



## CHAPTER 3

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# The Development Aid Situation in Malawi

Malawi, affectionately known as the Warm Heart of Africa, is a landlocked country in sub-Saharan Africa bordered by Mozambique, Tanzania and Zambia. It is small and densely populated, with a population of 15.4 million (National Statistical Office [NSO] 2008). 85% of the population live in rural areas. Its economy is mainly dependent on agriculture, which accounts for 30% of the Gross Domestic Product. Tobacco, tea and sugar are the major export commodities (National Statistics Office and ORC Macro 2011). Malawi has three administrative regions: Northern, Central and Southern which are divided into twenty-eight districts. It has nine major ethnic groups. The national language is *Chichewa*, spoken, and English is the official language. Malawi was ruled by Britain and known as the Nyasaland protectorate from 1891 until July 1964, when Nyasaland became Malawi, and gained republic status in 1966 (National Statistics Office and ORC Macro 2011).

Despite having natural resources such as water, forests, animal life and land, according to the United Nations (UN) Malawi is one of the world's least developed countries, displaying a low **Human Development Index** (HDI) rating along with low **socioeconomic development** indicators. Its ranking on the UN's HDI is 171 out of 187 countries: 0.385, below the mean for sub-Saharan Africa of 0.389, and its per capita GNI is estimated at \$911, below the mean for sub-Saharan Africa of \$2050 (UN 2011). In other words, Malawi is facing devastating levels of poverty, and people are dying, which is not only reflected

by official statistics but also by the number of coffin shops present on the streets of Lilongwe and Blantyre. Two-thirds of the population live below the national poverty line and more than one in five people live in ultra-poverty—unable to afford basic minimum food requirements (UN 2011).

## THE AID SCENE

Malawi has been receiving aid since its independence in 1964. It relies heavily on external aid. In 2011, 40% of Malawi's budget came from foreign donors (Donnelly 2011). And between 2007 and 2009 aid contributed approximately a fifth of the country's GNI (World Bank 2011). In 2008 Malawi received close to US\$1 billion in official development aid including from Britain, Japan, the USA, the IMF, the World Bank (Myroniuk 2011). Despite this aid dependency, Malawi experienced rapid growth between 2005 and 2010 and its economy grew at an average of 7%. The World Bank credited this growth to 'sound economic policies and a supportive donor environment' (World Bank 2013).

When the former President Bingu wa Mutharika and his Democratic Progressive Party won a landslide second term in the May 2009 elections it was seen as a remuneration for their success since their first election victory in 2004. However, from 2010 Malawi's economic growth began to slow (Wroe 2012). According to the World Bank this was due to a deterioration in the policy environment (World Bank 2013). This resulted in foreign exchange, fuel and electricity supply shortages and the cost of living kept going up.

In the late 1970s the International Monetary Fund and the World Bank offered financial assistance to countries in the Global South while applying a neoliberal economic ideology as a precondition to receiving the funds. Many countries in sub-Saharan Africa accepted the economic liberalisation measures and introduced rigorous structural adjustment policy reforms. Malawi was one such country. In 1979, with support from both institutions, and in response to a declining macroeconomic situation, the Malawi Government implemented economic stabilisation and structural reforms (Conroy et al. 2006). The IMF stabilisation policies aimed at restoring external sector balances through exchange rate management reforms and balance of payment support through Stabilisation Adjustment Loans (SALs). The World Bank provided development and reconstruction funds through Structural Adjustment

Policies (SAPs) and Fiscal Restructuring and Deregulation Programmes (FRDP).

These structural reforms were adopted in an attempt to liberalise the economy, broaden and diversify the production base, and allocate resources more productively (Munthali 2004). Although the specifics of SAPs differ, four basic elements were always present: currency devaluation, the removal/reduction of the state from the workings of the economy, the elimination of subsidies to reduce expenditures, and trade liberalisation. Such prerequisites were intended to lead to the adjustment of malfunctioning economies in order to become viable components of a global system (Riddell 1992).

