in both villages include the male and female initiation ceremonies, called *chinamwali*, which often take place in August; funerals; marriages (which also occur mostly in August); and *sadaka*, which are celebrations 40 days after a death as a form of remembrance. At funerals and *sadaka*, the uncle of the dead officiates. At the *chinamwali*, the male and female *anankungwi* officiate.

The three *anankungwi* in Perusi were selected by the elder women of the village and the CCAP church and are responsible for ten other villages in addition to Perusi. The *anankungwi* are among the oldest women of the village. Their responsibilities are to teach young girls traditional customs about marriage, birth, hygiene, general adult behavior, sexual behavior, and respect for parents and village elders. They are also responsible for determining how many girls are ready to attend the initiation ceremony each year. They establish a direct relationship with the family of each young girl, and girls visit them for "advice." A fee of MK 4.00 is charged for the initiation ceremony and additional fees are levied for further training. Sometimes

they exchange "gifts" and sometimes the young girls work for the *anankungwi* such as pounding maize, drawing water, or fetching firewood.

There are also three *anankungwi* in Pindani. Their geographical territory covers parts of Thyolo District up to Chiradzulu. The chief said the *anankungwi* were selected by elder women who know about advising young women. Other informants, including the *anankungwi*, say that the role is passed down from one generation to the next. Sometimes this is from mother to daughter, but it can also be from mother-in-law to daughter-in-law. As community members have a chance to disapprove of the younger *anankungwi* this is regarded as a participatory process. The future of the next generation of *anankungwi* in this village is uncertain because the husbands of the daughters of the current *anankungwi* are not supportive of their wives taking on this role and their husbands approval is necessary for their wives to be named *anankungwi*.

In Perusi, girls and boys attend one of two primary schools. Boys are more likely to attend school than are girls. The nearest secondary school is in Thyolo (about 26 kilometers away) but few village children attend. Girls are often encouraged to get married as soon as they finish primary school. They are "allowed" to get married as soon as they start their monthly periods, around the age of 14. One of the informants stated that "it's more or less our custom to educate boys rather than girls because girls leave school as soon as they have started menstruating, which is at the age of 12-14, to get married. By that age, a girls can be in standard five, six or seven, so we find it useless to educate girls." Other informants offered that it was a good idea to send girls away from their homes for secondary school so that they wouldn't get pressured to get married so early. Once girls begin menstruating they are considered grown-ups who can take care of themselves. They no longer require "protection" from elders. However, boys take longer to mature. Thus, a boy can get married only when he is old enough to "run the family business" (building the house, farming, and old enough to impregnate a woman), this is not usually before he is between 16 and 18 years of age.

Pindani's village dignitaries reported very similar information regarding the education of boys and girls. They attend a primary school in the next village. The only secondary school is in Thyolo (about 26 kilometers away). Like those in Perusi, some informants suggested that it was a good idea for girls to leave the village to get their education in order to delay marriage. Overall, while the percentage of girls from each village who had ever attended school was quite high, the educational attainment, based on years of schooling, was low.

Other institutions in Perusi which play important roles in the lives of young girls are the churches. The CCAP, the Providence Industrial Mission, the Assemblies of God, and the Roman Catholic churches are the largest. This was also the case in Pindani where the Roman Catholic Church, the Church of Christ, CCAP, the Lutheran Church, and the Seventh Day Adventist Church play a significant role in the lives of adolescent girls. These churches, moreover, restrict the daughters of their congregants from attending traditional initiation ceremonies; instead they advise girls through their own ceremonies. There are 16 churches in Pindani village.

Socio-economic indicators suggest that the villages are different from one another, in terms of ownership of radios, methods of household support, number of possessions per household and household constitution. However, house structure did not differ in the two villages (Table 3).

The Life of Adolescent Girls

The purpose of the initial survey of adolescent girls was to take a broad, exploratory approach to learn about roles and responsibilities, communication channels, and reported social norms which constitute their lives. The idea was that a first look at these issues would give direction to the in-depth, qualitative work.

Age in Years

Of the total sample of 215 girls, 209 reported their age. The age distribution of the total population is shown in Table 5. The girls were asked their age in several different questions. Once the data for these different variables (AGE

Table 3. Socio-economic Indicators of Households, by Village

	Pindani	Perusi
Household owns a functioning radio	43.8%	59.0%
Methods of Household Support		
Subsistence Farming	46.6%	68.1
Market Sellers	13.3%	30.9%
Father Earns Income	71.0%	77.0%
Mother Earns Income	26.6%	41.8%
Both Parents Earn Income	7.6%	28.1%
Neither Parent Earns Income	9.5%	9.0%
One Parent Earns Income	82.2%	62.7%
House Structure		
Glass Windows	51.0%	55.5%
Cement Floors	13.0%	18.0%
Tin Roof	40.0%	40.0%
Number of Possessions of Household*		
None	25.7%	17.2%
One	40.9%	25.4%
Two	22.8%	30.9%
Three	5.7%	20.0%
Four	4.7%	5.4%
All Five	0.0%	0.9%

* Defined as: watch, bicycle, goat, cow, pig

in YEARS, DATE OF BIRTH) were triangulated, it was clear that there were problems with reported age. In two-thirds of the responses, reported age differed by at least one year from "calculated age". Overall, there appears to be a bias towards a higher reported age. Only ten percent of the respondents had reported ages less than their calculated ages (based on year of birth), while 46% had reported ages greater than their calculated ages. During the analysis phase the interviewers attempted to return to those girls whose age and date of birth did not match, and

Table 4. Age Distribution of Adolescent Girls, Based on Year of Birth, in Pindani and Perusi (February 1992)

Age	Frequency	Percent
9	6	2.8
10	32	14.9
11	21	9.8
12	25	11.6
13	28	13.0
14	30	14.0
15	28	13.0
16	18	8.4
17	20	9.3
18	7	3.3

attempted to clarify the discrepancy. They were able to conduct a second interview in 87 (40%) cases.

After the second interview, the data were recalculated. The data in Table 4 reflect efforts to improve the quality of the data. At a later date informants were asked about how people calculate their ages. Information from these interviews enabled us to learn that birthdays are not celebrated; everyone adds a year to their reported age on January 1; and girls like to say they are older than they are.

School Attendance of Adolescent Girls

School attendance was higher than suggested by the data from the 1987 census. Most girls had been to school, and a majority were currently enrolled. Table 5 shows the percentage of girls from each village who have ever been to school. Forty-six percent had completed one to three years of school, 37.4% had completed four to six years of school, 16.6% had completed more than seven years of school and only 4.8% of girls had completed Standard Eight. There were no difference between villages in the percentages of girls who could read Chicheŵa (55%), and little difference in the percentage who had ever attended school.

Table 5. Education Status of Adolescent Girls in Two Thyolo Villages (February 1992)

	Pindani	Perusi
Ever been to school	85.0%	89.0%
In school now	76.4%	80.2%

Females in Household

Most of the respondents lived with their mothers (87.4%) in the same household. Fifty-five percent had older sisters; 58.6% had younger sisters living in the same household. These statistics did not differ by village. However, Table 6 shows that the percentage of maternal grandmothers living in the household did differ significantly by village. This is explained by the difference in kinship patterns between the Mang'angas among whom grandmothers live in the same compound with one of their daughters, and the Lomwe, among whom grandmothers generally live in another compound in the same village. In almost 90% of households, the mother was either married or living "in union." Divorce was not common and was mentioned in only 3.5% of responses. Never married was more common, mentioned in 6% of responses.

Table 6. Residence of Maternal Grandmother, by Village

	Pindani	Perusi
In household	11.0%	31.0%
In another household within village	27.0%	8.0%

Household Jobs of Adolescent Females

Adolescent girls were responsible for the following household tasks, listed in descending order of importance by percentage of mentions: carrying water (89.3%), cooking (78.6%), washing dishes (78.1%), cleaning house (51.2%), sweeping the

compound (45.6%), gardening (27.9%), drying/pounding/milling maize (24.7%), gathering firewood (21.4%), laundry (17.7%), and childcare (7.4%).

Church Attendance of Family and Adolescent Girls

Adolescent girls reported that they and their families were avid church-goers. In both villages, a majority of families attended church. Eighty-two percent of girls reported that their families attended church in the last month; approximately the same percentage of girls reported attending church as well. However, significantly more girls reported attending church in Perusi than in Pindani. These data support other information about the extent of church influence in the two villages. Table 7 depicts the data on church attendance by the girls in each village.

Table 7. Church Attendance of Families and Adolescent Girls, by Village

	Pindani	Perusi
Family attended church in last month	76.1%	88.1%
Girl attended church in last month	74.29%	89.0%

Communication Data Related to Adolescent Girls

Adolescent girls confirmed the information obtained from village dignitaries regarding communication channels. They reported that communication networks are distinguished by topic and social norms about communication are taught and reinforced in daily life.

There was a significant difference between villages in the percentage of girls whose household owned a functioning radio. In Perusi, 59% of girls reported that their household owned a functioning radio, while in Pindani, only 44% of girls reported this. However, while village level ownership of a radio does not appear to restrict access to radio, it does appear to influence listening patterns. In both villages, over 80% of girls reported that they had listened to the radio in the last

week. Girls in Pindani reported listening less than once per week, while girls in Perusi report listening daily or at least once per week. Table 8 shows these patterns. This information, together with the data showing travel by village suggests that girls in Perusi have greater access to information outside their communities.

Table 8. Pattern of Radio Listening by Adolescent Girls, by Village

	Pindani	Perusi
Listen daily	19.2%	23.9%
Listen once a week	34.6%	56.5%
Listen less than once a week	46.1%	19.57%

Travel Experience of Adolescent Girls

Most girls in both villages reported that they had not lived outside of their village for more than five years, but more than half had travelled outside their village and stayed in another village for less than one week. However, almost half of the girls in each village reported that they had lived in another village during the last five years. Those who had lived in another village most often lived with their grandmothers. There were no significant differences between villages in these data. However, there was a significant difference between villages in the amount of local travel girls had undertaken. Significantly more girls in Perusi reported having travelled to Thyolo (26 km.), to Malamulo (30 km.), and Blantyre (75 km.) than girls in Pindani.

Table 9. Travel of Adolescent Girls, by Village and Destination

	Pindani	Perusi
To Thyolo	35.24%	46.36%
To Malamulo	0.95%	7.27%
To Blantyre	4.76%	11.82%

Participant Observation of Adolescent Girls

In each village, one girl from each of the profile groups was observed for half a day, to learn through observation about the life of an adolescent girl. The observations confirmed much of what the girls themselves had reported about their household tasks and responsibilities. They also showed that the tasks do not differ by age, with one exception, that older girls (16-18) are considered responsible enough to select "relish" or vegetables from the family garden, or purchase them from the market.

Observation also showed that girls play together after school before they begin their dinner-related responsibilities. This is the only time of day they are "free" to play. This does not mean, however, that they only have peer contact during the afternoons. Girls spend time with their peers while doing chores, especially during water collection—which occurs a minimum of twice daily.

Observation at the water collection site revealed that water is collected primarily between the hours of 5 AM to 11 AM and again between 2:45 PM and 5:00 PM. There is no activity during the hours of 11:30 AM to 2:30 PM (the lunch hour) and none after dark. With few exceptions, water was collected only by girls and women between the ages of five and 40. Women used a variety of implements to collect and carry the water, including, in descending order of use, metal pails, plastic buckets, clay pots, metal tubs, and a basin. Activities at the well included filling pails and buckets; cleaning plates, cups and cooking pots; and washing vegetables. Clothes were not washed at this site. Topics of conversation included things sold at the market; sports activities; boyfriends; school activities; local events (births, deaths, market activities, and robberies); and illnesses of children.

When girls and women come to draw water, the first thing that they do is to clean the inside and the outside of the pail, which takes them almost five to eight minutes. Thereafter they draw the water into their pails. If the women or girls are too talkative they stay for another five minutes discussing their problems or sharing their secrets because this is the time when most of them are then able to discuss things. It takes almost ten minutes to come from Perusi to the well, another ten to fifteen minutes here at the well, and another ten minutes until they get home.

In-depth Interviews and Focus Group Discussions with Adolescent Girls

Two in-depth interviews were conducted with each of the 60 profile adolescent girls selected for in-depth study, for a total of 120 interviews. These were followed by 20 focus group discussions composed of the same girls. Differing results between age group and villages as well as between methods will be noted.

Household responsibilities. During in-depth interviews girls in all three age cohorts reported that they wake up early in the morning, between 5:00 and 6:00 AM. Their first responsibility was to draw water from the open well. After this, they swept the ground around the house before going to school. After school and before lunch, they collected the relish for lunch, cooked lunch, and washed plates and cups. In the afternoon they played with their friends. In the early evening, they made another trip to draw water from the open well, collected firewood, and assisted with cooking supper. Other activities included preparation and pounding of the maize, washing clothes, working in the garden, and perhaps, accompanying their mother to the maize mill. This was considered "feminine work." Girls who did not attend school performed more tasks than those who went to school. Older girls looked after young children and purchased relish from the market. Either older girls or mothers cleaned the house and only adult females cleaned the *chimbudzi* (pit latrine). In some families, only the adults (male and female) worked in the garden. Girls of all ages reported that they began to undertake these tasks when they were five years old and did them regularly by the time they were about eight years of age. There were no significant differences in responses from focus group discussions on this topic.

Education. Most girls in the 9-12 and 13-15 year age cohorts attended school. They reported that their fathers paid their school fees. A few girls, who reported not attending school, said it was because of the influence of older family members like grandparents or the family's inability to pay school fees.

Many girls 16-19 years of age reported attending school but less than those in younger cohorts. Fathers and other relatives such as older sister's husbands, brothers, grandfathers, and uncles paid the school fees of older girls. Those who did

attend school reported still being in primary school.^c Those who had stopped going to school reported an inability to pay school fees as the reason. Again, there were no significant differences in responses between methods.

Institutional influences. Girls of all three age cohorts reported belonging to a church. They reported that there were, however, no special activities at the church for young people. No other institutions were mentioned as having an influence in the girls' daily lives. Responses were consistent across methods.

Exposure to communication channels (traditional, media and other). Most girls in all three age cohorts reported being able to read and write Chicheŵa. Some reported listening to the radio, although most often they did not have a radio but listened to one belonging to someone else. Even when families owned radios they often did not function. The radio generally belonged to the father or other adult male in the family, and girls had to obtain permission to listen to it. This meant that they often had to listen whatever the adults (mostly males) were listening to, generally the news.^d Another popular program was *Tadzuka Sitidziwa Anzanthu*, a music program played on Sundays; selections were chosen by the listeners.

Girls did not report reading the Chichewa newspaper or English magazines. Girls attending school reported reading books for school. Almost every home had a bible but the girls generally did not regard it as a book. None of the girls reported seeing a travelling theatre or film, but all reported having seen agriculture extension agents.^e One girl reported having seen a play about health put on by the Ministry of Health staff about the health of people.

^c However, these data are biased by the fact that the few girls who were attending secondary school and were, therefore, not available to be interviewed were systematically discharged from the sample.