The IMF and World Bank argued that such reforms would reduce poverty. However, this model of development, whereby the North imposed conditions on the South, came under *attack*: programmes of the IMF and the World Bank in fact increase poverty. The ideology of neoliberalism required poor countries to reduce spending on social issues including health, education and development, while debt repayment and other economic policies prioritised (Sadasivam 1997; Geo-Jaja and Mangum 2001). Evidence shows that neglect and underfunding of the social sector particularly education and health, negate the development of a skilled labour pool, the capacity and capability build-up in research and policy, and the provision of the management talents demanded in an adjusting economy. As Stiglitz points out:

The IMF likes to go about its business without outsiders asking too many questions. In theory, the fund supports democratic institutions in the nations it assists. In practice, it undermines the democratic process by imposing policies. Officially, of course, the IMF doesn't 'impose' anything. It 'negotiates' the conditions for receiving aid. But all the power in the negotiations is on one side—the IMF's—and the fund rarely allows sufficient time for broad consensus-building or even widespread consultations with either parliaments or civil society. Sometimes the IMF dispenses with the pretence of openness altogether and negotiates secret covenants. (Stiglitz 2000, p. 56)

One report critical of World Bank conditionality produced by the Dutch NGO A SEED was based on desk research from country case studies including Malawi, Mali, Mozambique, Nicaragua, Zambia and Bangladesh. The report concluded that privatisation and liberalisation

policies that are neither designed, nor desired by countries, are still pushed through by the World Bank; it also reported that the implementation of World Bank promoted policies correlated with an increase in levels of poverty. The report called for the Dutch government to demand a phase out of economic policy conditionality, which would have brought it in line with other European governments, including the UK and Norway (Cabello et al. 2008).

The IMF in 1999 replaced Structural Adjustment Programmes (SAPs) with Poverty Reduction Growth Facility (PRGF) and Policy Framework Papers with Poverty Reduction Strategy Papers (PRSP) as the policy framework for determining loan and debt relief. PRSPs set out a country's macroeconomic, structural and social policies to improve growth rates and reduce poverty. Such strategies for reform were necessary for World Bank loans or lending by the IMF under the poverty reduction and growth facility. However, many critics uphold the view that the PRSPs are as equally detrimental as the SAPs. Countries still have to fulfil donor criteria; therefore, aid is still tied to conditionalities. Further, they did not incorporate gender, race and poverty interests (Bretton Woods 2004).

The Millennium Development Goals (MDGs) were also a further initiative to reduce poverty. Economic growth rates were not considered part of the MDGs, however there is widespread agreement that the MDGs placed poverty reduction at the centre of the development agenda at least in international discussions and policy discourse (Watkins 2011). At the Millennium Summit in September 2000, the largest gathering of world leaders in history adopted the UN Millennium Declaration, committing to reduce extreme poverty and setting time-bound targets, with a deadline of 2015. The MDGs were the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions—income, poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education and environmental sustainability. They were also basic human rights—the rights of each person on the planet to health, education, shelter and security. The purpose of the MDGs was not to change thinking but to change policies and outcomes. They were designed to 'encourage sustainable pro-poor development progress and donor support of domestic efforts in this direction' (Manning 2009, p. 19).

Critics of the MDGs say they were cobbled together in order to make politicians look grand for the UN Millennium Declaration and targets

were set in the absence of any idea of how they were going to be met, how much it would cost, or where the money was coming from. The ‘one size fits all’ target percentage reductions mean that countries that have achieved a lot in the past have big difficulties in meeting the goals, and gains (or lack of them) took no account of distribution across socio-economic groupings and that they are a factor in the rise of disease specific global programmes instead of sector-wide reforms. A further criticism of the MDGs is that they did not track misconceptions concerning the HIV virus. As England said: ‘We will not achieve better health care for the world’s poor without better national health systems to fund and deliver it, and we will not achieve that without a better international system for aid’ (England 2007, p. 565).

Malawi adopted an MDG-focused national plan to reduce poverty called the Malawi Growth and Development Strategy (MGDS) (2006–2011) (Kenny and Summer 2011). The MGDS addressed six thematic areas which were sustainable economic growth; social protection; social development; management and prevention of nutrition disorders and HIV/AIDS; infrastructure development; and improved governance. Despite developing a ‘home-grown overarching national policy for creating new wealth, for achieving sustainable economic growth and development and for combating endemic poverty’ (GoM 2007, p. 2) the former President, Bingu wa Mutharika, faced a strict set of aid conditionalities to disburse the US\$5.3 billion in foreign aid received between 2004 and 2011 (World Bank 2011). He had to run the Malawian economy along guidelines set out by the IMF, abide by various UN agreements, and adhere to Malawi’s constitutional framework.

Under his rule Malawi faced serious problems with international donors. In November 2009, he accused the World Bank and the IMF with causing foreign exchange shortages by forcing the country to liberalise the economy. Throughout 2010, the IMF pressured the administration to devalue the Malawi Kwacha in order to encourage investment and trade but the government ignored the advice. The IMF took the unusual step of asking a group of donors to release their budget support grants to Malawi, which they had been withholding until a new IMF programme was approved. The IMF board shifted the decision for a new programme for Malawi to mid-February, raising fears that donors would continue to withhold \$545 million in aid.

International donors became increasingly concerned with the government’s failure to devalue the currency and its repeated unconstitutional

behaviour, including the stifling of opponents, refusal of holding local elections and Mutharika spending eight million pounds on a private jet. This was expressed when a group called the Common Approach to Budgetary Support group (CABS), including Malawi's two biggest donors (the EU and DFID), called a meeting with the government in March 2011. The group announced that it was suspending aid and that it would permanently withdraw budgetary support if the government failed to address its concerns. A leaked document from the British High Commissioner demonstrated more explicitly why donors were worried. The Commissioner, Fergus Cochrane-Dyett, described Mutharika as 'becoming ever more autocratic and intolerant of criticism' (*The Guardian* 2011). The document indicated the willingness of the British government to suspend aid if the state of affairs persisted. When the document came to light in April, the government promptly expelled the diplomat from the country and Britain responded by announcing that it would review all of its ongoing financial support to the Malawian government.

The UK Department for International Development, then Malawi's largest bilateral donor with US\$121 million donated per year, of which \$49 million went to funding Malawi's public health sector, made its final aid disbursement to the country in March 2011, and decided not to renew a six-year spending commitment. Other development partners decided to end or suspend general budget support to Malawi (The World Bank, The EU, The African Development Bank, Germany and Norway) (Tran 2011), or tried to force change on a host of issues, including Malawi's enforcement of an anti-homosexuality law and government threats to freedom of speech and association. The World Bank withheld \$40 million in funding, Germany suspended \$16.5 million, because of the anti-gay laws and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) rejected a \$565 million plan (Donnelly 2011).

Following on from the Common Approach to Budgetary Support meeting Mutharika attacked Malawi's donors in a widely reported speech. He accused them of siding with civil society organisations against the government and claimed that, as he was Malawi's leader, donors should privilege their relationship with him. Mutharika's speech did not directly address the concerns raised by donors, referring to them only as 'lies' spread by civil society groups. Donors' decisions to withhold funds had a detrimental impact on Malawi's economy and healthcare

system as Malawi's health sector is nearly entirely donor funded. With foreign aid covering about 90% of the cost of all medicines in Malawi, drug stock-outs became more common and physicians frustrated they were unable to prescribe medicines, leading to low morale, IRIN (2011) notes. Mutharika stated that Malawi should become far less dependent on donors, despite its reliance on donor aid, which helped lead to substantial gains, including putting 270,000 people on antiretroviral treatment since 2004 (Donnelly 2011). Mutharika, however, praised China for its unconditional aid and said that China did not demand democratic reforms, good governance and anti-corruption drives as a condition for aid and trade.

In this section I have set the development aid scene in Malawi and demonstrated the powerful and influential role international donors play in influencing policy and programmes. I have shown how aid conditionality can lead to failed projects. I have also demonstrated how funding is donor led and if donors are not happy with what is happening in the country to which they are supplying aid, whether it is the way money is being spent, or the type of policies the government implements, then funding will be withdrawn. It further illustrates how donor policies do not take into account in-country situations and make their own conditions for the release of funds. In all these points made above I make a case that international aid is linked to conditions that often are not evidence-based but based on the perceptions highlighted by the Malawian elites. Further it shows that funding flows from donors can often be volatile and reflect priorities that are not shared by national governments. The next section looks at AIDS in Malawi.

## AIDS

UNAIDS, the joint United Nations programme on HIV/AIDS, was established in 1996 in an attempt to coordinate efforts to curb the pandemic. At the first ever Special Session on HIV/AIDS of the United Nations General Assembly (UNGASS) in 2001, UN Member States endorsed the *Declaration of Commitment on HIV/AIDS to address MDG 6*. This *Declaration* included time-bound pledges to generate measurable action and concrete progress in the AIDS response. Signed by 189 world leaders, the Declaration agreed that HIV/AIDS was a national and international development issue of the highest priority (UNAIDS 2006). This signed declaration led to increased funding for international

HIV/AIDS programmes. At the five-year review of implementation of the *Declaration of Commitment* in 2006, UN Member States reaffirmed the pledges made at the 2001 Special Session. In the *Political Declaration on HIV/AIDS*, Member states committed to taking action to move towards universal access to HIV prevention, treatment, care and support by 2010 (UNAIDS 2008).