^d In Malaŵi, there is one radio station, which plays both Chicheŵa and English programs, from 6 AM to 12 PM daily.

^e In Malaŵi, agriculture extension agents have travelling vans with 16 mm film showing capacity. These films are most often about agriculture, but are sometimes about health matters such as diarrhea prevention and treatment.

As noted earlier, there appears to be a correlation between travel outside of the village and exposure to communication channels. Girls who had travelled outside the village to other large towns also were more likely to be exposed to other forms of communication, including newspapers and magazines. Girls who had travelled to Luchenza (10 km. away), Thyolo (the district center 26 km. away), or Blantyre (the commercial capital 75 km away) reported having seen buses with advertisements on them. Consistent with the data obtained through the in-depth interviews and the adolescent survey, girls from Perusi appeared to be more likely to be exposed to a variety of communication channels as compared to those in Pindani.

Criteria for a best friend. Among the criteria girls 9-12 years of age cited for their best friend were sharing stories; having things in common; sharing jokes; sharing (keeping) secrets; having good behavior: disliking gossip; disliking boys; and being of the same age. Girls 13-15 years of age gave slightly different criteria for their best friends than girls of a younger age. Helping each other and sharing life dreams and experiences such as helping each other solve problems and talking about getting married became more important at this age. Other criteria were similar to those listed by the younger girls as well as others such as gossip; sharing secrets about boyfriends; sharing gifts given by boyfriends; and, encouraging each other to continue schooling.

Girls between the ages of 16-18 were even more straightforward about their criteria for a best friend. They gave fewer reasons for selecting someone as their best friend such as not revealing secrets (about boyfriends); not playing games; disliking gossip; helping each other solve problems; sharing experiences; encouraging each other to continue schooling; encourage each other not to get married too early; and helping each other. Again, there were no significant differences in responses across methods.

Treatment of boys and girls. Girls in each of the two youngest age cohorts reported that there was no difference in the treatment of boys and girls, although they reported that each had different responsibilities—"feminine" work and "masculine" work. They reported that differences in responsibilities were due to

boys being more powerful. Families did not differ in their expectations of brothers and sisters—both were expected to behave, grow up, get married, have children, and help others when needed. Girls reported that they were not told these things, they just "see them happening."

However, most girls in the oldest age cohort reported during in-depth interviews that there was a difference in the way girls and boys were treated, especially as they grew older: boys were allowed to go out in the evening, but girls have to be home by (5 PM) dark. Sometimes girls were not allowed to leave the house. The most important difference was that once a girl started menstruating she acted like the mother when the mother was away, and was respected by everyone in the family. Expectations of girls and boys were different as well, although the respondents did not specify just how these expectations changed.

Games. During focus groups the topic of games arose. The most popular games among girls were: Fly, Round Us, Netball, Fish-Fish, Hide and Seek, See-Saw, Touch, Stop, and Volleyball. These games were played in and out of school all year long. No special games that are played during the full moon or at particular times of the year.

Becoming a Woman: Initiation and Menstruation

Initiation

Responses gathered for this topic were generated from interviews with village dignitaries, in-depth interviews and focus group discussions with adolescent girls. Furthermore, data on this topic was also collected during focus groups with mothers as well as observations of and interviews with *anankungwi* and chiefs' wives concerning initiation ceremonies. During in-depth interviews, girls did not give much more information about initiation than they had during focus group discussions. In fact, most of the information about initiation was gleaned from observation and from interviews with the *anankungwi* themselves.

According to village dignitaries there are six types of *chinamwali* ceremonies conducted in Perusi—all through the CCAP church. The ceremonies include the *chinimwali cha chiputa* or initiation for young (premenstrual and newly menstruating) girls; the *chinimwali cha ndakula* which occurs when a premenstrual girl who has been previously initiated begins menstruating; the *chinimwali cha litiwo*, when a woman has her first pregnancy; the *chinimwali cha nanthalika (kutulutsa mwana)*, five or six months after the birth of the first child; the *chinamwali cha maumba*, during the initiation of the first born girl; and the *chinamwali cha chithwango*, during the initiation of the last born girl. The *anankungwi* officiate at all of them. All initiation ceremonies, with the exception of the *chinamwali cha chiputa*, are secret. The *chinamwali cha chiputa* is public and very popular.

The *anankungwi* of this village are given "refresher courses" every year to help them learn different techniques of teaching and conducting the *chinamwali* "following Christian ways." However a strong relationship between the *anankungwi* and an initiate requires payment (money or in-kind payment of work). Therefore, all visits with the *anankungwi* after the initiation ceremony entail the exchange of money (perhaps 10 - 20 tambala, the equivalent of 2 - 5 US cents); the services of the *anankungwi* for the initiation ceremony are also paid for by the family. The informants reported that the cost of initiation in this village is MK 4.00, a chicken, and an amount of maize flour.

Village dignitaries in Pindani only listed five types of initiation ceremonies. The principal ceremony (*chinamwali cha chirigono*) occurs when a girl is between 8 and 12 years of age, before she has begun menstruating. Formerly, this ceremony and the *chinamwali chotha zama*, which takes place after the girl has begun menstruating, were held separately, but today they are often combined. The three other ceremonies are as in Perusi, namely at a woman's first pregnancy, five to six weeks after the birth of the first child, and the initiation of the first born girl. The initiation ceremony for the last born girl was not mentioned.

In Pindani during the first part of the first initiation ceremony, girls are advised by older women. Only at the end of the ceremony do the *anankungwi* officiate. For those girls who have not begun menstruating, the initiation topics focus on behavior (being an adult), but when the girls have already begun menstruating, the topic focus changes to sex education. All the informants expressed their belief that the importance of the traditional initiation ceremony was so that young girls can live up to cultural norms. One of the informants provided the following rich detail about the ceremony:

When the dates have been set (for the initiation) they (the chief's wife and the anankungwi) set a place (usually close to a river) where it is hidden (called thedzo). The initial phase (first week) involves the initiates and their guardians. On the first day, all the initiates, guardians and observers or parents meet at the chief's place and he and the Chief Anankungwi officiate the ceremony. The parents of the initiates are given medicine to wash their hands. The anankungwi and guardians sing songs, dance all the way to the site of the ceremony. Then the anankungwi return to their homes and the initiates remain with their guardians. The latter teach the initiates about what to do or how to behave when the anankungwi come again to give advice. The initiates are taught songs, clapping of hands, kneeling and all that they will have to do when the anankungwi return. The first phase usually lasts seven days. The initiates and their guardians sleep at the chief's home during the first phase.

The second week, they continue the same activities until the return of the anankungwi. When the anankungwi come the guardians pick a plant called simba and replant it in the ground where the ceremony will be held. The anankungwi pluck the plant leaves and give it to every initiate as they sing a song. Then they drop the leaves to the ground and pick them up again. The guardians then blindfold the initiate and her mother. The two—girl and mother—rub their foreheads together and caress each other for some time. Later the cloths on their eyes are removed and the initiate and her mother look at each other and exchange the leaves. They take oaths to respect each other and then call each other's name. The girls then go away and their mothers remain at the spot. The mothers are further advised on how to treat their daughters, e.g., calling them by their clan name (chiwengo) and treating them like older women.

The mothers then return home and are supposed to inform their husbands of the events. Later, in the evening, both parents go to the anankungwi for advice. (This is the ceremony for parents of the first born girl). The advice given is about childbirth, e.g., they are retold or reminded of what they were told when they first got married, e.g., that sexual intercourse leads to conception and pregnancy to childbirth. Afterwards the woman is given medicine which she rubs on her husband's back when they get home. Then the medicine is put in a bath for the husband.

During the day the anankungwi give behavioral advice to the young girls about cleanliness and politeness. They admonish the girls not to enter their parent's bedroom and sing songs. On the second day, the anankungwi continue giving advice. Later, the older girls (who have experienced their menses) are withdrawn from the group and given special advice (chinamwali chotha zoma). In this chinamwali they are advised to be aware of their male friends—that they should avoid them because sexual relationships result in conception and pregnancy, and also lead to diseases like chindoko, chisonono and mabomu. They are also told to clean and to care for their sanitary towels well. After the ceremony in the evening more meaningful songs are sung. Early in the morning the girls take a bath and go to the chief's house where the closing ceremony takes place. Many more people go there to witness the event. Women dance, some strip their clothes and dance naked to get money from the spectators. The chief closes the ceremony when it is over.

The church-sponsored initiation ceremony, on the other hand, lasts one to three days and is "totally different" from the traditional ceremony and the deacon of the church officiates. One of the *anankungwi* reported that a difference between the church and traditional ceremony is the use of drums in the latter. The drums are used to create a rhythm for dancing and singing songs, called *masosoto*. The songs illustratively teach the girls the body movements pleasing to men which they can perform during sexual intercourse. *Masosoto* songs can contain "foul language" but "only the sober ones" are used in the church initiations. In the church *chinamwali*, one informant said, "they don't beat drums, the girls don't dance, they don't sing songs. It only takes a few days for the ceremony to get finished. The girls are advised in a Christian way, that is, the *anankungwi* doesn't reveal many things like they do in the village (traditional initiation). The parents don't pay gifts to the chief,

the parents don't pay a lot of money to the *anankungwi*, and the girls are advised at the church."

Girls 9-12 years of age knew little about the rite of initiation. They reported that girls and boys were "given advice" at a hidden place, and that the *anankungwi* of the village officiated at these ceremonies. In Perusi, girls reported that the initiation was held by the church, while in Pindani, girls reported that the initiation was held by the *anankungwi* and elder women of the village. The ceremony was held after the harvest in August or September. Girls of this age stated that they did not know "what happens there." One informant from Pindani reported that "the parents of the girl give money to the *anankungwi* and chicken plus flour to the chief. After the ceremony people dance and eat the same as they do on a wedding day." Other informants reported that the purpose of the ceremony was to advise young girls about good manners. They did not know of any special rules or ages for participation. None of the girls in this age cohort had been initiated.

Girls 13-15 years of age gave slightly more information about the initiation ceremony, but still no real details about the ceremony or its purpose. Some of these girls had been initiated. Apart from responding to direct questions about the ceremony, some girls also revealed in their responses to other questions that they were taught about personal hygiene and menstruation in the initiation ceremony. As with younger girls, there were some informants who reported that every girl participated and that there were no rules for age of participation. The most detail was given by one informant from Pindani:

The initiation ceremony is held after harvest in August when people have enough food. The anankungwi officiates. The chief announces that there is initiation ceremony. The parents give gifts to the chief's wife to inform her that their daughter wants to attend the ceremony. The gifts are one chicken and a basin of flour. The girls are advised for a week and after the ceremony they pay money to the anankungwi. The purpose is to teach young girls traditional customs.

Girls 16-19 years of age gave much the same information as the younger girls. They provided additional information about the payment to the *anankungwi*,

specifying that it was MK 4.00 each and that the purpose of the ceremony was to teach "modern girls some traditional customs so that the girls grow up with good manners." Other girls in this age cohort reported that during initiation the initiates were told to respect their parents, they were prohibited from sleeping with boys due to the risk of getting pregnant, and that they were prohibited to go to their parents' bedrooms as a way of showing respect. "They are even told how to respond to their husbands when doing sex." They were also told how to dress themselves and keep clean when menstruating. It was clear from the informants during these interviews that they were instructed not to talk about the content of the ceremony. Some even reported that the content of the ceremony was secret and if they revealed it, they would die. Most knowledgeable about the ceremony were the girls in this age cohort who lived in Perusi, where the ceremony is sponsored by the CCAP church.

In focus groups there was little discussion about the details or the role of the initiation ceremony. Girls did report that attendance at an initiation ceremony was an important rite of passage and that there was strong pressure to attend. "Every girl should attend an initiation ceremony by the age of 16." The little detail given included the purpose of the ceremony was "to advise young girls about traditional customs so that they should respect older people...I was told this by my grandmother before going to the ceremony." The cost of the ceremony in Perusi (church-influenced ceremony) was reported to be K4.50. The following response from a focus group illustrates adherence to customs governing the group dynamic:

Sometimes the initiation ceremony takes a month or a month and half for boys. Girls take only 2 to 3 weeks. Girls and boys are advised what to do. I went to attend the initiation ceremony myself but I can't tell you all what we were told because it is against our traditional customs. It is officiated by the anankungwi.

While village dignitaries had reported that the timing of the initiation ceremony is meant to coincide with menarche, mothers' reports suggested that there was more variability in the timing of initiation than had been initially suggested. Most mothers of 9-12 year old girls and 13-15 year old girls said that their daughters would

be ready to be initiated after they have begun menstruating. These mothers said that this occurred mostly at the age of 13 or 14 and above. However, some mothers said that they preferred to send their daughters to the initiation ceremony before they begin their periods, often as young as eight years of age, while others waited until their daughters began menstruating, as old as 16 years of age.

I feel shy when I see a girl who doesn't know what to do and what it is, when she starts her first period at a group where there are boys, e.g., at the church and mostly at school. (Other mothers commented that they)...also feel ashamed when that thing happens, but (they) prefer to send (theirs) when the girls do their first period so that they should not know much while young. (Other mothers commented)...I think it is indeed a good idea to send a girl to the initiation before she does her period because apart from knowing what to do when she starts her period...they know that 'when I do sex with a boy I will fall pregnant'.

Mothers with daughters within all three age cohorts commented, "it also depends on when the parents have enough money and food to send the child to the ceremony, and to pay for the *anankungwi*." Some mothers say that "some parents like to send their daughter twice to the initiation ceremony. They send her before she starts menses and after starting menses, depending on the money they have."

All mothers of girls in the oldest age cohort had sent their daughters for initiation, but they differed about when. Many mothers had waited until their daughters had begun menstruating; some had not. Some mothers of girls in this age cohort also gave a financial reason as the determining factor, rather than the biological maturity of their child. And a few mothers said that the daughter asked to be sent to the ceremony, and if they could afford to do so at that time, they did.

Mothers of girls in all three age cohorts said that at the initiation ceremony girls are taught how to behave as grown ups. They are taught to show respect for their parents (and other adults) by not entering their bedrooms "because they can find their parents doing sex. It is also not good for the daughter to see the sanitary towels for her mother." They are taught how to put on their sanitary napkins and how to take care of them. They are taught the general cleanliness of the body. They are

also taught about sex: "how to shake their waists when they are with boys doing sex;" ; sexual enhancement methods ; "how to respond to their husband to be when doing sex, but they are prohibited to do sex before marriage (because they should be) afraid to get unwanted pregnancies and venereal diseases;" and "not to have sex during their period because a man can get a disease called *chitayo* and die afterwards."

Observation of and Key Informant Interviews about Initiation Ceremonies

After all the interviews were completed, the research assistants were invited to observe the initiation ceremonies in each village. It should be noted that there was a famine in the southern part of Malaŵi in 1992, and that the two villages had decided not to hold the initiation ceremonies because of the lack of food. The project offered to provide the food for both villages so that the ceremonies would be held as usual.