Given the above, it has been argued that AIDS had become not just a health priority but a global development priority. This can be seen in the case of Malawi. The *National HIV/AIDS Policy* (2003) in its preamble summarises the impact of HIV/AIDS as:

- A public health issue because it directly affects the health of large numbers of people in society and reduces the overall health status and well being of the nation.
- A social issue because it adversely impacts families and communities resulting in excessive medical expenses, depleted family savings and leading to disposal of assets.
- An economic issue because it leads to a decline in economic growth, by reducing the productivity of the labour force.
- Development issues because it is weakening institutions and destroying institutional memory in both the public and private sectors—destroying their capacity to formulate, analyse and manage public policies, and develop programmes and strategies essential for economic growth. (Malawi, & Malawi. National AIDS Commission 2003, pp. 2–3)

UNAIDS was created because the epidemic was considered to be exceptional, thus requiring exceptional efforts at prevention and mitigation. That HIV requires a response above ‘normal’ health interventions began as a Western response to the virus (Smith and Whiteside 2010) and the international community has also said it was exceptional (Dionne et al. 2013). AIDS exceptionalists emphasise the importance of human rights issues in relation to AIDS. Those against exceptionalism, and particularly well-known, is England, who holds the view that funding for health systems and funding for HIV amounts to a zero-sum game: ‘until we put HIV in its place, countries will not get the delivery systems they need’ (England 2007, p. 1073). In other words, the HIV pandemic stimulated an exceptional response.

According to UNAIDS figures in 2007 an estimated 33 million people were infected with HIV worldwide of which 2.5 million people

were newly infected and there were 2.1 million AIDS-related deaths (UNAIDS 2007). Southern Africa is the area hardest hit by the pandemic, accounting for 68% of the global population living with HIV and almost 32% of all new HIV infections and AIDS-related deaths globally. It is projected that by 2015 more than 45 million people will have died from AIDS-related illnesses globally. A further 200 million people will be directly affected, based on conservative estimates that only 1 in 5 members of the family will be affected by each person who dies, and an additional 200 million people will be less directly affected (Poku 2005). However, the long-term impact of AIDS is hard to measure, because there is a differential impact over time as an infected individual's health deteriorates, and a time lag between infection and death (Poku 2004).

### MALAWI'S NATIONAL HIV POLICY AND SEXUAL CULTURAL PRACTICES

In Malawi, the government's national HIV policy stipulates that: 'many practices, including polygamy, extramarital relations and customary practices such as widow and widower inheritance, death cleansing, forced sex for young girls coming of age (*fisi*) increase the risk of HIV infection' (Malawi, & Malawi. National AIDS Commission 2003, p. 24). Practices exist that are perceived as culturally acceptable but said to spread HIV by legitimising high-risk behaviour. These include *chokolo* (widow inheritance), *nthena* (widower given wife's younger sister in the Northern region) widow cleansing, *m'bvade* (unmarried female's post-natal abstinence is concluded by surrogate sex), the use of *fisi* (surrogate) in male fertility in most ethnic groups; the use of *fisi* in initiation rites among the Yao; and the belief that STIs, including HIV, can be prevented by charms and 'vaccines' (Lwanda 2005, p. 125). Powerful and pervasive beliefs and practices, based on deep-rooted associations between sex, health, and illness, continue to influence sexual and reproductive health and health-seeking behaviour. However, given the secrecy that surrounds beliefs and practices which are linked to fertility, plus the many variations from village to village, it is very difficult to be specific about the extent to which these practices are continuing to take place or where they take place (P26, P37) which makes the link between them and HIV transmission more tenuous. I will now describe the following practices: polygamy, *fisi* and widow inheritance.