The initiation ceremony in Perusi was sponsored by the CCAP Church. It began on Wednesday, August 19, 1992. This year, a total of thirteen girls participated in the ceremony. The ceremony lasted five days, to August 24. In addition to the initiates, participants included other women of the community, and girls who had already been initiated (guardians of the initiates). The initiates were welcomed to the initiation ceremony by the male church elders and the female participants mentioned above.

Outside the church a fence made of banana leaves was constructed to ensure a protected space. Inside this space, the girls were given instruction. The first thing they were taught was the *masosoto*, a dance which emphasizes the movement of the hips. The first day lasted until 9:00 PM, during which time girls sang and danced. At 9:00 PM the girls were allowed to go inside the church to sleep.

At dawn of the second day, the girls were taken to the river to bathe. After their bath they were given breakfast with in the confines of the fenced-in area behind the church. Throughout the morning the girls were told parables by the older women.

One girl pretended to be poor dressed in rags and wanted help from other people. Three girls were shouting at her that they couldn't give her any help. The advice which was given on this parable was that when the girls goes home they should help the poor.

The girls were also read portions from the bible by the advisers regarding helping the sick and disabled, respecting elders, and helping their parents with household work. Examples of these readings are Corinthians Chapter 2, verses 114-117 and John, Chapter 9, verses 1-10.

In the afternoon and evening, the *nankungwi* came to talk with the initiates. They held prayers and gave advice through their readings of the bible. The verses which were read earlier in the day were repeated, to reinforce their messages. In the evening of the second day, the girls returned to the fenced-in area for more dancing and singing. In this ceremony, the girls were not allowed to "sing the songs of sin."

These activities continued for four days. On the last day, the *anankungwi* came again to the church for the final part of the ceremony.

The anankungwi took the girls from the church to the Namadzi River to be advised. She separated the young girls (from) those who (had) started menstruating for the first time. Out of 13 girls who were initiated two of them were ones who had started menstruating. To the younger girls the anankungwi stressed the importance of good behavior. They should respect grown ups. They should not laugh at lame people. They should help their parents with household work. To the older ones (those who were menstruating) the anankungwi advised them about maintaining general cleanliness, for example to take baths regularly when menstruating and to wash the sanitary napkins time and again. They were also told not to do sex before marriage but after marriage, to prevent unwanted pregnancies. They were also told that after they get married and while having their periods, they should hang a red bead on the wall to indicate that they are menstruating and stop having sex. They were also told that they should not do sex when having their periods because a man can get a disease and die afterwards.

In the evening of the final day, the girls were allowed to take a bath and dress in nice clothes. They were taken to the church for prayers. After the final prayers,

the initiates made a procession and village members followed them home, singing and dancing in celebration. The families of the initiates paid K 2.00 for the ceremony, which is split between the synod and the *anankungwi*.

The initiation ceremony in Pindani village was organized by the Chief's wife. It began on Sunday, the 2nd of August, 1992, and continued for two weeks, until Sunday, the 16th of August. Twenty-seven girls participated in the ceremony, although only 16 girls participated the first week; the remaining 11 girls "registered" and began participating during the last week.

In order to register their daughters, parents (mothers) went to the Chief to tell him that their daughters were ready for the initiation ceremony. The parents brought a chicken and some maize flour (*ufa*). After each girl was registered, the Chief informed the *anankungwi* to prepare for the ceremony.

During the first week, the initiates concentrated on dancing. Each initiate also had a partner, or guardian who had previously been initiated. These guardians are called *mikolozolo*; they were the ones who taught the initiates how to move their waists while holding their hands up to touch the back of the head, for the *masosoto* dance. The initiates were also given advice from older women of the village (those women whose daughters have already participated in an initiation ceremony) through the singing of songs and the telling of parables, called *zisimo*. An example of one song follows:

The first stanza, the girl is complaining that the husband she is married to doesn't know how to farm. (Since every woman here in villages wants to get married to a man who knows how to farm even though the man is educated and works in town they expect him to farm when he comes home for a holiday.) The second stanza, the girl is complaining that her husband doesn't do sex though they are married.

The parables were acted out by guardians. Most of the parables covered topics of obedience to parents, respect for the elderly and the sick, taking care of the dead, performing household chores, and taking care of friends who were parentless or more unfortunate than themselves. An example of one parable follows:

Then came two girls, one pretended to have a big wound on her leg and was walking with the help of a big stick. The other girl pretended to be a relative of the one with a big wound whether a sister or aunt, and was telling her to clean plates. The girl with a big wound always gave an excuse when asked to do any job that she was feeling pain because she had a big wound. Then a voice came from the spectators saying "Your boyfriend wants to see you. He is at the road's junction." The girl with the big wound started to run to meet her boyfriend at the junction. (Everybody laughed because at this time the girl threw away her stick and started to run without caring that she had a big wound.) Then one of the two girls told the initiates that they should stop malingering, and start helping their parents with any kind of job they are asked to do.

The ceremony continued in this manner for 12 days. The initiates (*anamwali*) stayed at the Chief's house but in a separate place and each morning they went to stay at the river so that the community members would not see them, especially men and those females who have not undergone initiation. Each evening they went back to the Chief's house to have their supper. Older women still went there in the evening to advise the girls through songs. During this period, the initiates were not allowed to take a bath.

On the 15th of August, the *anankungwi* arrived to advise the girls.

On Saturday the anankungwi came. They were a total of 4. The anankungwi sang songs while three men beat drums. The people danced with the anankungwi while other people were just singing songs and clapping their hands. People gave the anankungwi money until every anankungwi had her own money. Even the men who were beating the drums were also given money and they call this kufupa or mfupo in Chicheŵa. The anamwali and their guardians were not allowed to go out and they were put in a fence. Only those who had undergone initiation were allowed to see the anamwali. The people kept on singing and dancing and thereafter the anankungwi ordered the guardians to take the anamwali out. The guardians took their anamwali while running very fast so that people should not see them. They led them to the road which leads from the river to a place they call panphambano in Chicheŵa. They were given advice by the anankungwi. They advised them to respect grown ups and to avoid prostitution. They also told them to stop visiting their parents' bedrooms. The people sang songs, then the anankungwi ordered them to imitate the sexual act. The anamwalis slept on top of their guardians as if doing sex with a boy. (I asked one of the anankungwi, Mrs. Brighton, what it meant and she told me that they

were teaching the girls what they will do in the future with their husbands.)

The girls who had begun menstruating were separated from those who had not begun menstruating on Sunday morning. Two of the *anankungwi* advised the girls who had already begun menstruating. Three of the twenty-seven girls had begun menstruating and they were taken to the river to be advised.

The anankungwi advised the girls to take care of their sanitary towels and also advised them to take a bath time and again when having menses in order to look clean. They told them never to sleep with a man when having menses because they can give the man chitayo and the man can easily die. They also advised the girls never to add salt to relish until they get married. They said in the future, when they are married and after having menses they will sleep with their husbands and then they can add salt to the relish.⁸

The other twenty-four girls were taken by the other two *nankungwi* to an isolated spot to be advised.

*Firstly the anankungwi stressed the importance of respect. They told the initiates to start respecting all grown ups. They said, if they were entering their parents bedrooms they should stop. Secondly they were told to love each other even those who are parentless. Thirdly, they were told to stop laughing at lame people, if they had that habit before. Fourthly, they were told to stop malingering as it is the habit with a lot of girls when asked to do some kind of job. (To my surprise the *anankungwi* did not bother to tell those young initiates about general cleanliness of their bodies.)*

After the girls were advised by the *anankungwi*, the initiates were taken to the river to bathe. The water they bathed in was mixed with some traditional medicine. After the bath, the initiates applied cooking oil to their bodies to make it look shiny. Their hair was also cut short by their guardians. The initiates were dressed in new dresses, new *chitenje*, and new shoes. At this point, two initiates at a time were placed on a door, carried by their guardians. The guardians carried the doors on top

⁸ This is because salt transfers sexual energy and those who are not adults can be harmed by eating food salted by those who are menstruating but not yet sexually active.

of their heads so that the *anamwali* could be seen very well by all the community members. Songs were sung, men beat drums, and the two initiates moved their bodies as they were taught during the ceremony. Two plates were placed on the door and people threw money into the plates. The money was for the *anankungwi*. Money was also given to the initiates. After each set of girls had been carried around, the girls were placed on a mat and the next set was taken up, until all 27 girls had been displayed.

After this parade, the initiates were given special *nsima* (maize meal) with chicken which had been mixed with traditional medicine. Then the same traditional medicine was put on a cloth and was soaked in cooking oil. The initiates were instructed to take the cloth and touch the feet of their parents with the cloth. At this time, the final advice was given to the initiates by the *anankungwi*. This advice concentrated on sexual matters, which, the *anankungwi* stressed, should be used after they were married.

Once the ceremony was complete, the girls' parents each paid K 2.00 to each of the *anankungwi* (for a total of K 8.00 per girl) and K 2.50 to the Chief. Then the *anankungwi* ordered the girls to clap their hands as one way of saying "goodbye" to the Chief, and the community members danced the *malipenga* (a traditional dance) while the girls were escorted to their homes.

Key Informant Interviews about the Initiation Ceremony

After observing the initiation ceremonies, a few key informant interviews were held with *anankungwi* and chief's wives from each village to clarify certain details and traditions surrounding the ceremonies.

The Chief's wife in Pindani told us that the ceremony was secret and that there was a lot of magic involved in such a ceremony. She also told us that the parents of the initiates were instructed not to have sexual intercourse during the entire two

weeks of the ceremony. The parents were warned that if they did not abstain during this period, their daughters will have diarrhea and die.^h

During the initiation of a girl, the parents have to abstain from sex. From the day the girl leaves for initiation, the parents and their relatives who are also married have to abstain (it is only those of their relatives who live close to the girl's parents). These people abstain until the girl comes out of the initiation ceremony. However, when the ceremony at the chief's house is over, the girls go back to their parents and stay in a separate house, the parents continue to abstain for two more nights and then they can lead normal lives. At the chief's house, on the last night, the chief's wife appoints one family which has to have sexual intercourse and early in the morning the woman is supposed to cook nsima ndi ndiwo (maize meal and chicken, particularly), which she takes to the chief. The chicken is mixed with medicine. The nsima and relish is then distributed to all the initiates. Then the girls can leave for their parents' homes ceremoniously. When they get home their parents continue to abstain. The girls sleep in a separate house. Early in the morning they go to the river to bathe. They do the same thing on the following day (parents still abstaining). Then on the third day the initiates, after taking a bath at the river together, run to the chief's house and kindle a fire, then clap hands telling the chief that everything is now over. On the night of that day the parents and everyone else who had abstained continue their normal family life. It is important for the parents to go by the rules of abstention because if they don't their girl will have diarrhea and will die. This really happens because the whole ceremony is associated with magic.

The costs of the ceremony, including the costs of new clothing, payment to the *nangkungwi*, payment and gifts to the chief, food for the ceremony, a new dwelling for the initiate, and gifts to the guardians, were calculated to be MK 135.00. per initiate. This is roughly equivalent to US \$35.50 and as a relative cost in a village, extremely expensive.ⁱ However, the "cost" of not participating in an initiation ceremony is also quite high. Girls who have not participated are excluded from many

^h In fact, one girl did die after the ceremony this year, and the Chief was very careful to report that this was due to an illness (he suggested meningitis, but the illness was not confirmed by the health center), rather than due to improper behavior on the part of the initiate's parents.

ⁱ The daily wage of a rural laborer during 1990 was estimated to be US \$1.00 and the per capital GNP US \$180.00 (UNICEF State of the World's Children, 1990.)

activities and may be ostracized from casual conversations between other girls of the same age. Figure 2 shows the relative costs for items associated with the initiation ceremony.

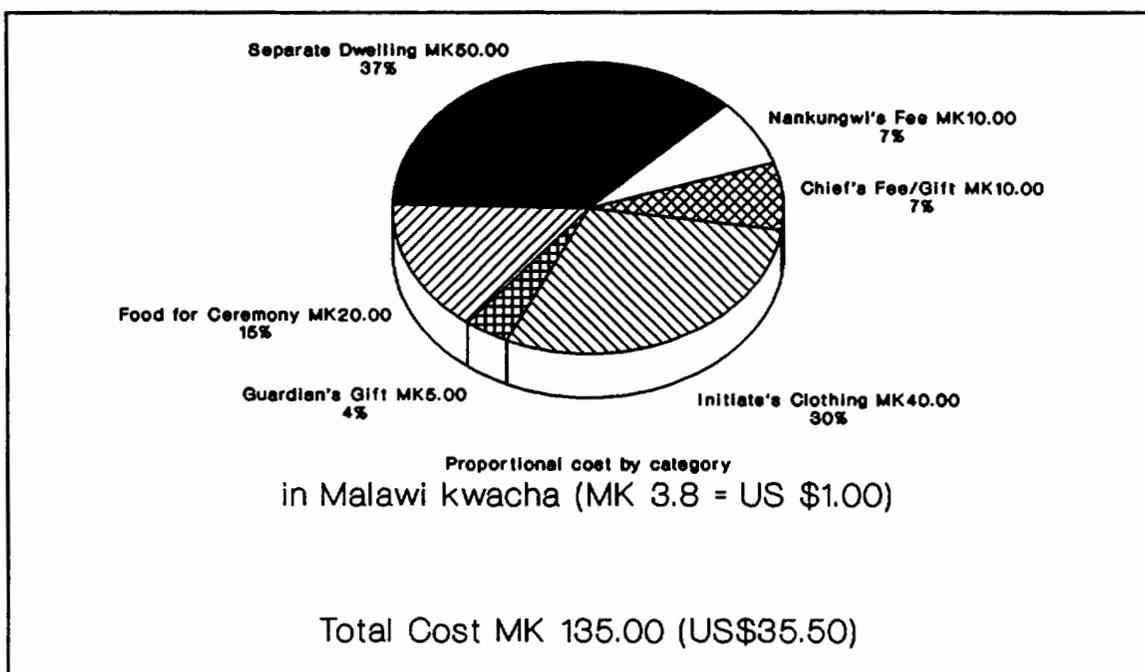
Menstruation. The following responses from adolescent girls on menstruation were generated through in-depth interviews and focus group discussions. There were no significant differences in the proportion of girls in each village reporting knowledge about menstruation. Approximately 70% of girls in both villages reported that they had heard of menstruation. The percent of girls, however, who admitted that they had started having periods was quite different between villages: 37% of girls in Pindani reported having menstruated, while 63% in Perusi reported this. There doesn't appear to be an obvious explanation for these reported differences.

There was great diversity among 9-12 year old girls in what they knew about menstruation. During interviews some stated that they knew nothing at all, while others reported that they had heard of it from friends, but knew no details. Some knew that girls menstruate but not the age at which it begins. A few informants could give an age by which most girls menstruate. Those who knew about menstruation had learned about it from friends.

Only one girl in the youngest age cohort had already started menstruating. She reported that "when (she) started (her) first period (she) was afraid to tell (her) mother because (she) didn't know anything about it so (she) told (her) sister. (She) told (her) mother and the mother told (her) grandmother who told (her) everything about it. (Her) grandmother told (her) to wear a piece of cloth which is put on top of the 'pant gassette,' in order to absorb blood (as most of the people do with cotton wool and pads.) When the cloth is full of blood (she) changes it and washes the dirty one with water and soap."

During interviews girls 13-15 years of age gave more details about menstruation, even if they had not yet experienced it themselves. As with girls in the younger age cohort, they reported learning about menstruation from friends. Once they had begun menstruating, their grandmothers or aunts told them "all about it" and how to keep themselves clean during their periods. Girls also learned about menstruation

Figure 2. Costs of Adolescent Female Initiation (Thyolo, 1992)



from the *anankungwi* during the initiation ceremony. They reported that they took extra baths during their periods to avoid smelling bad. When they started their periods, all girls reported that they told their elder sisters or best friends "who act as messengers to tell their mothers or aunts to tell them what to do." They were given their first *chitenje*^j at this time and were sent to the initiation ceremony.

Girls in the 16-19 year age cohort had all started menstruating. Most of them admitted that they did not know anything about menstruation before they started. While some girls reported that they had heard about menstruation from older friends who had already begun menstruating, it seemed that no details were provided in these conversations. Some girls reported being surprised when they actually began to menstruate. Girls who began menstruating later than their friends reported being

^j A *chitenje* is a piece of cloth worn by women either as a skirt or over a skirt to protect themselves (from dirt and to cover their private parts visually). Usually only worn by "adult" (menstruating) women; giving one to an adolescent girl may signify achievement of adulthood.

"happy" when they finally started. They said that the choice of who to tell when you start your period depends on "whom you are free to talk to."

Interestingly, in focus groups most girls ages 9-12 and 13-15 said that they did not own a *chitenje* yet, and did not specify why a girl would wear one, other than to protect their dresses from stains during cooking. However, older girls aged 16-18, and girls aged 13-15 who had begun menstruating and been given a *chitenje* described its use related to menstruation. Consistent with reports on menstrual status, there were significant differences between villages in the proportion of girls admitting to owning a *chitenje*. In Pindani, 43% of girls admitted to owning one, while in Perusi, 58% of girls said they did. Furthermore, it is unclear what the significance of this brazen signal is other than to indicate that a girl has begun menstruating. However, it surely reinforces the true "norms" associated with the status of having a period, and thus those of being an adult woman.

In response to being asked when they begin treating their daughters as grown ups mothers cited menstruation as the turning point. Moreover, mothers of daughters in all age cohorts expect their daughters to behave differently than they did when they were considered young girls. For example, they should stop playing with young children, especially girls who have not yet begun menstruating, and start bathing regularly to keep themselves clean. They should also show respect to adults and do most of the work on their own as a grown up without being told. At this time they will also begin (or have already begun) to call their daughters by their *chiwongo* (clan name used to show respect) rather than their first names. Some mothers commented that girls at this age are expected to work at home "more than they are doing now because now they spend most of their time playing with their friends and coming home very late."

Communication Networks Related to Menstruation

Officially, communication channels for adolescent girls are distinguished by topic. Girls are taught by their mothers about household duties such as cooking, farming,

raising children, keeping a home and sewing; whereas, *anankungwi* teach girls about marriage and birth. Information on health is communicated by health workers, health surveillance assistants (health workers who are responsible for outreach) and in health education classes in school. Grandmothers and maternal aunts tell girls about menstruation and becoming a woman. A young girl cannot talk about sex with her parents but she may do so with her (maternal) aunt, grandmother, or even the *anankungwi* who officiated at her initiation ceremony.

In both villages, exactly half of the girls reported learning about menstruation from friends (Pindani = 51%, Perusi = 49%). Most of the other half did not mention a source of information on this topic. Those that did mentioned maternal grandmothers, older sisters, maternal aunts, and maternal uncles. These data not differ between villages. One important difference was that 15.5% of girls in Pindani reported learning about menstruation from their mothers, as compared to 4% in Perusi. Forty-six percent of girls in Pindani reported talking to their mothers about problems with their periods, but only 21% of girls in Perusi did. By contrast, 7% of girls in Pindani talked with their older sisters about problems with their periods, while in Perusi twice as many did. Twenty-five percent of girls in Pindani would talk to their friends about this topic, as compared with 46% in Perusi.

Importantly, girls who have not yet menstruated are not allowed to admit they know about menstruation, nor are they allowed to discuss the topic. This was made clear in focus groups with girls who had not yet menstruated. These girls refused to discuss the subject. Girls who had already menstruated reported that they learned about menstruation from the *anankungwi*, their aunt, their grandmother, and in some rare cases, their mother, once they began menstruating. The following responses were generated from a focus group discussion:

It was so wonderful when I started having my periods. I went to tell my mother because I didn't know what it was, and the thought which was coming in my brain was that, I had started suffering from bilharzia. My mother told me to go to my Aunt because she could tell me what it was. (I was) very ashamed, before the eyes of my mother after when I was told the whole truth about it. (I asked her to tell me what really made her to

be very ashamed)...it is our custom that the mother can not say anything about it to her own daughter and the fact that (it was) my first period, it made me to be very shy because I was afraid that my mother would tell my father..." (Another girl said) "I went to tell my grandmother when I started doing my periods. I was also shocked to see what I saw and the thought came into my head that I had internal bleeding." (Another girl said) "I went to tell my grandmother what I saw, but I didn't think it was anything. I knew already what it was because I was already told by older friends when I was 10 years old.

Personal Hygiene

During interviews and focus groups most girls 9-12 years of age said that there were no restrictions about bathing with other girls, which they did once or twice a day. Younger girls bathed only once, while older girls bathed twice. Some girls reported that the difference was due to menstruation, while others suggested that the number of baths taken depends on the weather, in cold weather older girls bathed only once a day while younger ones could go three days without bathing but in hot weather older girls liked to bathe twice a day and younger girls at least once. This cohort also reported that they bathed naked but observed that older girls bathe with their underpants on. All girls said they were allowed to bathe only with other girls. A few girls reported that there were restrictions about bathing and exposing themselves to younger girls once they had begun menstruating which is why older girls did not bathe with the younger ones.

Girls 13-15 years of age, who had started menstruating, and girls who were 16-19 years of age reported that there were restrictions about bathing with younger girls. "You (only) know yourselves whom to bathe with. It looks incredible for a big girl to bathe with a girl of 6 or 7 years of age. If it happens that is when they are bathing at the river. Big girls cannot do that at home (because they are) afraid that their parents will shout at them, because one has to respect her body, my grandmother told me." "When you start your first period, there are restrictions about bathing with others. You can't bathe with a person who hasn't started her first period. (I was)

told by (my) aunt when (I) started my first period." Again, there were no significant differences in responses between methods.

During an in-depth interview one informant described the method of soaking up the blood:

according to the traditional customs a girl is supposed to put on small pieces of cloths. It is made in such a way that it can't fall down because it is tied at the ends of the cloths with a small string which goes around the waist. It is a taboo for us to put on cotton wool or pads. This is exactly what we are told by the anankungwi or any woman.

while the following responses were generated during a focus group discussion:

There are no restrictions about bathing with others (as a young child). But when a girl is menstruating she respects herself by not bathing with friends....what we are not allowed to do is to bathe with young girls of 10 and below. When a girl has started menstruating she considers herself to be a grown up and is prohibited from playing with little girls. There is no problem to bathe with your agemates or any older girls with an exception of those who have children. (I asked her to tell me why can't she bath with a woman who has got a child.) Everybody who has a child is a mother. Even though she is young but the fact that she has a child or children, she is a mother, she is no longer a girl and it is for that reason that you can't bathe together.

Sexual Behavior, Sexuality, and Marriage

As in the previous section responses for this section were gathered from village dignitaries, in-depth interviews and focus group discussions with adolescent girls, as well as from focus groups with mothers.

Village dignitaries reported that girls are "expected" to wait to begin sexual relationships until they are 14 years of age, but "nowadays one can find a girl of 12 or 13 already having sexual relationships." While girls may refuse a sexual invitation, the only acceptable reason for refusing is menstruation.

Sex education occurs officially in the second initiation ceremony (when a girl begins menstruating) but also during the first ceremony with the girls who have already begun menstruating. The informants reported that girls are told about the

risks of having sex, contracting STDs and AIDS. Girls are encouraged to marry and discouraged from having premarital sex. Informants reported that prevention of pregnancy and illness is taught through abstinence, not the use of contraceptives. Informants reported that sexual enhancement is only taught after marriage, when giving the *mwambo wa mbanja* to the newlyweds. The wife in particular is taught the body movements which she has to do to increase sexual pleasure and help her husband enjoy the sexual act.

Girls and boys can get married as soon as they are old enough to "run a family." Those who are "uneducated" (have attended only primary school) get married earlier (from 14-16 years of age) than those who are educated. Informants reported that, in the past, a girl was expected to delay having sexual intercourse until she was married. They implied, however, that girls were currently having sexual intercourse before marriage.

Although it is often difficult to get information about such a sensitive topic as sexual behavior, the initial Adolescent Survey included questions concerning sexuality. In addition to direct questions addressed to the respondents about their sexual behavior, the survey included several questions about the sexual behavior of other girls the same age. The data show that there were, as expected, differences between the willingness of girls to talk about the behavior of friends and schoolmates, versus their own behavior. On average, about 40% of girls reported that other girls the same age as themselves were having sexual relations. This was significantly different between villages. In Pindani, fewer girls reported that girls their age were having sex (32%) versus 46% in Perusi. When asked about their own sexual behavior, no significant differences between villages were found but the percentages were half of the estimates given about the sexual behavior of other girls. In Pindani, 17% of girls admitted having had sex; in Perusi, 24% did.

Play and Sexual Activity Between Boys and Girls

Most girls 9-12 years of age reported that there were no restrictions about boys and girls playing together. However, some girls reported that their mothers did not

allow them to play with boys "at night when the moon shines and a lot of girls and boys like to play." This girl reported that at these times of the month, "boys and girls like holding each other and sometimes they beat each other when the girls do not follow what the boys want." Other girls reported that they were not allowed to take off clothes in front of boys or hold them. This restriction was created to avoid temptations. A few girls of this age were told not to "chat" with boys and to avoid "easy friendships" which may lead to "*uhule* - prostitution." Girls in the youngest age cohort, moreover, reported that girls begin having sex by age 10. "Sometimes we even find little girls of under five doing sex with the little boys."

Girls in the 13-15 age cohort reported that there were restrictions about girls and boys playing together. "When we were young there were no rules about boys and girls playing together. When we reached 12 years of age we were told to stop playing with boys. This was to show respect to ourselves. Mothers and aunts watch to make sure we follow the rules." At this age, as with the younger age cohort, however, there did not appear to be rules about brothers and sisters playing together.

Talking about sexual activities between boys and girls in the 13-15 age cohort said, "first they do 'it' secretly by meeting at a hidden place when they want to have a chat. They do some holding and kissing. Then they do the big thing." Girls reported that they look forward to having sex with excitement. They said they made appointments to meet their boyfriends usually in very secluded places, such as a forest, caves or under the bridge where people could not see them. "Then it is right in those places where boys and girls do sex peacefully."

Some girls said they wait to be initiated before having sex. They regarded themselves as grown-ups after the initiation and were also eager to practice what they had learned from the *anankungwi*. Others said that girls wait until they have their first period to start having sex. And still others in this age group said that girls begin having sex very early, around the age of 10. In general, girls believed that their friends looked forward to this time with excitement. However, some girls said that

their boyfriends begged them to have sex or that sometimes they were forced to do it.

Girls 16-19 years of age were forbidden to play with boys "because we might fall in love with them." Other girls reported that if they fall in love with boys, "we might be tempted by the boys and sleep with them and get pregnant." At this age, while there still appeared not to be general rules or restrictions about brothers and sisters playing together, some girls reported that they no longer played with their brothers "to show respect for each other." Like girls in the 13-15 year old age cohort, they reported that when they were young there were no special rules about playing with boys. When they began menstruating, however, they were told to stop playing with boys because they might fall in love with them, causing "easy friendships...In so doing we might get pregnant after sleeping with boys...Our parents are not happy with these unwanted pregnancies."

They said that girls started having sex at any age, provided they had a boyfriend. As with girls of the middle age cohort, girls this age reported that some girls have sex before starting their periods, some once they have started menstruating, and other after they have been initiated. Many of the reasons they gave for the age difference between girls at the time they started having sex is similar to those given by 13-15 year old girls. They also said that some girls accepted a sexual invitation because they did not want to disappoint their boyfriends or that they were afraid of being beaten. Additionally, some girls reported that boys had to give girls money to tempt them into having sex. Significantly, in focus group discussions no admission was made by any age cohort that they knew of any other girls having sex.

Mothers of girls in all three age cohorts expect their daughters to have sex before marriage, because "nowadays almost every girl does sex before marriage." They said that in the past, girls waited to have sex until after they were married but now "it is impossible because girls seem to know much even before they are told at the initiation ceremonies." Mothers said that "girls used to have boyfriends whom they were playing with [touching] at the dances in the full moon but they weren't doing sex." Mothers think that girls look forward to having sex "with excitement" after

being told about it at the initiation ceremony. Most of the mothers of girls in the youngest age cohort believed their daughters would not have sex before they began menstruating or before they were initiated; however some mothers of girls 13-15 and 16-18 said that even young girls do sex before they have begun menstruating but after they have been initiated: "even the young girls do sex when they are playing in the full moon so I don't encourage my daughter to play during the full moon and I make sure that she is at home."

While there was not much difference between mothers of the youngest age cohort and those of 13-15 year old girls, the one significant difference was that mothers of the older cohort admitted that their daughters might already be having sex. Moreover, mothers of girls 16-18 all believed their daughters were having sex:

When there are dances at night the girls find a chance to meet with their boyfriends and do sex. The girls go out at night secretly because they sleep in their own houses, small houses built by their fathers to show that the girls are really grown-ups. The older girls cannot sleep in the house with their parents to show respect to each other.

Communication about Sex

Girls 9-12 years of age reported that their friends who were having sex talked among themselves about what happened in a sexual encounter. They were willing to share this information without revealing its source. Male sexuality was discussed between girls, "especially when girls are in their multitudes at the river or when going or coming from school."

Girls between 13 and 15 years of age reported that their friends talked about sex and male sexuality. "I found three girls at the open well telling each other how they feel when doing sex. One was telling her friends that her first time to do sex she felt very painful but now she feels OK and she does enjoy it." Male sexuality was discussed between girls mainly at the river when taking their baths, when going or coming from school, or when going to collect water at the open well.

Girls between 16 and 19 years of age shared their sexual experiences with their best friends. However, some girls reported that they did not talk with other girls

about their sexual experiences because girls kept these things to themselves. Other girls reported that they only tell their best friends because "they are the ones who keep secrets."

In focus group discussions, on the other hand, girls reported learning from older female friends and from grandmothers about "growing up" but only from older female friends about sex. The definite restrictions governing "public" communication between women of different age ranges and biological markers, such as menstruation or childbirth became quite apparent from data collection through this investigative method.