*Polygamy* has been identified by the Government of Malawi as accelerating the spread of HIV. If one partner is infected within a polygamous family the number of persons at risk becomes higher than in a monogamous family. But it is not polygamy itself that spreads HIV but the practice of unsafe sex. A polygamous family in which all partners practise safe sex in their extramarital affairs is no more at risk than a monogamous family, particularly given that men in a so-called monogamous relationship may still be having affairs. Therefore, what is important is not polygamy or monogamy but the practice of safe sex in extramarital relationships. Fighting against polygamy will not make people practise safe sex. Polygamy is deeply ingrained in a number of African countries, and is part of a complex set of social and economic relations, which means it is unlikely that the practice could be eradicated. According to Jacoby (1995) there is 'polygamy belt' stretching across Africa, from Senegal to Tanzania. Despite the extensive polygamy discourse, monogamy dominates in Malawi. The extent of polygamy in Malawi was measured in the 2004 Malawi Demographic Health Survey. Overall 84% of all currently married women are in monogamous unions, 12% are in polygamous unions with one cowife and 3% are in polygamous unions with two or more cowives. These statistics demonstrate that only a small percentage of women are in polygamous unions. This raises questions why the Government of Malawi is concentrating on changing this practice as a root trigger of AIDS.

*Widow inheritance* is also cited in Malawi's HIV policy as a practice that contributes to the spread of HIV. Widow inheritance is a practice whereby widows are 'inherited' by a male family member of her late husband, often the brother. It was initially designed as an economic relationship, so that the wife and her children could continue to be supported by the deceased husband's brother. Since it is believed that the brother who died must have died of AIDS, the practice came to be considered a risk factor in HIV transmission. According to Swidler and Watkins (2009) it is unlikely that widow inheritance does much to transmit HIV: rather, it is transmitted through marriage or extramarital partnerships. Here it is important to note again that the probability of transmission of HIV in a single act of unprotected intercourse is very low—1 in 1000 (.001) if there are no current STIs or ulcers and if the sex occurs outside the brief window period or at the end, when viral load is high. Even if there are other risk factors the risk increases to 8 in 1000 (.008), still low.

Thus, the probability of the virus being passed on from the brother to the widow or vice versa is very low. However, if the widow or the brother had contracted HIV before the widow inheritance practice took place then if unprotected sex is carried out the probability of contracting the virus can increase. As Lwanda (2005) points out he noted five examples of educated Christian men who had inherited their relatives' widows with tragic results. There were clear signs and symptoms suggestive of AIDS in all cases. Again it is not so much the practice that is conducive to the spread of HIV but the practice and negotiation of safe sex.

*Fisi* is also described in Malawi's HIV policy as a practice which contributes to the spread of HIV during initiation ceremonies. Initiation ceremonies celebrate the transition to adulthood, and in that sense are equivalent to a Bar Mitzvah or a Latin American Quinceanera festivity. In Malawi, traditional initiation counsellors typically provide information on the expected conduct of the initiates, both male and female, when they become an adult. Initiation ceremonies are far more frequently celebrated for girls than for boys. At initiation, girls who have started menstruating are separated from those who have not. They are advised to 'avoid' male friends because of the risk of pregnancy and sexually transmitted infections. Some respondents told me that girls are taught how to respond to future husbands when having sex, although secrecy prevented them from telling me more. However, rapid external societal changes have taken place, which have brought about changes to the nature of some rituals. For example, traditionally, when a girl and boy who had reached puberty were accepted as 'girlfriend and boyfriend', the closing of the initiation ceremony would present the opportunity for them to consummate the relationship. As such, they then reached adulthood as a married couple. Yet there is a dearth of data exploring the impact of initiation ceremonies on young people in sub-Saharan Africa.

Among some societies in Malawi and Zambia (Moyo and Müller 2011) a man is hired as a *fisi* (hyena) to have sex with the female initiates. One explanation for such a practice may be that the introduction of formal education schedules has resulted in girls being initiated at a younger age, and before they are considered ready for marriage. According to Coombes (2001), such rituals are said to increase exposure to STI/HIV and pregnancy, and undermine the human rights of children, and their ability to recognise and resist sexual abuse.

## VIEWS ON CULTURE

Cultural norms are widely held in Malawi that women should be inexperienced and naive in sexual matters and that pleasing men is the primary goal of sex (P7, P26). From very young ages, girls are treated as sexual beings whose primary objective is to please men, while boys are never taught what it takes to please a woman sexually. A review of cultural beliefs and practices influencing sexual and reproductive health and health-seeking behaviour (Matinga and McConville 2003) found that, as in other countries in the region, the main risk factor concerning sexual and reproductive health in Malawi is that ‘being a man’ means being dominant and in control, particularly in sexual liaisons. Females who want acceptance in society are expected to be meek, and sexually submissive to the point where it is not acceptable to say ‘no’ to sex (Coombes 2001). This may reflect the fact that whereas Malawi’s complex history has resulted in the coexistence of both matrilineal and patrilineal kinship systems, both are strongly patriarchal (i.e. power lies with the male members of the family). The belief in the ‘powerlessness’ of females in sexual decision-making continues to place both women and men—young or old, married or unmarried—at great risk.