If a girl is at the age of 25 or 29 and there are other girls present of the same age who do not have children, they cannot chat together. Those having babies are segregated (from) these women and mock them for still being young. Even if she is a woman of 30, 40, 50, 60, it is the same thing. They are still young, they don't know much, and they can't share secrets...But if a girl of 15 has got a baby she can share secrets with other women who also have children even if they are older than herself, even those at the age of 30 or 35. (I then asked them to tell who told them all this)...We see this happening in our village...I was told by my grandmother... (another girl said)...my grandmother, aunt and the anankungwi told me...(another girl said) it was the anankungwi and the grandmother. (Another girl said)...I was told by the anankungwi, my Aunt, but above all I see this happening (in the village).

Focus groups with mothers showed that there was not a consensus among mothers of 9-12 year old girls about where girls first learn about sex. Some thought that they first learned about sex from the initiation ceremony. Others thought that they hear about it from friends ("those having bad manners, those who have boyfriends and do sex with them, they tell their friends who are innocent and they become tempted to give it a trial for themselves." However, mothers of 13-15 year old girls were certain that their daughters had learned about sex from friends before they attended the initiation ceremony. Mothers of 16-18 year old girls made the following distinction: "girls may learn about sex from their friends, but in the initiation ceremony it is the first time they learn about sexual matters in a detailed way."

Sexual Enhancement Techniques

All girls 9-12 years of age and most girls 13-15 years of age had never heard of sexual enhancement techniques. Girls 13-15 years of age who did know about these techniques said that some girls put roots in their vagina so that "by the time they will meet with their boyfriends, their sex would be greater and sweeter." The roots made the body hot and men liked it that way. The roots were removed before having sex. Some women put roots in the vagina to make it dry, but not necessarily to enhance sex.

Most girls 16-19 years of age knew about sexual enhancement techniques, and gave the same answers as those given by girls 13-15 years of age. They reported, additionally, that the roots used for sexual enhancement were in a powder form and were removed before sex so that their partners were unaware of their use. This information was shared between friends.

Refusal of Sexual Invitations

Girls 9-12 years of age said during in-depth interviews that girls could refuse a sexual invitation by saying that they did not want to get pregnant or that they did not want to have sex. They were unable to comment on whether or not refusals worked.

Some girls 13-15 years of age were confident that girls could refuse a sexual invitation or put limits on it by saying that they wanted to wait until marriage to have sex, by just saying no, by saying that they were afraid of getting pregnant, or that they were afraid of getting an STD. The most successful method of refusing sex was to tell the boy that they were having their periods. They reported that the deterrent was the fear of contracting a dreaded and fatal illness, called *chitayo*, which a male could get from having sex with a menstruating female. Other girls of this age cohort said they did not know if a girl could successfully refuse a sexual invitation, because they had never done so. Other girls said that girls did not refuse a sexual invitation, even if they could.

Girls of the 16-19 year age cohort agreed that a girl could refuse a sexual invitation and gave the same excuses as the younger girls. They also felt that some

girls did not refuse sexual invitations, adding that sometimes the girl was more interested in having sex than the boy. Other girls said they could refuse a sexual invitation by saying that they did not want to get AIDS. None of the girls commented on the boys' reaction to this excuse. While girls felt confident that they could refuse a sexual invitation, one girl recounted a story about her friend: "when her boyfriend approached her to have sex she refused, so the boy forced her until he removed her pants and at last they had sex. She told me that she even cried because she was afraid of getting pregnant and stopping school." Another girl said that some boys became furious if girls refused their sexual invitations.

In focus groups, girls reported being able to refuse a sexual invitation for several reasons: menstruation, fears getting pregnant or contracting an STD. In only one focus group did a girl report an additional reason: because she was afraid of getting AIDS.

Mothers of 9-12 year old girls said that girls can refuse a sexual invitation by saying that they are having their periods, they are afraid to get pregnant, and they are afraid of getting an STD or AIDS. Mothers of 13-15 and 16-18 year old girls gave the same reasons but added that if a boy refuses to use a condom, a girl could refuse to have sex with him. Mothers of 13-15 year old girls and 16-18 year old girls also said that while they can refuse a sexual invitation, they don't, because they are just as interested in having sex as the boys.

Pregnancy Prevention and Abortion

Girls 9-12 years of age had heard about birth control methods from friends and that birth control pills and condoms prevented pregnancy. They also reported that some girls got strings with *mankhwala* called *nkuzi* to put around their waists to prevent pregnancy. They had heard of abortion: "girls take some drugs which they drink to remove the pregnancies. Mostly they go to a *sing'anga* or to an old woman who give them medicine to do the abortion."

Most 13-15 year-old girls reported knowing methods to prevent pregnancy. The most well known method was the *nkuzi*. Other methods included not having sex,

using condoms, and "birth controls from the hospital." Friends told each other about these methods. One girl said that girls did nothing to avoid getting pregnant even though they knew pregnancy resulted from having sex. Several girls in this age cohort did not know how to prevent pregnancy but they also appeared to be girls who had not yet had a sexual encounter. These girls also knew that abortion was illegal but knew that many girls used abortion to end pregnancies. The most frequently mentioned method used to induce abortion was "drinking a lot of tablets." They reported that abortion was dangerous because the *mankhwala* used was poisonous and could cause death or infertility . It was believed that school-going girls more commonly practiced abortion because they did not want to drop out of school to have a baby.

All girls of 16-19 years of age mentioned at least one method of birth control, the most common being abstinence and the use of condoms. Fewer girls mentioned the string with traditional medicine as an effective method. Most of these girls knew about abortion and could recount specific instances when their friends or neighbors had aborted a fetus. Some of the methods reported used to induce abortions included traditional medicine and chloroquine tablets. The consensus in this cohort like the one above was that abortions were more common among school-going girls than those not attending school. Responses from focus groups generally resembled that generated during interviews.

Mothers of 9-12 year old girls and 13-15 year old girls said that girls can prevent pregnancy by avoiding sexual intercourse. Other mothers said that those mothers who "know medicine of preventing their girls from getting pregnant say they give a girl a string which she puts around her waist and can not get pregnant, because the string has got some magic powers. By doing so that means a girl can only prevent herself from getting pregnant but not venereal diseases." Mothers of girls 13-15, when probed, admitted that giving this string to the girl might be seen as encouraging her to have sex. Mothers of 9-12 and 13-15 age cohort said that they had heard about condoms, "but I can not encourage my daughter to tell her boyfriend to use one (condom), if she has one (boyfriend) that is, because she might think I am happy

with what she is doing." Giving a girl a condom, or encouraging her to use one, would be the same as encouraging them to have sex.

Mothers of girls in all three age cohorts would prefer that their daughters have a child out of wedlock than try to abort the child. Anecdotes about young girls killing themselves were shared. Many said that being pregnant out of marriage is bad, but killing a child (and perhaps killing oneself) is worse. Some mothers talked about the conflict in the family that occurs when a young girl becomes pregnant. "The parents are furious, especially the father...they are disappointed because the girls stop school and they lose the money they pay the girls for school fees."

Marriage

Girls 9-12 years of age reported during interviews that girls married "at any age" to their boyfriends whom they chose themselves. Girls this age did not really know how marriages were arranged, other than the uncles of the girl and boy negotiated and the parents agreed. They reported that after the families agreed, a celebration was held at the church, in which the couple take vows before the priest and community members. Some girls aspired to get married and move into town, while others wanted to remain in the village with their families.

Girls in the 13-15 age cohort reported that boys and girls fell in love and decided for themselves to get married. Some had sex before marriage. There was no age restriction, as long as they were old enough to run a family. Some girls made the distinction that girls who did not go to school got married very early (between 16 and 20) while school-going girls got married at the age of 20 and above. Others reported that many girls were forced by their parents to stop school and get married so that they could help their parents in the household and the garden. As with the younger girls, girls in this age cohort either wanted to move with their husbands into town or remain in the village with their families.

Girls 16-18 years of age gave the same reasons for early marriage among girls as did the 13-15 year-olds but they were more specific about the details of marriage negotiations between families.

Many girls have the boyfriends and sometimes they fall in love with (them). Marriage is not arranged by the mother because that is the old custom. A girl or a boy these days cannot accept the idea of the parents arranging a marriage for her... when a girl has fallen in love with a boy, the boy tells his uncle that he wants to marry the girl. His uncle goes to the girl's uncle to inform him about this. The uncle asks the girl if she really loves the boy. If she says yes then they agree for the day when they do chinkhoswe (engagement day). After this, the boy can marry the girl or if the boy has enough money he can do the wedding ceremony by inviting a lot of people to celebrate with him...on each side the ankhoswe who is the uncle or the aunt of the boy and girl are involved. The ankhoswe gives permission, negotiates and makes (the final) decision.

As with the other two age cohorts, girls in this cohort reported either that they would like to get married and move to town or stay in their village with their families.

On the other hand, girls reported during focus group discussions that in these villages community members follow matrilineal and matrilocal marriage customs. Girls stay in the village and the husband comes to live with the matrilineal family. Marriage agreements are negotiated by the maternal uncle for the family. Marriage ceremonies are held in the months of August and September, after the harvest and during school holidays.

Marriage is not arranged by the parents. The parents don't arrange a family for the girl. The girls have their own boyfriends. When they want to get married they tell their parents and the parents tell their uncle. The boy comes with his uncle to meet the uncle of the girl that he is in love with. If the uncle and the girl agree, then they prepare a day for both families to meet. When that is done and the ankhoswe (the intermediaries) for the two sides agree that the two can marry each other, it is at this point that relatives of both families begin preparing for the engagement ceremony. They call it chinkhoswe (engagement) in chicheŵa. At this ceremony the relatives of the two (get to) know each other better. It is more or less a party. Goats and chickens are killed for this celebration. When the engagement is done people look forward to the real marriage ceremony where vows are made at the church. The uncles of the two families are the ones involved. The parents have no authority. The one who gives permission and negotiates and makes decisions is the uncle of each partner. I was told this by my grandmother. (I asked the group what is the marriage ceremony, who is involved and if they have been to one.) A marriage ceremony is when a man and woman exchange vows in church in the presence of the priest and many people who go to

witness them getting married so that they can become one flesh. The people who are involved are the man and the woman getting married, the uncle of the girl and the uncle of the boy who acts as the ankhoswe of the two sides, and the priest who blesses the wedding.

Health and Health-Seeking Behavior

The responses generated for this section came from the same sources and methods presented in the previous sections.

Village dignitaries in Perusi stated that girls get health care from the local clinic (about six kilometres away), at the District Hospital, or from the local traditional birth attendant. Sometimes they also receive treatment from the local healers, the *sing'anga*, but (unlike the health center) they may not go to a *sing'anga* unaccompanied by an adult. It is unclear whether this is because the visit to the *sing'anga* involves a payment or if the treatment requires supervision by an adult. (Informants from Pindani reported that there is a traditional birth attendant in the village, but no informant from Perusi offered this information.)

These same informants could name the three most important STDs: *chindoko* (chancroid or syphilis), *chizonono* (gonorrhoea), and *mabomu* (buboes), and knew that these illnesses were transmitted through sexual intercourse. Informants named traditional remedies for treating these illnesses, as well as treatments provided at the clinic. All informants had heard of AIDS but not HIV. The symptoms of AIDS, as reported by informants, were a slimness and a malnourished look. Informants knew that AIDS caused suffering for a long time and ended in death. They believed that AIDS could be prevented by not "indulging in" prostitution. Village dignitaries in Pindani could give the names of the major sexually transmitted illnesses, including AIDS. None were aware of the HIV virus.

Health Seeking Behavior

Health seeking behavior was determined by age and religious affiliation. Most girls 9-12 years of age reported that their parents (mothers) accompanied them to the

clinic or *sing'anga* when they were ill. At the clinic the medicine was free, but not at the *sing'anga*. Some girls reported that their parents buy *mankhwala* (medicine) for them when they are ill. A few girls reported being allowed to go alone to the clinic but not to the *sing'anga* because there they had to pay for the medicine. Girls who were members of the Apostolic Church did not take medicines of any kind; those who belonged to the Seventh Day Adventist Church were forbidden to take traditional medicine.

More girls 13-15 and 16-19 years of age were allowed to travel to the hospital alone than girls of 9-12 years of age but they are still not allowed to go alone to the *sing'anga*. Again, the reason was that the hospital did not charge for medicine while the *sing'anga* did. Another reason was that "there are special rules at the *sing'anga* which a girl can't afford to follow on her own." However, a few girls in these two age cohorts did report going to the *sing'anga* by themselves.

Several girls in each age cohort distinguished between types of health care providers based on the type of illness. Illnesses thought to be caused by witchcraft were treated by the *sing'anga*. Also, women suffering from *mauka* (vaginal itching) preferred to go to the *sing'anga*. During focus group discussions girls who belonged to the Church of the Apostles reported they did not go to the clinic or to the *sing'anga*, because they were not allowed to take either cosmopolitan or traditional medicine. And, Members of the Seventh Day Adventist Church did not go to the *sing'anga* because they were not allowed to take traditional medicines.

Use of Condoms

Most 9-12 year old girls reported during interviews that they did not know anything about condoms. One girl said that condoms could be obtained at the hospital and that a condom should be thrown away after use, but she really didn't know what a condom was used for. However, most 13-15 year old girls knew about condoms and their purpose. They knew that boys wear them on their penis, that condoms were distributed free of charge at the hospital and that they could be

purchased in stores. They reported that they had heard about condoms on the radio, from friends, from school, from family members, and from posters and the nurses at the hospital. However, some girls in this age cohort had never heard of condoms and had never seen one. It is not clear whether any of the girls in this age cohort had actually used a condom themselves.

Almost all girls in the 16-19 year old age cohort knew about condoms, how to use and dispose of them. Some girls reported using them to avoid getting pregnant and contracting STDs. They said that using a condom was just as good as "doing it plain." However, girls also reported that boys did not like using condoms.

While girls did not admit to much familiarity with the use of condoms during group discussion, girls in the older age cohort did report that "boys don't like using condoms because they don't feel sweet when doing sex, they like doing it plain."

Knowledge about HIV/AIDS/STDs

During in-depth interviews all girls in the 9-12 year old age cohort reported that they had heard about AIDS and knew that it was a disease with no cure. Many girls could name symptoms, such as diarrhea, thinness, and fever. Only one girl knew about HIV. Many of the girls had heard about the illness from the radio and from informants in the quasi-urban centres of Malawi (thus the pseudonym, "the radio disease" and *matenda wa boma*, the illness of the District centre"), from friends, from health workers, from church officials, and from their teachers at school. They had never met anyone with AIDS and assumed that AIDS patients were "kept" at the hospital. None of these girls thought that they were at risk of getting this illness. They did not know much about other STDs.

Girls 13-15 knew more about STDs than the younger girls and could name at least three. They knew the symptoms such as boils, bad odor, difficulty walking, discharge and itching, and pain when urinating. Girls knew that these diseases were transmitted through sexual intercourse and could be treated by drugs from the hospital. Many girls mentioned using condoms as a way to prevent these illnesses. All girls in this cohort also knew about AIDS but few knew about HIV. They named

symptoms such as thinness, paleness, and sores on the body, but said that it was difficult to recognize an AIDS victim because these symptoms were common to many illnesses. They reported that one could get the illness by sharing used razor blades, scissors, getting injections with unsterile needles, sharing toothbrushes, and by having sex with an AIDS victim. They reported that a person could prevent AIDS by using a condom or not having sex with "easy partners."