The following is an excerpt from my journal notes.

Angela is currently working as a consultant employed by UNDP. She is working with the Ministry of Agriculture on a communications strategy. She and I talked over lunch about relationships. Angela is from Uganda. We talked about African men. She said African men are the same wherever you are. They have extramarital affairs and they perceive having more than one woman as moving up the social ladder. She told me her husband had an affair and she did not find out until she was informed that one of the children had died. But not her child, the child her husband had fathered with another woman. Angela is still married to him and I asked why? Why have you not divorced him? She said that in Africa it is difficult to divorce your husband. It is frowned upon – a type of social stigma is attached to divorce. She explained that if she were to divorce her husband then everything she has achieved in her life would mean nothing. (Journal entry, 7 February 2009)

This conversation highlights how male promiscuity is problematic for women: it locks them into relationships in which their sexual behaviour is highly controlled through views of modesty. They are vulnerable to

infection by a construction of masculine sexuality that pursues promiscuity. This reality again contests the argument that prevalence is higher in rural communities that carry out harmful cultural practices. Women's weak societal position and practices that remove choice from them compound gender imbalance (Geisler 1997, p. 92). For example, men offering to pay more money to sleep with sex workers without a condom. This male dominance extends to exposing elite women to STIs through the sexual behaviour of their men who have mistresses. Thus, high socioeconomic status is, in Malawi, a risk factor for HIV infection. Higher HIV prevalence rates are found among women in the highest wealth quintile than the lowest. Further, women with a secondary or more than secondary education have higher HIV prevalence rates than women with no education (MDHS 2010).

The societal norms that enable men to engage in multiple sexual relationships both before and after marriage are manifested in extramarital relationships, divorce and marriage-remarriage cycles. One person told me 'there is this belief that for you to be recognised as a man in the society you have to have multiple partners' (P42). Another said 'men take pleasure in having multiple sexual partners' (P41). Women perceive that they are at risk because their husbands have unprotected sex with other partners and because women are much less likely to engage in higher-risk sex than men (MDHS, survey 2005, p. 201). Men perceive that the risks they face arise from having unprotected sex with other partners.

I interviewed a lawyer who has a Ph.D. She told me:

It's normal for men to have multiple sexual partners but not because that is a cultural practice, no, that is an issue of behaviour. But you see that issue of behaviour is very much influenced by our culture. And hence, we all know worldwide that HIV/AIDS is fuelled by multiple sexual partners, especially in cases where people are not resorting to protected sex. And that is the case in Malawi. Another link that you can see between the influences of our culture on HIV/AIDS spread is that women tend to take a subordinate role in society, usually they are voiceless. So you find that in cases where a man and a woman want to engage in sexual intercourse, you find that the woman is so powerless; as a matter of fact you don't question what a man wants to do, especially for the rural folk. They will never demand for protected sex, they never bargain for things like condoms. There are a number of factors that contribute to this; the economic factors, because women are trading sex for money and that leaves you at a very bargaining point; the cultural practices that have employed us as women

not to question the ways of our husbands for instance. so you find that in the many family set up the women cannot say to their husbands that you know what I think lets go without sex because I don't know if you've been handling yourself right, No, ok but can we please have protected sex. But, what is the case to me is that our culture has influenced our behaviour, where the man is superior the woman is subordinate, where it is the sign of masculine power to have as many sexual partners as you can, and where it is actually law as custom for a man to have as many wives as possible, and you see how that can really offer a very environment for the transmission of HIV/AIDS coupled with of course other factors. When you look at the issue of HIV/AIDS, mind you, I like a holistic approach to the factors that fuel it because they work so much in complementation of each other, you can never isolate culture as a separate factor, you see that also the economic factors come in because if the women were empowered economically then maybe this whole question of men having multiple sexual partners would have died a natural death because sometimes you are forced to be in the polygamous arrangement because you want to benefit economically. So, when you go try and also explore how these other factors are complementing. The dual system of the law that we have at the moment, I know if you go back to the law commission they will tell you that they've tried to consolidate our marriage laws into one act, and maybe you may wish to explore how they have tackled this issue that for as long as that legislation remains the bill the situation at the moment is that our law recognises marriages that are constructed under the marriage act that's strictly polygamous marriages, then it recognises marriages that are constructed under the Christian rights act and customary marriages, which are potentially polygamous; and which, unfortunately, so many of us are governed by. Even myself, I constructed a religious marriage, I went to my church, the Roman Catholic Church; but at the end of the day that's not a marriage under the marriage act. If my husband were to choose to have another wife, he could. (P26)

I interviewed a Cabinet Minister who has a Ph.D. She told me:

A real man must propose a woman because a woman does not propose a man. So the traditional practice is that you wait for a man to propose you and therefore men take pleasure in having multiple sexual partners and they are known as these are the real men. On the other hand women feel they have to be proposed. That's a sign that you are beautiful. If nobody proposes you, you must be an ugly woman. So those are parts of the social cultural practices that are taking place. While on the other hand traditionally you are initiated not to say no to sexual intercourse because if

you say no you are sending the man to another woman and you lose out. Especially in marriage and therefore women have no power to negotiate for safer sexual intercourse. So you have that dilemma. And women are expected to be faithful while it is ok for men to be promiscuous. So there is an imbalance. So these are some of the cultural practices that are out there. (P41)

## CONCLUSION

In this chapter I have set the development aid scene in Malawi and demonstrated the powerful and influential role international donors play in influencing policy and programmes. I have shown how aid conditionality can lead to failed projects. I have also demonstrated how funding is donor led and if donors are not happy with what is happening in the country to which they are supplying aid, whether it is the way money is being spent, or the type of policies the government implements, then funding will be withdrawn. It further illustrates how donor policies do not take into account in-country situations and make their own conditions for the release of funds. In all these points made above I make a case that international aid is linked to conditions that often are not evidence-based but based on the perceptions highlighted by the Malawian elites. Further it shows that funding flows from donors can often be volatile and reflect priorities that are not shared by national governments.

## REFERENCES

- Bretton Woods. (2004). Retrieved January 14, 2012, from <http://www.bretton-woodsproject.org/art.shtml?x=42231>.
- Cabello, D., Sekulova, F., & Schmidt, D. (2008). *World Bank conditionalities: Poor deal for poor countries*. Amsterdam, The Netherlands: A SEED Europe.
- Conroy, A., Blackie, M., Whiteside, A., Malewezi, J., & Sachs, J. (2006). *Poverty, AIDS and hunger: Breaking the poverty trap in Malawi*. Hampshire: Palgrave Macmillan.
- Coombes, Y. (2001). *A literature review to support the situational analysis for the national behaviour change interventions strategy on HIV/AIDS and sexual and reproductive health*. London: DFID.
- Dionne, K. Y., Gerland, P., & Watkins, S. C. (2013). Aids exceptionalism: Another constituency heard from. *AIDS and Behavior*, 17(3), 825–831.
- Donnelly, J. (2011). Battles with donors cloud Malawi's HIV prevention plan. *The Lancet*, 378(9787), 215–216.