Girls in the 16-18 year age group all knew about STDs, their symptoms, and how they were transmitted. Many said that they were at risk of getting one. By contrast, although all girls in this group knew about AIDS, few mentioned that they were at risk of getting AIDS. They said that one could avoid AIDS by not having sex with barmen, easy partners, or an AIDS victim, and by not borrowing razor blades or used scissors. They appeared confident that they could protect themselves from the illness and that they could identify an AIDS victim from the symptoms. None of these girls said that they knew anyone suffering from the illness.

During focus group discussions girls aged 9-12 were not asked about STDs and did not report knowing about AIDS. Girls aged 13-15 and 16-18 knew about the most common STDs (syphilis, gonorrhea, and buboes), their symptoms, and how to prevent them (not having sex, using condoms). Girls of the younger age cohort did not include AIDS in their discussion of STDs, while girls aged 16-18 did include AIDS in their list of STDs. All girls in this cohort reported knowing about AIDS and its common symptoms.

Some mothers of girls in all three age cohorts had some knowledge about condoms and their purpose. Many did not know anything about condoms, but there appeared to be a correlation between age of daughter and amount of their knowledge; as the age of the child increased, so did the proportion of women who reported knowing something about condoms. None of the mothers of girls of any age cohort had ever used one themselves, even those that did know what condoms were used for. A few mothers knew that condoms were provided free of charge at the district hospital, and reported they were useful for child-spacing. However, they believed that few people travel the distance to the district hospital to get them for

any purpose. Some mothers also heard on the radio that they were being sold in shops.

Mothers of girls in all three age cohorts didn't believe that boys knew how to use condoms. They were unanimous in believing that people would make more frequent use of condoms if there were a village-based distributor. They thought their daughters would go secretly to get them at a local place, even though the mothers could not encourage them to do so.

All mothers of girls 9-12 and most mothers of girls 13-15 could not believe their daughters knew anything about condoms. Some mothers of girls 13-15 thought their daughters knew about condoms and knew where they could be gotten. "A girl who is wise can tell a boy or a man to use a condom for her own protection from getting the sexual transmitted diseases or pregnancy. If a boy says no then a girl should refuse doing it plainly." Mothers of girls 16-18 thought their daughters knew about condoms but doubted if they were using them.

All mothers of girls in all three age cohorts had heard of AIDS, and could name several symptoms. They reported that a person could get AIDS by having sex with "easy partners" , borrowing toothbrushes, razor blades, scissors and sewing needles from friends, and "doing sex anyhow." Young girls in the village could also get it, and they should avoid having sex so that they don't get AIDS. None of the women knew anything about HIV. Moreover, mothers of 13-15 year old girls and 16-18 year old girls were more open to the idea of encouraging their daughters to use condoms, because they admitted that their daughters were at risk of getting AIDS and STDs from sex.

Hypothesis-Testing Phase

The following results were generated from Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys conducted in ten Thyolo villages. Responding to the surveys were adolescent girls and *anankungwi*.

Village Selection

As described in the methods section, the selection of villages was meant to be based on several criteria, the most important of which was the distinction between villages which had traditional initiation ceremonies and those which had church-affiliated initiation ceremonies. In order to determine which villages fell into each category, the chief of each village was asked two questions: (1) Who selects the *anankungwi* who perform the *chinamwali* in this village? and (2) Who sponsors the initiation ceremony in this village? If the chief answered "church" to both questions, the village was presumed to have a church-affiliated initiation ceremony. If the chief answered "the chief" or "the residents of the village" to either question, the village was presumed to have a traditional ceremony. It appears, however, from the results of the data, that the distinction in types of initiation ceremonies seen in Perusi and Pindani is either not typical of the rest of Thyolo, or the questions posed to the chief were not sufficient to distinguish between villages whose initiation ceremonies were church-affiliated and these traditional ones. However, while the chiefs' responses led to a selection of villages which were believed to fit the criteria outlined above, the data from the *anankungwi* KABP shows that the final selection of villages did not allow such clear-cut distinctions to be made.

After the villages were selected, four questions meant to distinguish between traditional and church-influenced ceremonies were asked of *anankungwi*. In response, 69.6% said they were selected by church leaders; 91.3% reported that they were given instruction by a religious institution; 50% of *anankungwi* of both types of villages reported that they were trained by the church; and an equal number of *anankungwi* in both types of villages named a church which sponsored the initiation ceremony. It was decided that the analysis would not attempt to make such a distinction between villages. Instead, for the Adolescent KABP, all analyses would be provided by age of girl or menstrual status, rather than by type of village. For the *Nankungwi* KABP, the results would be reported for all 23 *anankungwi* who responded.

Responses of Adolescent Girls

Thirty girls from each of the ten villages, totalling 300 girls, participated in the survey. The resulting reported distributions for age and biological indicator are shown in Table 10. Since the reported average age of menstruation is 14.5 (standard deviation 1.15), and 32% of girls had attained menarche by age 14, the method of sample selection appears to have been appropriate to achieve a well-balanced sample of adolescent girls between the ages of 9 and 18. Sixty-eight percent of the adolescent girls who participated in the survey reported current school attendance. Of those who reported that they had stopped attending school (61/300), 59% (36/61) cited lack of school fees as the reason for

Table 10. Age Groups and Menstrual Status of Adolescent Girls from Ten Thyolo Villages (August 1992)

Age Group	%
9-12 Years	17%
13-15 Years	43%
16-18 Years	40%

Menstrual Status	%
Pre-Menstrual	33.3%
Menstruating	66.6%

stopping. The mean educational level of the sample was Standard Four; 95% had not gone beyond Standard Eight. Sixty-two percent (186/300) of the girls could read the Chicheŵa sentence shown to them. Ninety-two percent of the girls reported having attended church in the last month.

Becoming a Woman: Initiation and Menstruation

When asked to name the first person to tell them about menses, respondents named grandmothers, friends, and mothers in approximately equal proportions (27.6%, 22%, and 19.3%, respectively). Only 28 girls (12.9%) mentioned the *nankungwi* as their first source of information about menstruation. Twenty-eight percent (83/300) of the girls would not admit to knowing about menstruation.

When asked to name the person(s) to whom they would go for advice about "female matters," respondents named mothers and grandmothers in equal proportions (57.7% and 52.3%, respectively), friends (28.7%) and maternal aunts (20%). Only 16 girls (5.3%) mentioned the *nankungwi* as a person they would seek out for advice.

Fifty-seven percent (170/300) of the girls reported having participated in an initiation ceremony. Of these, 23% (40/170) reported having been initiated before their first menstrual period. Six percent (11/170) reported having been initiated twice; the majority of respondents reported having been initiated after beginning menstruation (109/170).

The reported mean age at initiation was 13.83 (standard deviation 1.98), approximately three-quarters of a year less than the reported mean age of menstruation. These data do not contradict those above showing that a significant proportion of girls do attend initiation before reaching menarche.

Ninety four percent (282/300) of girls reported that the initiation ceremony is an important ceremony for the village. For 81%, participation in the initiation ceremony meant that they are considered an adult. For 96%, having been initiated meant that they must respect adults. For 40% (120/300), having been initiated meant that they have "permission" to begin sexual relations. In addition, as a result of the initiation ceremony, 42.9% of girls (73/170) reported that they were "newly" interested in having sexual relations.

The reported mean length of the initiation ceremonies for these villages was 7.68 days, with a median of 5 days. This length corresponds closely to the length of the church-sponsored initiation ceremony observed in Perusi village.

Ninety-eight percent of girls who had participated in an initiation ceremony reported that elder women helped in the initiation ceremony. Girls reported that elder women teach them about the same topics as *anankungwi*. Table 11 shows the reported differences in subjects taught between elder women and *anankungwi*. There appeared to be a perceived difference in the roles of both parties in that the *anankungwi* appeared to teach more of the issues related to sexuality. This may be a difference in emphasis, due to the fact that the older women participated

throughout the entire ceremony, while the *anankungwi* participate principally on the last day.

It is interesting to note that the teaching of STDs and HIV/AIDS was existent but not consistent.

Sexual Behavior and Sexuality

Fifty-six percent (169/300) of the respondents reported that they had had sexual intercourse. The data clearly show that the mean age at first sexual encounter was

Table 11. Subjects taught by Elder Women and *Anankungwi* during Initiation, in Ten Thyolo Villages (August 1992)

Subject Taught	Elder Women		Nankungwi	
Respect	133/170	85.3%	142/170	83.5%
Hiding Menstrual Towels	82	52.6%	103	60.6%
Keeping Clean/Menses	79	50.6%	103	60.6%
Not enter parents' room	78	50.0%	81	47.6%
Bathing rules	62	39.7%	81	47.6%
Dances	59	37.8%	64	37.6%
Songs	53	34.0%	57	33.5%
Parables	36	23.1%	51	30.0%
Sex	30	19.2%	53	31.2%
Pregnancy	25	16.0%	53	31.2%
STDs	15	9.6%	31	18.2%
Sexual Enhancement	7	4.5%	17	10.0%
Family Life	5	2.9%	0	0.0%
HIV/AIDS	2	1.3%	3	1.8%

younger than both the mean age of initiation and the mean age at menstruation. The mean age at first sexual intercourse was 13.63 (standard deviation 1.92). Six percent of girls reported that they first had sex at age 10; only six percent waited to have sex until they were 17. Fifty-eight percent (98/169) of girls reported that they had had sex before beginning to menstruate. And 59% (99/169) reported that they

had had sex before being initiated. A total of 116 or 68.6% reported having sex before either initiation or menarche.

The mean number of sexual partners reported was 1.94. As would be expected, the mean number of partners rose concurrently with the age of the respondent. Only 15 (8.8%) girls reported having four or more partners. Sixty-six percent (112/169) of girls reported that they had been offered money or gifts in exchange for sex. Fifty-five percent responded positively when asked if they had ever been forced to have sex.

When asked about sexual enhancement methods, only 19% (33/169) of those who reported having sex knew about roots for drying out the vagina. Twenty percent reported knowing about roots which make the vagina smell sweet. In contrast, 66% reported knowing about how to move their waists (i.e., dancing sexually) to entice their partners.

When asked to name a person from whom they first learned about sex, 65.3% (153/234) of those who admitted knowing about sex reported that they learned about sex from a friend. Twenty-two percent (66/300) did not admit to knowing about sex at all. Of those who admitting knowing about sex, 230/234 (98%) said that they would talk with their best friend about sex. Thirty-one percent (72/234) said they would talk with their boyfriends, 27% said they would talk with their grandmothers, and 19% said they would talk with their maternal aunts about sexual matters. None of the girls mentioned their mothers as a person with whom they could talk with about sex, only 2% said they could talk with a *anankungwi*, and none of the girls mentioned a health worker as a person with whom they could talk about sex. Eighty-five percent (199/234) said that their best friend was a source of "reliable" information about sex. When asked directly whether they could talk to their boyfriend about sex, 89% (208/234) said yes.

When asked whether boys and girls should be encouraged to talk together about sex, 68% (204/300) said no, 15% weren't sure, and only 17% said yes. Of those who said yes, when asked if boys and girls should be encouraged to talk together about sex in an organized group, a resounding 85% (44/52) said no.

Health and Health-Seeking Behavior

The communication channels for health matters in general and about AIDS specifically appeared to differ substantially, and reflected the attention that has been given to the AIDS message in the radio, by the church, and through other "mass" media channels such as newspaper, posters, pamphlets and films. AIDS also appeared to be talked about among friends to a greater degree than other health topics which may actually have more day-to-day relevance and importance, such as malaria, for example. Table 12 shows the differences in channels (and perhaps, by association, in importance) between messages about AIDS and other health matters.

Table 12. Communication Channels Used for Passing Messages about AIDS and Other Health Topics

Source	AIDS Messages		Other Health Topics	
	Count	Percentage	Count	Percentage
Radio	145/247	58.7%	109/300	36.3%
Hospital/Clinic/ Health Worker	123	49.8%	166	55.3%
Church/Mosque	109	44.1%	61	20.3%
School/Teacher	107	43.3%	143	47.6%
Friends	96	38.9%	72	24.0%
Family/Relative	85	34.4%	82	27.3%
Village Leaders	54	21.9%	100	30.0%
Party Leaders	45	18.2%	71	23.6%
Health Extension Workers	45	18.2%	129	43.0%
Newspaper	32	13.0%	22	7.3%
Posters	42	17.0%	7	2.3%
Pamphlets	16	6.5%	5	1.6%
Film	13	5.3%	3	1.0%
Video	7	2.8%	3	1.0%
Market Place	7	2.8%	2	0.6%
Gov't Personnel	5	2.0%	6	1.3%
Nankungwi	2	0.8%	1	0.3%

Knowledge about AIDS was widespread. Eighty-two percent (247/300) of girls reported that they had heard of AIDS. Of these, 67.6% reported that they knew someone with AIDS, and most girls could name one or more symptoms. The most commonly mentioned symptoms were "becoming thin" (84.2%), "pale hair or skin" (60.3%), and "diarrhea" (30.8%). However, these were symptoms which could be associated with many other illnesses.

A vast majority of respondents knew that AIDS was caused by a virus (76.1%), but many respondents also mentioned other incorrect causes, such as mosquitos (37.7%), homosexuality (35.2%), contaminated water or air (24.7%), eating non-

Table 13. Responses to the Question: "How can AIDS be spread?" by Adolscent Girls

Response	Number	Percent
Receiving blood	232/247	93.9%
Sharing razor blades	231	93.5%
By used needles	229	92.7%
Sex with "easy" partners	223	90.3%
Sharing toothbrushes	216	87.4%
Sex without a condom	171	69.2%
Cheek kissing	124	50.2%
Mosquitoes	102	41.3%
Sharing clothing	83	33.6%
Touching	81	32.8%
Public toilets	79	32.0%
Eating together	73	29.6%
Shaking hands	69	27.9%
Living in the same house	67	27.1%
Sitting near AIDS patient	53	21.5%
Travelling	43	17.4%
Immunization	40	16.2%
Mother-to-Child	180	72.9%
Breastfeeding	111/180	58.7%
During pregnancy	85	45.0%
Casual means	50	27.7%
During birth	26	13.8%

nutritious foods (23.5%), or behavior (4.4%). Most girls reported that the **symptoms of AIDS** could not be treated (89.5%), and that an AIDS patient could not be cured (98%). Respondents all named several methods by which AIDS could be spread. The most often reported responses were those mentioned on the radio and through other official communication channels: receiving blood, sharing razor blades, used needles, having sex with "easy" partners, and sharing toothbrushes. Substantially less respondents reported that AIDS could be spread by having sex without a condom than the other five reasons, and most respondents also mentioned at least one incorrect method of spreading AIDS. In addition, most respondents did know that mothers could transmit AIDS to their children, although the means by which this would happen was not consistently known (Table 13).