- England, R. (2007). The dangers of disease specific aid programmes. *British Medical Journal*, 335, 565.
- Geisler, G. (1997). Women are women or how to please your husband: Initiation ceremonies and the politics of 'Tradition' in Southern Africa. *African Anthropology*, 14(1), 92–128.
- Geo-Jaja, M. A., & Mangum, G. (2001). Structural adjustment as an inadvertent enemy of human development in Africa. *Journal of Black Studies*, 32(1), 30–49.
- Malawi, & Malawi. National AIDS Commission. (2003). National HIV/AIDS Policy: A Call to Renewed Action (Vol. 2). Office of the President and Cabinet, National AIDS Commission.
- Government of Malawi. (2007). *Malawi and the millennium development goals*. Lilongwe, Malawi: Government of Malawi.
- IRIN. (2011). MALAWI: UK aid cuts hit health care. Retrieved June 6, 2011, from <http://www.irinnews.org/report/92877/malawi-uk-aid-cuts-hit-health-care>.
- Jacoby, H. G. (1995). The economics of polygyny in sub-Saharan Africa: Female productivity and the demand for wives in Côte d'Ivoire. *Journal of Political Economy*, 103(5), 938–971.
- Kenny, C., & Summer, A. (2011). *More money or more development: What have the MDGs achieved?* Washington, DC: Centre for Global Development.
- Lwanda, J. (2005). *Politics, culture and medicine in Malawi*. Zomba: Kachere.
- Macro, O. R. C. (2005). *Malawi demographic and health survey 2004*. Zomba, Malawi: National Statistical Office.
- Manning, R. (2009). *Using indicators to encourage development: Learning lessons from the millennium development goals* (No. 2009: 01). Danish Institute for International Studies.
- Matinga, P., & McConville, F. (2003). *A review of cultural beliefs and practices influencing sexual and reproductive health and health-seeking behaviour, in Malawi*. Lilongwe: Department for International Development Malawi (DFID).
- Moyo, N., & Müller, J. C. (2011). The influence of cultural practices on the HIV and AIDS pandemic in Zambia. *HTS Theological Studies*, 67(3), 412–417.
- Munthali, T. (2004). *The impact of Structural Adjustment Policies (SAPs) on manufacturing growth in Malawi* (No. 0410002). EconWPA.
- Myroniuk, T. W. (2011). Global discourses and experiential speculation: Secondary and tertiary graduate Malawians dissect the HIV/AIDS epidemic. *Journal of the International AIDS Society*, 14(1), 47.
- NSO. (2008). *Multiple indicator cluster survey*. Zomba: National Statistical Office.
- NSO, M., & Macro, I. C. F. (2011). *Malawi demographic and health survey 2010*. Zomba, Malawi and Calverton, MD: NSO and ORC Macro.
- Poku, N. K. (2005). *AIDS in Africa: How the poor are dying*. Cambridge, UK: Polity Press.

- Poku, N. K., & Whiteside, A. (2004). Introduction: Africa's HIV/AIDS crisis. In N. K. Poku & A. Whiteside (Eds.), *The political economy of AIDS in Africa* (pp. xvii–xxii). Hampshire, UK: Ashgate.
- Riddell, J. B. (1992). Things fall apart again: Structural adjustment programmes in sub-Saharan Africa. *The Journal of Modern African Studies*, 30(1), 53–68.
- Sadasivam, B. (1997). The impact of structural adjustment on women: A governance and human rights agenda. *Human Rights Quarterly*, 19(3), 630–665.
- Smith, J. H., & Whiteside, A. (2010). The history of AIDS exceptionalism. *Journal of the International AIDS Society*, 13(1), 47.
- Stiglitz, J. (2000). What I learned at the world economic crisis. *Globalization and the poor: Exploitation or equalizer*, 195–204.
- Swidler, A., & Watkins, S. (2009). “Teach a man to fish”: The sustainability doctrine and its social consequences. *World Development*, 37(7), 1182–1196.
- The Guardian*. (2011). Britain expels Malawi ambassador in retaliation after envoy is ordered out. Retrieved June 14, 2011, from <http://www.theguardian.com/world/2011/apr/27/britain-malawi-ambassador-expelled?INTCMP=SRCH>.
- Tran, M. (2011). Britain suspends aid to Malawi. Retrieved July 14, 2011, from <http://www.guardian.co.uk/global-development/2011/jul/14/britain-suspends-aid-to-malawi>.
- UN. (2011). *One plan annual report: United Nations Country Team*. Lilongwe, Malawi: UN.
- UNAIDS. (2006). *2006 report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS.
- UNAIDS. (2007). *Practical guidelines for intensifying HIV prevention, towards universal access*. Geneva, Switzerland: UNAIDS.
- UNAIDS. (2008). *2008 report on the global AIDS epidemic*. Geneva, Switzerland: UNAIDS.
- Watkins, K. (2011). The millennium development goals: Three proposals for renewing the vision and reshaping the future. Retrieved October 10, 2013, from <http://www.scribd.com/doc/2442520/Millennium-Development-Goals>.
- World Bank. (2011). *Global monitoring report 2011: Improving the odds of achieving the MDGs*. Washington, DC: World Bank.
- World Bank. (2013). *Malawi overview*. Retrieved October 6, 2013, from <http://www.worldbank.org/en/country/malawi/overview>.
- Wroe, D. (2012). Donors, dependency, and political crisis in Malawi. *African Affairs*, 111(442), 135–144.
- Young, J., & Mendizabal, E. (2009). An anthropological critique of development: The growth of ignorance, volume 53 of ODI briefing paper. London: Overseas Development Institute.

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