It is clear that the substantial levels of knowledge about AIDS in this population has not translated into perception or understanding of their own risk of contracting the illness. When asked whether they believed that their own chances of contracting AIDS was "not likely," "good," or "moderate," only 14.1% (35/247) responded with either "good" or "moderate," leaving 86% thinking that they were not likely to be at risk of contracting this illness.

In contrast to their low level of perceived risk about AIDS, their perceived risk of STDs was substantially higher. Sixty-five percent of girls reported that they were at risk of contracting a sexually transmitted disease, such as syphilis, gonorrhea, or buboes.^j To fully understand the differences in perceived risk, confidence intervals were calculated to the responses to the question: "Do you need to protect yourself from contracting the following illnesses?" Table 14 shows the differences in perceived risk for the three major STDs and AIDS.

^j Buboes is not actually the name of a disease, but secondary symptoms which result from various sexually transmitted infections occurring in the genital area.

Table 14. Confidence Intervals for Responses: Proportion of Girls who Report that they Need to Protect Themselves from Three STDs and AIDS (n=300)

STD	Mean	Lower	Upper
<i>Mabomu</i> (Buboes)	65.7	60.3	71.0
<i>Chisonono</i> (Gonorrhea)	63.0	57.5	68.5
<i>Chindoko</i> (Syphilis)	64.7	59.2	70.1
AIDS	48.0	42.3	53.7

Finally, there was clearly not an accurate understanding about the difference between HIV seropositivity, having AIDS, and transmitting the virus. Only 36.8% of girls (91/247) responded positively when asked whether a person can have the AIDS virus and look healthy; 81.4% (201/247) reported that if a person could have the AIDS virus and look healthy, they could transmit the virus to another person.

Knowledge about condoms was also inconsistent. Most girls (71.7%) reported that they knew what a condom was when shown one. However most girls were not sure (77.4%) when asked how often a condom should be used during sex (all the time, most or some of the time, if the boy is ill, not sure), and most thought that traditional treatment was more effective than a condom in protecting a girl from an STD (Table 15).

Table 15. Knowledge about Condom Use among Adolescent Girls (n=231)

Question: What is the best way to protect yourself against STDs?			
Traditional Treatment	85	36.7%	
Use a condom	55	23.8%	
No sex	40	17.3%	
Question: How often do you need to use a condom?			
All of the time	43	18.6%	
Most/some time	5	2.1%	
If boy is ill	4	1.7%	
Not sure	179	77.4%	

When asked about their ability to use condoms for their own sexual activity, 47.9% (103/215) of those who said they knew about condoms felt they could influence their partners to use one. Most girls (74.9%) agreed that they could use some help in learning how to convince a boy to use a condom and most (77.2%) admitted that they needed help in learning how to use a condom themselves. More disturbing however, and perhaps a commentary on the power differentials in these sexual relationships and the perceived negative attitude of males towards condoms, was that a majority of girls reported that they would rather risk pregnancy than ask a boy to use a condom (57.2%).

Responses of Anankungwi

Twenty-three *anankungwi* from ten villages participated in the survey. As mentioned above, the data did not support a clear distinction between those *anankungwi* who performed "traditional" initiation ceremonies, and those who participated in ceremonies in some way influenced or sponsored by the church. What appears to confuse the issue more was the fact that *anankungwi* were invited to come from other villages to officiate in initiation ceremonies, and thus those villages where the chief sponsors the initiation but invites a "church-trained" *anankungwi* to officiate "in a sense makes the initiation ceremony 'church influenced' while in the true sense the village itself was not." [Chilowa, personal communication 3/92]

Of the twenty-three *anankungwi* surveyed, 12 (52%) had been performing their role for more than 11 years, while only 6 (26%) had been performing their role for less than 5 years. All 23 *anankungwi* stated that they performed initiation ceremonies. 91% (21) of the respondents reported that they had been given instruction regarding the ceremony by a religious institution.

Sixty-nine percent of the *anankungwi* reported that the initiation ceremony in their village is given to girls after menstruation, while 31% reported that the ceremony is given for girls both before and after they begin menstruating. All of

those who reported giving the ceremony to girls before and after menstruation stated that the content of initiation ceremonies for girls who have begun menstruating is different than those for girls who have not yet begun menstruating. The two differences in the ceremonies noted by *anankungwi* were that (1) girls who have not yet started menses are taught more about respect, while those who menstruate are taught more about sexual matters; and (2) girls who menstruate have longer ceremonies than girls who have not yet menstruated. The observation of ceremonies in Perusi and Pindani support the former statement but do not support the latter.

The *anankungwi* were split approximately equally about whether or not girls who have been initiated are then free to consult the *anankungwi* after initiation. In addition, most (20/23) stated that the relationship established by the *anankungwi* with the initiate is actually with the adolescent girl and her family, not just the girl. These data support other data from in-depth interviews showing that some *anankungwi* preferred to maintain a ceremonial role and a distance from everyday interaction with adolescent girls, while others enjoyed a continuing relationship with the adolescent girl and her family. However, in either case it is clear that the *anankungwi* cannot be thought of as a personal and confidential resource for an adolescent girl.

When asked about the communication channels and social networks available to adolescent girls for female issues (menstruation, marriage, sexuality, female health), 22/23 *anankungwi* admitted that talking with aunts and grandmothers was not sufficient for adolescent girls, and that they needed others to talk with about these issues. Other types of persons mentioned by *anankungwi* as sources of information and support on these issues included: friends (95.5%); elder women (54.5%); and *anankungwi* (45.5%). It is also interesting to take note of the contrasting data - those potential resources which were not mentioned, including: maternal aunts (86.4%); elder sisters (86.4%); boyfriends (90.9%); mothers (95.5%); cousins (95.5%); health workers (100%); traditional healers (100%); and traditional birth attendants (100%).

In answer to the question: What is your role as *anankungwi* in the village? each *anankungwi* gave a different response. There are several primary categories under which these responses fall, including performing initiation, giving advice, performing other ritualistic functions, and helping to maintain the peace and harmony in the village.

Data from the exploratory phase gave the impression that the status of *anankungwi* was in question, and that young women were not interested in taking on or being selected for the role as the older women had been in the past. The data also implied that young men were especially negative about the role of and need for the *anankungwi* in the village, and that increasingly, husbands whose wives were selected for *anankungwi* would not give their permission for their wives to take up this role. In this survey, 65.2% of the respondents believed that young women appreciated the role of and need for the *anankungwi* in the village, giving the impression that the exploratory data was correct. The data were even more strongly supportive of this hypothesis with regard to young men: 47.8% (11) said that men did not appreciate them, an additional 6.8% (2) were not sure whether they did or not.

The list of services reportedly offered by the *anankungwi* to young girls was quite varied, and included ritualistic behavior, providing advice, and providing herbal medicine as "protection" or to increase fertility. It appears from the responses that *anankungwi* performed other functions in the communities in which they reside, such as herbalists, spiritual leader, and elder stateswomen.

Within the initiation ceremony itself, *anankungwi* reported that they gave advice and sometimes traditional medicine for female matters, sexual matters, adult behavior, and herbal protection. This list of responses supports the data from other sources, including in-depth interviews with chiefs, chief's wives, *anankungwi*, adolescent girls, and the participant observation of the initiation ceremony itself.

The list of responsibilities of "elder women" within the initiation ceremony is more concise. Older women's responsibilities were of a supportive nature, and were described as assisting *anankungwi* in giving advice, performing rituals within the

ceremony, and to participate in the singing, dancing, and prayer activities which take place during the ceremony itself.

Topics *anankungwi* teach in the initiation ceremony are consistent with that learned from in-depth interviews with village dignitaries, adolescent girls, and *anankungwi* themselves, as well as that observed during the ceremonies themselves. These include issues and social norms related to respect for elders, menstruation, sexuality, and sexually-transmitted illnesses.

Significantly, 95.7% (22) *anankungwi* believed that young girls are at risk of STDs and AIDS. When asked what could be done to prevent the spread of STDs or AIDS in their own village, *anankungwi* responses included: giving advice to girls to delay initiation of sexual activities until marriage; advising girls to limit the number of sexual partners and to limit their choice of sexual partners to those known by their parents; to teach girls about these diseases; to have girls and boys use herbs (traditional medicine) before having sex; and by making sure that all girls who have menstruated have gone for initiation ceremonies.

When shown a condom, only 17.4% (4) of *anankungwi* correctly identified it. When asked directly what a condom was, 65.2% (15) did not know. Of the eight *anankungwi* who knew what a condom was, five knew that it could be used to prevent pregnancy; seven knew that it could be used to prevent STDs; six knew that it could be used to prevent AIDS; and all eight knew that it could be used for child-spacing. All eight *anankungwi* agreed that condoms should be made available at the community level. While there was no consensus on how they should be distributed and by whom, it is interesting to note that the suggestions included only village dignitaries, not community health workers nor health assistants.

5. Discussion

The HIV seroprevalence data in Malawi suggest that as many as one out of every four girls may be at risk for contracting the AIDS virus. The data show conclusively that adolescent girls do not have an adequate understanding of their personal risk for contracting HIV. There are two reasons why this is the case. The first is that the messages which have been disseminated to date have been created for the general public and are not specific to this target audience. Traditionally, this audience has been difficult to reach because they believe they are invulnerable. Thus it becomes even more imperative to develop specific messages for this age group so that they understand that the message is for them. Their impression is also that AIDS is an illness of outsiders, of the *boma* (District Center) and of core transmission groups like bargirls/men and truck drivers. They believe they know the boys with whom they develop relationships ("My mother knows his mother"), and so these boys couldn't cause them harm. While it would be a shame to have to wait until a community member becomes ill with AIDS to point out to these girls (and their families) that AIDS is a "local" illness, it would not be surprising if their impressions didn't change until this happened. (However, since 82% of girls in the KABP said they knew "someone" with AIDS, the illness has clearly reached the rural areas, at least enough to create concern among community members.)

The second reason that adolescent girls underestimate their own risk for contracting HIV is because little or no information about the virus, and especially about the qualities of a person who could be carrying the virus, have been disseminated in Malawi. Messages showing apparently healthy, young, typical males and females need to be shown to introduce the idea that HIV can be transmitted by anyone, not just an "easy partner" or an obviously ill person. Serious attention should be paid to this issue, given the fact that an increasing number of young rural girls are being sought out by urban men—who are sometimes known as "Sugar Daddies"—who solicit sex for money. While part of this problem is structural (how else will these girls get a little "pocket money"?), if girls can at least begin to be suspicious of these

types of liaisons, perhaps they can begin to learn skills to ensure that condoms are used in these relationships.

Adolescent girls clearly participated in sexual activity beginning at an early age. There are many sources of encouragement for this behavior, including, as might be expected, friends and boyfriends, and as might not be expected, mothers, other elder women of the community, and the initiation ceremony itself. Although reported social ideals for initiation of sexual activity exist, it appears that community members do not uphold these ideals, nor do they appear to put much stock in whether or not they are adhered to by young women. In fact, older women of the community appear to understand quite clearly that young girls are having sex outside of marriage and at younger and younger ages. For example, elder women mourn the increasing numbers of abortions being performed on young women, but they have not developed strategies to limit them. The other more negative effects of engaging in sex at an early age, such as increased risk of HIV infection, have not really hit home for these women. As hypothesized in the theoretical framework, until community members feel that HIV infection is a threat to their community, they will not develop an effective response to prevent it.

The data clearly show that the government efforts to educate the general public about AIDS and STDs has had some impact. There appears to be a high level of knowledge about AIDS and STDs but a substantially lower perceived self-risk than should be the case, given the "facts" related to HIV/AIDS and STD transmission as detailed through this information. These data lead to the conclusion, therefore, that the facts were being parroted back, but also that there was a low level of understanding about what these facts really mean, and how they relate to the individual. This demonstrated that government efforts to educate the public about these topics have not been targeted to the appropriate population segments. The messages were very general and thus gave the impression that the problem was "someone else's." The data, moreover, on the source of AIDS messages supports this. Messages which came primarily from public sources such as the radio, or biased sources such as the church, were not very specific about safe sex, nor were they

targeted to any one segment of the population. Certainly, messages from these sources could not be targeted to adolescent girls who are not, according to the idealized version of female sexuality, having sex in the first place.

It appears that adolescent girls learn most of their information about sex from friends, and from the initiation ceremony, whether the ceremony is church-influenced or traditional. In fact, however, the information transmitted does not appear to teach them much of anything about their own bodies or sexuality. Instead, it focuses on ways in which to please men and the rudiments of sexual activity.

Adolescent girls' sources of information regarding STDs and AIDS are even more limited because, for the most part, they are "official." The information, which is most often transmitted by the radio or church officials, is not personal or targeted to young girls. This is especially true since enforced social norms about what can be communicated to young people about sex are adhered to in these very public arenas. In order for a message which is disseminated widely (could be heard or seen by all age groups) to be acceptable it must, therefore, be quite vague and only "factual" in nature. Moreover, because Malaŵi broadcasts only one radio station, and since this station is for general consumption, messages through this medium will remain targeted for the wider population. Until there is a relative proliferation of radio stations, and a consequent expansion of radio ownership, it is unlikely that this channel could be used effectively to reach adolescent girls about such sensitive subjects as safe sex.

The initiation ceremony is a ritual, covering and marking the passage from childhood to adulthood. With this transition comes the acceptance of responsibility and the permission to engage in different kinds of behavior. The content of the ceremony is highly secretive and informants claim that the ceremony involves magic. Since it is such a highly valued ceremony, girls who are not initiated are stigmatized. Surprisingly, the timing of the ceremony is not consistent. It may or may not occur before or after menstruation or at a fixed age interval. Although it is meant to be timed to coincide with menstruation, most girls are initiated before beginning menses. The in-depth interviews with *anankungwi* showed that the idealized plan for initiation

was that girls would be initiated in a public ceremony before beginning their menses, and in a private ceremony once their menstruation begins. The other data shows that social norms are that a girl is most often initiated only once, and that the *anankungwi*, in fact, is not the primary (nor first) communicator of information about menstruation.

The associated costs of initiation are quite high. This high cost, therefore, may influence whether or not a girl is allowed to participate, and certainly will limit a family's ability to have their daughter participate twice. The traditional ceremony is long (7-14 days) and involves activities which appear to make sex "enticing" - including in some ethnic groups (Chewa, especially), men who play the role of "hyena," and undertake a ceremonial deflowering (intercourse with the girls). Girls were also taught actual physical movements to enhance the sex act, dances to move their bodies in specifically enticing manners and sexual enhancement methods (roots in the vagina, e.g.) in combination with other seemingly contradictory advice such as avoiding sex before marriage. The initiation ceremony may currently include information on sex and STDs, but this was not consistently shown in the data. The church-influenced ceremony is three to five days long emphasizing religion and other aspects of adult responsibility, while down-playing sexual issues. This de-emphasis on sex, however, does not appear to positively influence girls' sexual behavior, i.e. delay their participation in sexual relationships. Both ceremonies discuss cleanliness during the menstrual period, not putting salt in the communal cooking pot during menstruation, and parables about being a well-behaved adult in the community.

The relationship between adolescent girls and *anankungwi* is quite formal and rather restricted. In some villages, *anankungwi* are very removed and are treated as important dignitaries who may not be approached without a great deal of ceremony. In other villages, *anankungwi* are more integrated into the community and could be encouraged to take on additional duties related to the advising of young girls. Currently they are not freely accessible to young girls outside the ceremony. Furthermore, they say that the younger generation of women, and men to an even

greater degree, have begun to question their value. Some *anankungwi* may therefore be interested in training which would modernize their role. However, this cannot be expected to remain consistent across communities.

The most important message that could be disseminated is one addressing the timing of initiation of sexual activity along with the timing of the initiation ceremony. If community members were willing to openly admit that girls were having sex before marriage, and that these girls needed to learn skills to protect themselves from risks of STDs and AIDS, then the adult women could address these topics directly in two ways. The first would be to encourage girls to (1) wait to have intercourse until after the initiation ceremony; and (2) teach them skills to avoid infection once they begin having sex.

The data clearly show that if the initiation ceremony was not held before a girl had begun menstruating and there existed an enforced social norm restricting sexual activity until after initiation, a significant delay could be impacted on the timing of the initiation of sexual activity. Of a total of 169 girls in the KABP sample who reported having sex, 116 reported having had sex either before initiation or before they began menstruating. If initiation and menstruation were timed together, the intervention would have the effect of delaying 116/169 or 68.6% of sexual initiations. Table 16 shows the data that support this hypothesis.

Currently, the teaching related to "female matters" is left to the grandmothers and mothers of adolescent girls. The passing of information (one cannot really call it teaching) related to sexuality and sexual behavior occurs between friends or peers, most often between "best friends." These two networks do not overlap and probably should not overlap. On the one hand, interventions could be developed to reach older women of the community with information about HIV/AIDS/STDs, while simultaneously working to improve peer counseling/interactions/information-giving on these subjects on the other.

While issues surrounding sexuality and power dynamics are complicated in adolescence, there appear to be strategies which could be tested to limit the vulnerability and increase the knowledge and skills of girls in this age group.

Table 16. Number of Girls who Had Sex Before Initiation or Menses

Age at First Sex	Before Initiation or Menses
9	1
10	10
11	14
12	22
13	25
14	26
15	12
16	4
17	2
18	0
	116/169 (68.6%)

Furthermore, there are ways to include the older women and men of these communities to strengthen the potential for reinforcement of acceptable strategies. Interventions which might be tested include the following:

- **Peer group educators** appear to be a channel currently in use in an informal manner, but this would be difficult to implement on a national basis.
- **Initiation ceremony** is a channel but is not sufficient due to its timing and the associated costs.
- *Anankungwi* are currently unavailable to young girls but might be interested in training to enhance their roles.
- Roles in traditional Malaŵi society are quite structured. Women perform specific tasks, such as collecting water, which are never performed by men. The site of water collection turns out to be a **gathering place for women/girls** where a great deal of information is informally passed. A community bulletin board could be placed at the site of water collection, containing information for women only, and could be another potential "channel" of communication for women.

- **Interventions which encourage the discussion of sexual responsibility** between girls and boys need to be explored. Since 91% of KABP respondents attended church in the last month, the church could be an institutional home of such an intervention. However, there may be great cultural resistance to this type of intervention, since only 21% of KABP respondents agreed with the statement: "Girls and boys should be encouraged to talk together about sexual responsibility" and of these, only 13% said this should be in a group.
- **A community-based condom distribution (CBCD) program** should be explored. Currently free condoms are distributed at the district hospital in the child-spacing clinic (one day per week), making them out of reach for most village members. Along with CBCD, there would have to be information on use and proper disposal, as well as some skill development on negotiating their use and ensuring that they were used properly. Interviews with village dignitaries and focus groups with mothers revealed consistent support for such a program. KABP response supports the need for training in condom use - 53% said a girl needs help in negotiating condom use with her boyfriend; 55% said that a girl needs help in learning how to use a condom.
- **Books on cultural norms** - currently books on cultural norms for each ethnic group are distributed. The book on the Chewa culture, for example, contains a discussion of the initiation ceremony. In this "proper" ceremony, the role of the "hyena" (*fisi*) is discussed (see above). Either this book should be rewritten to drop this ceremonial role or the hyena should wear a condom during the ceremony.

Finally, community-based research, while useful to understand determinants of sexual behavior and effective in documenting social change, also has both positive and negative effects on social change in itself. The research conducted in these communities encouraged elder women to think about how social norms had broken down over the years. The research methods utilized, especially focus groups, enabled women to talk among themselves about subjects which may have been "taboo" for casual group discussion. It encouraged them to consider solutions to prevent younger girls from engaging in risky behavior before they were prepared or able to negotiate safer sexual practices.^k

^k It is questionable, however, whether women or girls in these communities will be likely to attain enough power to be able to successfully control their sexuality or their fertility in the near future. This has more to do with the role of women generally in these communities than their interest or willingness to change the

The presence of outside organizations conducting research in these communities led to considerable expectations on the part of community members about "payment" for participating in a research study. Since water collection is a female responsibility, the community requested, and were given, funds to build safe wells for community water consumption. The year of the study coincided with a drought and consequent severe food shortage in the research communities. In order to assure that the initiation ceremonies would be held, the principal investigator was requested and agreed to provide food for the ceremony participants. While it is certainly fair that communities which participate in research should be compensated for their efforts, researchers should work with community representatives to find ways to compensate participants in a manner which will benefit the community but also minimize artificial social change.

system.

6. Conclusions and Recommendations

In general there was a great deal of congruence between results from different methods; and, to a large degree, the KABP survey data supported the hypotheses which were developed in the exploratory phase. The greatest differences in responses from one method to another were found when social norms prevented the passing of information, or idealized "norms" manifested rather than actual behaviors.

In the first instance, survey instruments and focus group discussions were unable to elicit information about menstruation from pre-menstrual girls, because social norms regarding communication about these subjects were enforced by village members. These same girls, however, would admit to knowing about menstruation in more confidential interviews; indeed, they did so readily.

In the second instance, village dignitaries and *anankungwi* reported that girls were told not to have sexual intercourse before marriage, and that this message was consistently given by village elders and in the initiation ceremony. In-depth interviews with girls, focus group discussions with mothers, and discussion with village elders and *anankungwi* revealed however that girls had sexual intercourse prior to marriage, often prior to initiation, and sometimes even prior to menstruation. This was well known by female elders of the community, and even sanctioned, in that some mothers gave their daughters traditional medicine to prevent pregnancy. The initiation ceremony taught girls highly suggestive and sexually enhancing movements, and may actually have encouraged sexual activity in those girls who had not started having sex prior to the ceremony. Despite the fact that village dignitaries and *anankungwi* reported that sexual activity among young girls is discouraged, it is quite prevalent.

What has not yet developed, in response to this situation, is a widespread or concerted endeavor to either discourage such behavior or, alternatively, to promote the knowledge and skills to prevent the negative ramifications associated with an early initiation into sexual activities.

Juxtaposed to this high level of sexual activity on the part of adolescent girls is their evident lack or less than ideal level of knowledge about risk and the consequences of sexual activity. Most do not perceive themselves to be at risk for HIV/AIDS; some perceive themselves to be at risk for other STDs; but most do not have the skills to negotiate safe sex. It appears that they would rather risk negative consequences than exert any influence over their sexual partners in the process of protecting themselves. Clearly these young women need additional knowledge and skills to protect themselves, but they cannot do this alone; they will also need the support of older women and men in the community who currently are closing their eyes to this behavior, to their ability to intervene, and to the girls' resulting risk and vulnerability.

It may also be concluded that discussions about risk and protection are not transmitted effectively through the radio and church. These arenas in turn maintain a low level of perceived risk and a superficial grasp of information and skills related to condom use in this adolescent population. Conversely, the intimate messages that are transferred through parables or songs in the initiation ceremony, are taken quite literally and accepted by this population as meant for them and them alone. Furthermore, the initiation ceremonies seem to exacerbate the situation. Indeed, since the *anankungwi* is the primary adult communicator about sex and sexuality, and the messages conveyed by them may sanction sexual activity more than limit its prevalence among unmarried girls.

Currently both traditional and church-influenced ceremonies do a great deal to entice young girls into having sexual intercourse, but do not appear to give the same attention to the transfer of information and skills required to enable these young girls to undertake changes in behaviors safely. There is no question that these forums would be suitable for teaching girls how to protect themselves from STDs and HIV/AIDS; however, this should not be the first time girls hear about these topics since it is very likely that they will have been having unprotected sex before such discussions take place. Furthermore, to include this kind of information in the initiation ceremony would first require the training of all the adult women in a

community, since they, together with the *anankungwi*, are the teachers of all information passed on during these ceremonies. The logistics of training all the adult women in every community in Malawi are rather daunting, but certainly this would help to reinforce the knowledge and skills transmitted to young girls, as well as improve channels of information which currently provide information on these and related subjects already.

Recommendations

It seems that community-based condom distribution, accompanied by skills training in negotiation and condom use, would probably be the most effective HIV/AIDS preventive intervention for those girls already engaging in sexual intercourse. For younger girls, including specific information on HIV/AIDS and risk in the community-based communication networks (peers, initiation ceremony, church activities) as well as in school lessons, would also be useful.

Most important, however, would be a commitment on the part of community elders to strengthen currently unenforced social norms about abstaining from sexual behavior before menstruation and initiation, while delaying initiation until after the onset of menstruation. As the data show, the mean age of initiation was not significantly different than the mean age at first intercourse, 13.83 and 13.63, respectively. The mean age of menstruation, however, is significantly older at 14.50. The data clearly show that if the practice of holding initiation after the onset of menstruation was strictly enforced, and if girls did not have sex until after initiation, 69 percent of adolescent girls would delay intercourse for at least one year. This would provide more time for girls to learn about risk for HIV/AIDS and other STDs, and about how to successfully negotiate condom use with their partners well before they begin having sex.

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Collaborating Institutions and Description of the Research Team

This study was undertaken by a team of investigators from Malaŵi and the United States. The institutions involved were:

- The University of Malaŵi, Chancellor College, Centre for Social Research and Department of Sociology, Women in Development Programme; and
- The Johns Hopkins University, School of Hygiene and Public Health, Departments of International Health and Epidemiology.

When the study was funded by ICRW, the Principal Investigator, Dr. Gina Dallabetta, was resident in Malaŵi and a co-investigator of a NIH-funded study examining HIV prevalence in a population of pregnant women in the commercial capital, Blantyre.¹ Early in the study, Dr. Dallabetta left Malaŵi to take a new position in the United States with the FHI/AIDSCAP Project. While Principal Investigator of the ICRW-funded study, Dr. Dallabetta was responsible for setting up the administrative and supervisory mechanisms, selecting the field site, selecting the field researchers, and for the financial agreements with all staff and consultants.

In January 1992, Dr. Helitzer-Allen was asked by ICRW to take up the responsibilities of Principal Investigator. Dr. Helitzer-Allen had played a central role in the design and implementation of the exploratory phase of the study. In her capacity first as co-investigator and later as Principal Investigator, Dr. Helitzer-Allen designed the research protocol, helped to select the field research team, trained the field research team, wrote the field research instruments, supervised and communicated from the United States and played a central, onsite role² in the final

¹ Miotti, P and Dallabetta, G. "HIV Infection in Malaŵi Women and their Children."

² The funds for this intensified research activity were provided by the U.S. Agency for International Development, under Cooperative Agreement DPE-5951-A-00-9033-00 for the Health and Child Survival Fellows Program with the Johns Hopkins University Institute for International Programs.

two months of data collection in the field. While in Malaŵi, she also assisted Dr. Chilowa with the design of the final survey and worked directly with the data entry and analysis team to produce the results reported herein.

Dr. Wycliffe Chilowa, Acting Director of the Centre for Social Research, University of Malaŵi, was co-Principal Investigator of this study. His primary responsibilities were to design and implement the final survey. He wrote, pretested, and revised the final survey instrument; hired, trained, and supervised the field research team in the data collection; and helped to interpret the results. He also assisted with selection of the field site, made supervisory visits to the field site, and when needed, provided interpretations of cultural factors thereby ensuring the appropriateness of all study activities.

Ms. Mercy Makhambera, a candidate for a master's degree from the University of Malaŵi, Department of Sociology, Women in Development Programme, provided consultation to the study in two capacities: data collection from older women, and analysis of culturally contextual data.

Ms. Anne Marie Wangel was the field supervisor for the study. Ms. Wangel was employed by the Johns Hopkins Project of which Dr. Dallabetta was co-investigator, and worked under Dr. Dallabetta as a supervisor for the clinical component. Ms. Wangel contributed 50% of her time for the ICRW study. In this capacity, she helped select the field research team and the field research site, developed and maintained relationships with officials at the national, regional, district and community levels, supervised data collection, supported the field research team, and ensured that data entry was proceeding in a timely manner.

Drs. Neil Graham and Paolo Miotti, faculty at the Johns Hopkins University School of Hygiene and Public Health, Department of Epidemiology, provided technical assistance in the design of the final survey and in the interpretation of the results.

Mr. Colin Flynn, programmer with the Johns Hopkins University School of Hygiene and Public Health, Department of Epidemiology, provided technical assistance in analyzing the data from the three surveys undertaken during this study.

Mr. Joseph Canner, data analyst for the Johns Hopkins HIV in Pregnancy Project, provided technical assistance in design and data entry.

Dr. Robert Hornik is the Technical Advisory Group (TAG) member assigned to oversee the work and provide technical guidance. The study design, quantitative instruments, data analysis, and the conclusions drawn from the results have benefitted from Dr. Hornik's contribution.

ABOUT THE WOMEN AND AIDS RESEARCH PROGRAM

The Women and AIDS Research Program was initiated in August 1990 with support from the Offices of Health and Women in Development of the U.S. Agency for International Development. The objective of the program was to support research in developing countries to identify the behavioral, sociocultural, and economic factors that influence women's vulnerability to HIV infection. The program also sought to identify opportunities for intervention to reduce women's risk of HIV infection.

The first phase of the program supported 17 research projects worldwide: seven in Africa, five in Asia, and five in Latin America and the Caribbean. The studies focused on women and men in rural and urban communities, school-based and nonschool-based adolescents, and traditional women's associations. The focus of the second phase of the program, which began in August of 1993, is to support eight of the original seventeen projects in the design, implementation, and evaluation of interventions developed from the research findings of the first phase of the program. The second phase of the program is expected to be completed by February of 1996.

Publications from the Women and AIDS Research Program

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1. **Women and AIDS: Developing a New Health Strategy** by G. Rao Gupta and E. Weiss.

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1. **AIDS Prevention Among Adolescents: An Intervention Study in Northeast Thailand** by E. Thongkrajai, J. Stoeckel, M. Kievying, C. Leelakraiwan, S. Anusornteerakul, K. Keitisut, P. Thongkrajai, N. Winiyakul, P. Leelaphanmetha, and C. Elias.
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